Georgia
Certificate of Need Application

FOR OFFICE OF HEALTH PLANNING USE ONLY	
PROJECT NUMBER **GA**	DATE STAMP
COUNTY:	Signed Original ________ Fee Verified ________

GENERAL INFORMATION:

The Certificate of Need (CON) application is the required document that the Department reviews in the analysis and evaluation of proposed projects to establish or expand healthcare services and facilities in accordance with CON Administrative Rule 111-2-2. Requests to develop or offer new institutional health services must be completed and submitted ***only*** on the Department's application and supplemental forms, which are available at the Department's website: https://dch.georgia.gov/con-applications-and-forms.

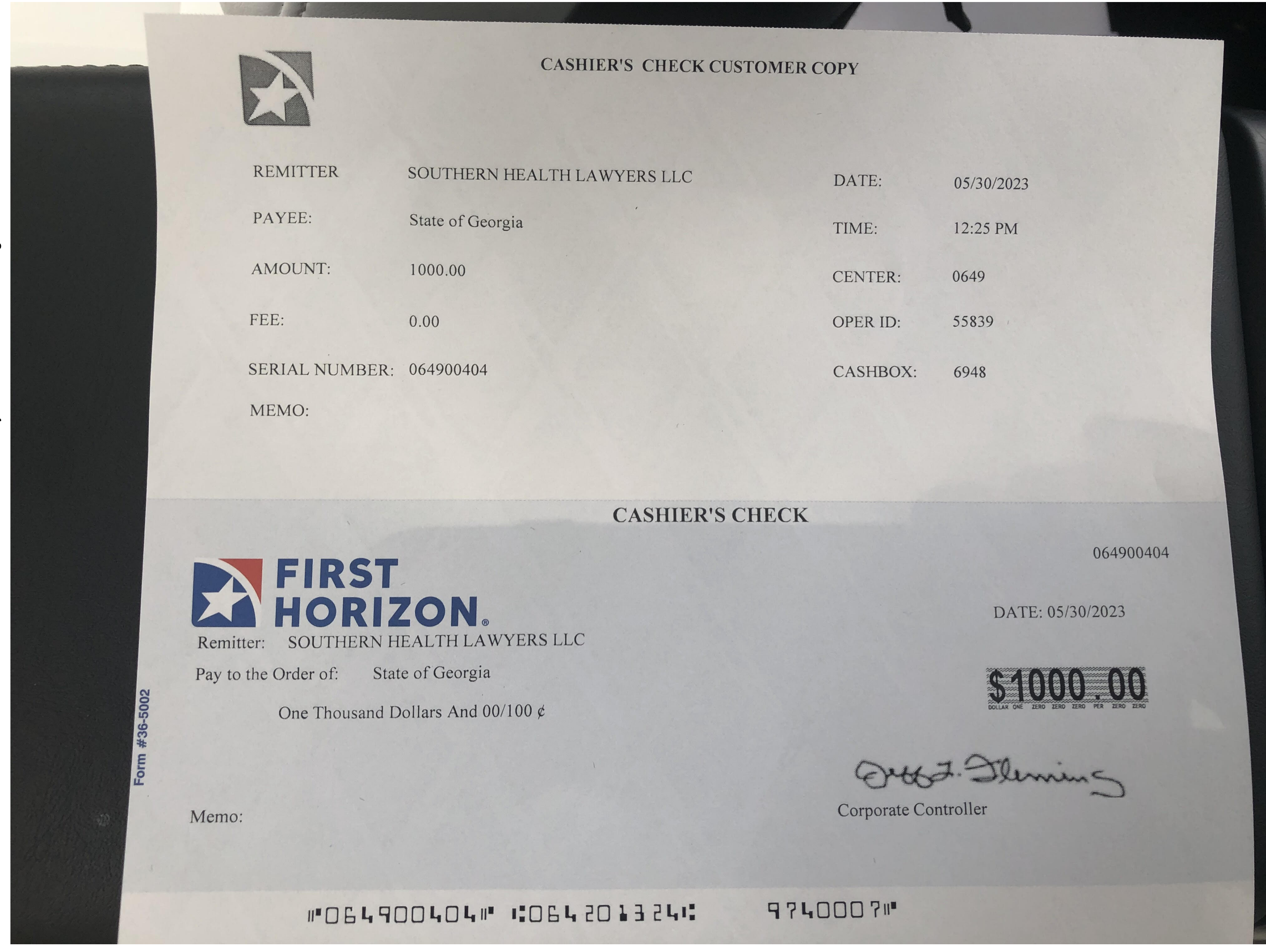
1. Applicants must submit one (1) copy of the signed application. The application must be submitted electronically using the Department's web portal available here: https://dch.georgia.gov/office-health-planning-applications-and-requests-forms-0.

2. The filing fee shall be made payable to the "State of Georgia" and shall be remitted by Certified Check or Money Order. A copy of the Certified Check or Money Order must be included with your web portal submission.

3. Failure to submit the required filing fee and a complete copy of the application will result in non-acceptance of the application.

