



HEALTHCARE FACILITY REGULATION DIVISION

RE: Relocation of Ambulatory Surgical Centers (State Licensure)

This letter will provide information regarding the relocation of your Ambulatory Surgical Center (ASC). This Section is responsible for licensing ASCs under State Law and assisting the Centers for Medicare and Medicaid Services in performing the certification function for those providers wishing to participate in the Medicare program.

STATE LICENSURE APPLICATION REQUIREMENTS:

Before this Section can survey your facility for a license to operate an ASC at the new location, you must submit the following documents:

- 1 A completed application to operate an ASC.
- 2 A copy of the CON or LNR (Letter of Non-Reviewability) authorizing the relocation.
- 3 A copy of the construction plan approval and final inspection and occupancy letters issued by the state architect.
- 4 A copy of the fire safety authority (city, county, or state) inspection report which states an inspection has been made of the premises and that state and local fire safety requirements have been met.
- 5 Copy of the certificate of occupancy for the ASC.

STATE LICENSURE SURVEY:

Please mail the completed application and the CON or LNR to the attention of the Program Director of the Acute Care Unit at 2 Peachtree St., NW, Suite 31-447, Atlanta, Georgia 30303-3142 as soon as possible. The remaining required documents may be faxed to 404-657-8934. As soon as you can determine a date when the center will be ready, please contact this office to make arrangements for your licensure survey. The survey process consists of a tour of your facility to ensure that all preparations are complete and the center is ready to receive its first patient. Surgery may not be performed at the new location until the licensure survey is completed and any deficiencies found corrected.

ISSUANCE OF A PERMIT NUMBER:

At the conclusion of the survey, if your facility has been found to be in full compliance with the Rules and Regulations for Ambulatory Surgical Treatment Centers (Chapter 290-5-33), your permit will be issued effective the last day of the survey. If deficiencies are cited, your permit will be issued effective the date this Section receives an acceptable plan of correction.

Under State law and regulations, you must notify this Section at least 30 days in advance of any change in ownership. The State Permit is not transferable.

MEDICARE APPLICATION REQUIREMENTS:

If your ASC is also Medicare certified, in order to make the relocation change with Medicare, two forms must be completed. You must submit a completed Form CMS-377 noting all information for the new ASC location. This form should be mailed with the State application.

Second, you must provide the Medicare Administrative Contractor (Carrier) with an updated supplier enrollment application (855B form). Supplier enrollment applications (855B forms) are available for downloading at <http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf> along with a user's guide providing instructions for completing the forms. The Carrier for Georgia is Cahaba Government Benefits Administrators, LLC. The supplier enrollment application (855B) must be submitted directly to Cahaba GBA, Attn: Georgia Provider Enrollment, P.O. Box 12967, Birmingham, AL 35202. The Carrier can be reached by calling Provider Enrollment at 1-866-582-3246. If you require help or assistance in completing the CMS 855B form, contact the Carrier, not the Healthcare Facility Regulation Division (HFRD). The Carrier will notify HFRD of its recommendation for approval or denial of enrollment for your ASC. HFRD cannot complete the change in location with Medicare until the Carrier approves your enrollment application (855B) and HFRD is notified.

If we can be of further assistance to you, please contact the Acute Care Unit Program Director at (404) 657-5449.

ENCLOSURES:

**License Application
Form CMS-377**

**DEPARTMENT OF COMMUNITY HEALTH
HEALTHCARE FACILITY REGULATION DIVISION
HEALTH CARE SECTION
2 PEACHTREE STREET NW
SUITE 31-447
ATLANTA, GEORGIA 30303-3142**

APPLICATION FOR A PERMIT TO OPERATE AN AMBULATORY SURGICAL TREATMENT CENTER

Pursuant to O.C.G.A. 31-7-1 et seq. Application is hereby made to operate the Ambulatory Surgical Center which is identified as follows:

SECTION A - IDENTIFICATION

Date of application: _____ Type of application: Initial _____ Change of Ownership _____ Address _____ Name _____
Scope of Services _____ Other _____

Name of Ambulatory Surgical Center (This name will appear on Permit)			

Address _____	City _____	County _____	Zip+4 _____
Phone: (____) _____ - _____ FAX: (____) _____ - _____ E-Mail Address: _____			

Official Name and Address of ASTC Governing Body			

Name of Person Delegated Responsibility for Day-to-Day Management/Administration of ASTC (regulation 290-5-35-.03 (5))			
_____			Title: _____

Agent for Service/Legal Representative name: _____			

Complete Address of Agent for Service/Legal Representative			

Classification (check one)

Single or Multi-Specialty (Certificate of Need required)

Physician Owned Single Specialty (Letter of Nonreviewability required)

List Type and Scope of Surgical Services (refer to regulation 290-5-33-. 04)

Number of Operating Rooms

Number of Minor Procedure Rooms

Patient Capacity of Recovery Rooms

Days and Hours of Operation (for the ASTC only)

SECTION B – STAFF

List Names, Addresses, and Specialty of Professional Director and Other Physicians on the Medical Staff

Professional Director: _____

 _____

SECTION C – PROVISIONS FOR CARE

List All Health Care Providers with whom the Center has Arrangements/Contracts (specify services)

Name

Service

SECTION D – OWNERSHIP INFORMATION

Type of Ownership

Individual

Partnership

Corporation

Other (specify) _____

1. List Names and Addresses of All Owners with 5% or More Interest (refer to regulation 290-5-33-.03 (2))

2. Centers Organized as a Corporation or Partnership – List Names and Addresses of Officers of the Corporation or Principle Partners

