



## Drug Abuse Treatment and Education Program Application Packet

Applications must be completed online through the application portal: <https://gahles.dch.georgia.gov/>

All applicable documents listed below must be uploaded to the portal. You will receive an acknowledgement email once the application has been submitted.

Applications are reviewed in the order they are received. The initial review of the application will be completed within **30 business days** from the application submission date. If additional information or documentation is required, you will receive an email from the Department with instructions. **Failure to submit requested information, documents, or pay required fees will result in the denial of your application. Application fees are non-refundable.**

Rules and Regulations for Drug Abuse Treatment and Education Programs can be accessed here: <https://rules.sos.ga.gov/gac/111-8-19>

For general application questions, please email the Department at [Licensure.Application@dbhdd.ga.gov](mailto:Licensure.Application@dbhdd.ga.gov).

Documentation required to be submitted with the application:

### **Initial:**

- 1.) Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not applicable, provide documentation showing legal authority.
- 2.) City/County zoning approval.
- 3.) Notarized affidavit of personal identification (form attached below).
- 4.) Copy of photo ID that was shown to the notary public.
- 5.) Proof of ownership/legal control of the property (deed, lease, or bill of sale).
- 6.) Fire safety inspection report performed by the state fire marshal (must be completed within 12 months of application submission date).
- 7.) Facility floor plan that includes square footage of all rooms.
- 8.) Certificate of Occupancy for the building.
- 9.) Clinical Laboratory Improvement Amendment Certification or Waiver (CLIA) if diagnostic drug testing will be performed onsite. If testing occurs off-site, provide a copy of the CLIA for the vendor performing the testing.
- 10.) Medication Assisted Treatment (MAT) Affidavit, as applicable (form attached below).
- 11.) Sanitation agreement.

**Change of Ownership:**

- 1.) Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not applicable, provide documentation showing legal authority.
- 2.) Notarized affidavit of personal identification (form attached below).
- 3.) Copy of photo ID that was shown to the notary public.
- 4.) Proof of ownership/legal control of the property (deed, lease, or bill of sale).
- 5.) Executed legal transaction documents for the business entity (bill of sale, closing documents, etc.).  
The document must be signed by the previous governing body/owner and include the effective date.

**Relocation:**

- 1.) City/County zoning approval.
- 2.) Notarized affidavit of personal identification (form attached below).
- 3.) Copy of photo ID that was shown to the notary public.
- 4.) Proof of ownership/legal control of the property (deed, lease, or bill of sale).
- 5.) Fire safety inspection report performed by the state fire marshal (must be completed within 12 months of application submission date).
- 6.) Facility floor plan that includes square footage of all rooms.
- 7.) Certificate of Occupancy for the building.
- 8.) Clinical Laboratory Improvement Amendment Certification or Waiver (CLIA) if diagnostic drug testing will be performed onsite. If testing occurs off-site, provide a copy of the CLIA for the vendor performing the testing.
- 10.) Sanitation agreement.

**Increase in Capacity:**

- 1.) Notarized affidavit of personal identification (form attached below).
- 2.) Copy of photo ID that was shown to the notary public.
- 3.) Fire safety inspection report performed by the state fire marshal (must be completed within 12 months of application submission date).
- 4.) Facility floor plan that includes square footage of all rooms.

**Governing Body Name Change (not change of ownership):**

- 1.) Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not applicable, provide documentation showing legal authority.
- 2.) Notarized affidavit of personal identification (form attached below).
- 3.) Copy of photo ID that was shown to the notary public.
- 4.) Letter on business letterhead explaining the governing body name change and effective date.

**Change in Service (add/remove), Decrease in Capacity, Change in ASAM Level, Change in Population Served or Facility Name Change:**

- 1.) Notarized affidavit of personal identification (form attached below).
- 2.) Copy of photo ID that was shown to the notary public.

# O.C.G.A. § 50-36-1(f)(1)(B) Affidavit

By executing this affidavit under oath, as an applicant for a license, permit or registration, as referenced in O.C.G.A. § 50-36-1, from the Department of Behavioral Health and Developmental Disabilities, the undersigned applicant verifies one of the following with respect to the application for public benefit:

- 1.) \_\_\_\_\_ I am a United States citizen
  
- 2.) \_\_\_\_\_ I am a legal permanent resident of the United States
  
- 3.) \_\_\_\_\_ I am a qualified alien or non-immigrant under the Federal immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. My alien number is: \_\_\_\_\_

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1 (f)(1)(A), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as:

\_\_\_\_\_.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, in, \_\_\_\_\_, \_\_\_\_\_.

(day)                      (month)                      (year)                      (city)                      (state)

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Printed Name of Applicant**

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE  
\_\_\_\_\_ DAY OF \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC

My Commission Expires: \_\_\_\_\_



Georgia Department of Behavioral Health and Developmental Disabilities

Medication Assisted Treatment (MAT) Affidavit for Drug Abuse Treatment and Education Program (DATEP)

<b>Name of Facility</b> (DATEP Licensee)	
<b>Name of Affiant</b> (Authorized representative of Governing Body)	
<b>Facility Address:</b>	
<b>County:</b>	
<b>State:</b>	

**Before me, the undersigned authority personally appeared who, being duly sworn by me, affirms as follows:**

- A. I, the above-named Affiant, have personal knowledge of the matters addressed in this affidavit and the attestations made herein.
- B. I am over 18 years of age, and I am of sound mind and capable of making this affidavit in support of the facts stated herein.
- C. I am a duly authorized representative of the governing body of the above-named DATEP Licensee which is licensed by the Department of Behavioral Health and Developmental Disabilities.
- D. I acknowledge that DATEPs are subject to regulation pursuant to O.C.G.A. § 50-36-1 et seq., Comp. Rules and Regulations 111-8-19 and 111-8-53, hereinafter known as the “body of controlling laws.”
- E. The DATEP will adhere to all rules and regulations outlined in the body of controlling laws.
- F. Buprenorphine and Suboxone will only be prescribed and dispensed by a holder of a Drug Enforcement Administration (DEA) Controlled Substance Registration Certificate permitting the holder to prescribe and dispense Schedule III medications for Opioid Use Disorder.
- G. The DATEP will ensure that all Medication-Assisted Treatment (MAT) services provided are compliance with applicable state and federal laws and regulations.



**D·B·H·D·D**

**MAT Affidavit Continued**

- H. The DATEP does not function as a methadone clinic which would require licensure as a Narcotic Treatment Program pursuant to O.C.G.A. § 26-5-44.
  
- I. I understand and acknowledge that the Department of Behavioral Health and Developmental Disabilities will rely upon the sworn statements made herein.

\_\_\_\_\_  
**Signature of Affiant**

\_\_\_\_\_  
**Printed Name of Affiant**

\_\_\_\_\_  
**Title / Position of Affiant**

\_\_\_\_\_  
**Date of Signature**

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE  
\_\_\_\_\_ DAY OF \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC  
My Commission Expires: \_\_\_\_\_