4. Applications received after 3 p.m. will be deemed accepted the next business day.

PLEASE COMPLETE THE FOLLOWING TABLE TO VERIFY PROPER SUBMISSION OF YOUR APPLICATION	
Applicant Legal Name: Axzons Homecare Ltd.	
1. Have you submitted one (1) copy of this signed application via the Department's web portal?	■ **Yes** ☐ **No**
2. Is this application being filed by or on behalf of a hospital in a rural county? *("Rural County" means a county having a population of less than 50,000 according to the United States decennial census of 2010 or any future such census. Ga. Comp. R. & Regs. r. 111-2-2-.01(52))* If **YES** ➔ No filing fee is due. Enter $0 at Line 4. If **NO** ➔ Continue to next question.	☐ **Yes** ☐ **No**
3. Enter Total Cost Applicable to Filing Fee *(From Line 16, Question 22, Page 13)*	$85,000
4. Calculate the Filing Fee and Total Amount Due *(Check one of the following and enter the amount in the column to the right)* ■ Line 3 is between 0 to $1 million ➔ Enter $1,000.00 ☐ Line 3 is between $1million and $50 million ➔ Enter Line 2 x .001 ☐ Line 3 is greater than $50 million ➔ Enter $50,000.00	$1000
5. Have you submitted payment by Certified Check or Money Order made payable to the "State of Georgia" for the amount listed in Line 4 above?	■ **Yes** ☐ **No** ☐ **N/A**



CASHIER'S CHECK CUSTOMER COPY

REMITTER	SOUTHERN HEALTH LAWYERS LLC	DATE:	05/30/2023
PAYEE:	State of Georgia	TIME:	12:25 PM
AMOUNT:	1000.00	CENTER:	0649
FEE:	0.00	OPER ID:	55839
SERIAL NUMBER:	064900404	CASHBOX:	6948
MEMO:			

CASHIER'S CHECK

064900404

FIRST HORIZON®

DATE: 05/30/2023

Remitter: SOUTHERN HEALTH LAWYERS LLC

Pay to the Order of: State of Georgia

$1000.00

DOLLAR ONE ZERO ZERO ZERO PER ZERO ZERO

One Thousand Dollars And 00/100 ¢

Form #36-5002

Memo:

Corporate Controller

⑈064900404⑈ ⑆064201324⑆ 9740007⑈

COMPLETENESS CHECKLIST

Please complete the following checklist to ensure that you have included all necessary materials to deem your application complete. Please note that completion of this checklist does not mean that your application is indeed complete as the Department will need to verify the adequacy and completeness of the materials provided. Nevertheless, this checklist should prove helpful as a way to double check before submission of your application.

Item Required	Location	Check if Included	Check if N/A
Copy of Licenses/Permits (for existing facilities)	Question 3, Page 1 & 🗁 Attached at **APPENDIX B**	☐	■
Authorization to Conduct Business	Question 8, Page 3-4 & 🗁 Attached at **APPENDIX C**	■	
Lobbyist Disclosure	Question 13, Page 6	■	
Documentation of Site Entitlement	Question 17, Page 8 & 🗁 Attached at **APPENDIX D**	■	
Detailed Description of the Proposed Project	Question 18, Page 9	■	
Financial Program	Questions 22, Page 13	■	
Equipment Purchase Orders/Invoices	Question 22, Page 13 & 🗁 Attached at **APPENDIX G**	☐	■
Proof of Necessary Financing	Question 23, Page 14 & 🗁 Attached at **APPENDIX G**	■	
Financial Statements	Question 24, Page 14 & 🗁 Attached at **APPENDIX G**	■	
Financial Pro Forma	Question 25, Pages 15-19	■	
Architect Cost Estimates (Certified within 60 days)	Question 32, Page 26 & 🗁 Attached at **APPENDIX I**	☐	■
Schematic Plans	Question 32, Page 26 & 🗁 Attached at **APPENDIX I**	☐	■
All Applicable Service-Specific Review Considerations	Question 48, Page 37 et seq. & 🗁 Attached at **APPENDIX N** etc.	■	☐
Signature (In Blue Ink)	Page 39	■	☐

Question	Response
Have you submitted a copy of this application to the County Commission in the County where the project will be located? Proof of such submission must be included with this application. 🗁 Attach such proof at **APPENDIX A**.	■ YES ☐ NO
Have you submitted a complete copy of said application? The application must include a copy of the signature at Page 39.	■ YES ☐ NO
Have you included the appropriate filing fee as calculated and reported on the cover page of this application? The filing fee must be made payable by Certified Check or Money Order.	■ YES ☐ NO ☐ N/A
Have all required surveys of the Applicant and any and all affiliate organizations been submitted to the Office of Health Planning for the most recent three (3) years?	■ YES ☐ NO
Has post-approval reporting for any and all previous Certificate of Need projects of the Applicant and any and all affiliate organizations been submitted to the Certificate of Need Program, if such reporting is due?	■ YES ☐ NO
Has the Applicant and any and all affiliate organizations satisfied previous indigent and charity care commitments?	■ YES ☐ NO
Has the Applicant satisfied any and all fines, if any, which have been levied by the Department for violation of the Certificate of Need Rules or Statute?	■ YES ☐ NO