SECTION E – CERTIFICATION

I certify that this Facility is devoted primarily to the provision of **SURGICAL** treatment to patients not requiring hospitalization and that this facility will operate in accordance with the rules and regulations governing ambulatory surgical treatment centers. I further certify that the information provided in connection with this application is true to the best of my knowledge and belief. (Refer to regulation 290-5-33-.01 (A))

Signature of Principal Officer of Governing Board

Title

Date

(For Department Of Community Health Use Only)

Date Received

Center Permit Number

Reviewed by

Effective Date

Fire Safety Statement Attached: Yes No

Approved

Date

Copy of CON or LNR Attached: Yes No

AMBULATORY SURGICAL CENTER REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Please see statement on reverse and read the following instructions before completing this form)

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions of Coverage are met. Assistance in completing the form is available from the State agency.

Answer all questions as of the current date. Return the original and first two copies to the State agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

Medicare Supplier Number - Insert the facility's six-digit supplier number. Leave blank on initial requests for certification.

Related Provider Number - Complete this block when a facility is participating under more than one provider number, such as a facility also

participating as a hospital. The number in this block for each related provider will be the provider number of the highest level of care.

NOTE: If an ASC is operated by a hospital, has a Distinct Part SNF, ICF and ICF/MR, the related provided number field on the application for each provider (including the hospital) will have the hospital provider number.

State/County and State Region Codes - Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.

Item III - If a service is provided directly by the facility, place a '1' in the appropriate block. If a service is provided through an outside source (i.e., by contract or referral), place a '2' in the appropriate block.

Item IV - 'X' the appropriate blocks representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties).

Medicare Supplier Number <small>AS1</small>	Related Provider Number <small>AS2</small>	State/County Code <small>AS3</small>	State Region Code <small>AS4</small>	Fiscal Year Ending Date <small>AS5</small>
I IDENTIFYING INFORMATION	Name of Facility		Street Address	
	City, County, and State		Zip Code	Telephone No. (Include Area Code) <small>AS6</small>
II TYPE OF CONTROL (x one box) <small>AS7</small>	1. <input type="checkbox"/> Proprietary		2. <input type="checkbox"/> Non-Profit	3. <input type="checkbox"/> Government
III ANCILLARY SERVICES (Place '1' or '2' in blocks) <small>AS8</small>	1. <input type="checkbox"/> Laboratory	2. <input type="checkbox"/> Radiology	3. <input type="checkbox"/> EKG	4. <input type="checkbox"/> Pharmacy
IV SURGICAL SPECIALTIES (X appropriate blocks) <small>AS9</small>	1. <input type="checkbox"/> Cardiovascular	6. <input type="checkbox"/> Ophthalmology	11. <input type="checkbox"/> Thoracic	
	2. <input type="checkbox"/> Foot	7. <input type="checkbox"/> Oral	12. <input type="checkbox"/> Urology	
	3. <input type="checkbox"/> General	8. <input type="checkbox"/> Orthopedic	13. <input type="checkbox"/> Other (Specify) _____	
	4. <input type="checkbox"/> Neurological	9. <input type="checkbox"/> Otolaryngology	_____	
	5. <input type="checkbox"/> Obstetrics/Gynecology	10. <input type="checkbox"/> Plastic		
V FACILITY CHARACTERISTICS	1. Number of Operating Rooms _____ <small>AS10</small>		2. Date Center Began Providing Services _____ <small>AS11</small>	

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR A REQUEST TO PARTICIPATE OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Signature of Authorized Official (sign in ink)	Title	Date
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According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0266. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

STATE OF GEORGIA)
)
COUNTY OF _____) AFFIDAVIT RE: PERSONAL IDENTIFICATION
) FOR LICENSURE/REGISTRATION

PERSONALLY APPEARED before the undersigned officer, duly authorized to administer oaths, came the undersigned, who after having been duly sworn, states under oath, the following:

1. That my name is _____ and that I am who I say I am;
2. That my address is _____;
3. That I have presented sufficient personal identification to the notary that is true and accurate;
4. That I am legally in the United States of America;
5. That I am applying to the Georgia Department of Community Health, Healthcare Facility Regulation Division, to operate a business/activity that is subject to regulation by the Department of Community Health; and that this affidavit is a material part of the application; and
6. That if the Department subsequently determines that the material information contained in this affidavit is false, I will be in violation of licensing/registration requirements, which may result in revocation of my license or registration.

Sworn to and subscribed before me)
This _____ day of _____, ____)
)
)
)
) _____
) Affiant

NOTARY PUBLIC)
STATE OF GEORGIA)

My commission expires: _____.

LIST B

Documents That Establish Identity

For individuals 18 years of age or older

- Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
- ID card issued by federal, state, or local government agencies or entities provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address (including U.S. Citizen ID Card [INS Form I-197] and ID Card for use of Resident Citizen in the U.S. [INS Form I-179])
- School identification card with photograph
- Voter's registration card
- United States military card or draft record
- Military dependent's identification card
- United States Coast Guard Merchant Mariner Card
- Native American tribal document
- Driver's license issued by a Canadian government authority

Source: http://uscis.gov/graphics/lawsregs/handbook/hand_emp.pdf US Handbook for Employers, page 23.