INSTRUCTIONS

1. **Please read all instructions and review the application form before attempting to complete and submit the application.**

2. **A CON application must be submitted on the Department's application and supplemental forms only. Supplemental forms are provided for letters of opposition, additional and amended information. These forms may be obtained on the Department's website: https://dch.georgia.gov/con-applications-and-forms.**

3. **In completing the CON application, if a particular rule or consideration requires substantiating documents such as a finance letter or architect's letter as an appendix, the requested documents must be placed with the noted appendix without exception and must conform to the Instructions for Organization of Appendices on the next page of these instructions.**

4. **This application must be typewritten or completed and printed in this MS Word format. Handwritten responses must not be submitted and will not be accepted.**

5. **All questions must be answered. If a question is not applicable, so indicate.**

6. **Throughout this application, the following symbols are utilized for emphasis:**

   🗁 **Emphasizes instances where supporting documentation is requested and required to be attached into an Appendix; and**

   ☞ **Emphasizes important instructions or notes that should be adhered to.**

7. **A signed application (in the correct organizational structure) is required in addition to the appropriate filing fee for an application to be accepted by the Department. Please review the CON administrative rules for detailed explanation of appropriate fees, filing dates, and times.**

8. **Please remit the following items to the address below: a copy of the web portal submission confirmation form; and, the filing fee in the form of a Certified Check or Money Order made payable to the "State of Georgia."**

   Department of Community Health
   Office of Health Planning
   CON Application
   2 Peachtree Street, NW, 5th Floor
   Atlanta, Georgia 30303

9. **Faxed copies of documents and information are not official submissions. All submissions must be via the Department's web portal.**

10. **If you are seeking an emergency review per Rule 111-2-2-.07(1)(k), include a cover letter behind the main cover page of this application expressing the reasons that an emergency review should be granted.**

INSTRUCTIONS FOR
ORGANIZATION OF APPENDICES

The organization of appendices is mandated by this application and the Table of Appendices that follows.

APPLICANTS MUST NOT VARY FROM THIS ORGANIZATIONAL STRUCTURE.

1. Appendices must be separated by lettered tabs.

2. Each Appendix may have more than one document in which case the Appendix must be separated by dividing sheets. Dividing sheets must be appropriately labeled with the Appendix Letter and the name of the document that follows the sheet. The documents within such an Appendix should be organized in the order in which they are requested in this application.

3. In the event there are no applicable documents pertaining to a specified Appendix in the table below, include the appropriate lettered tab with a sheet of paper indicating “Not Applicable.”

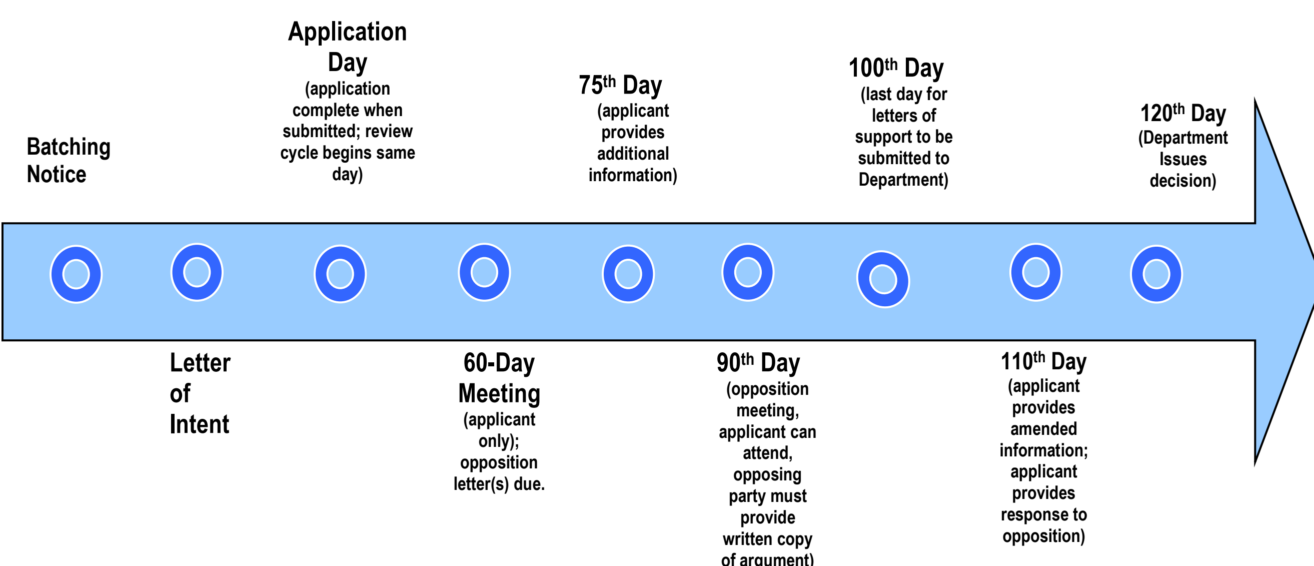
TABLE OF APPENDICES	
Appendix Name	**Appendix Letter**
Proof of Submission to County Commission	A
Licenses/Permits	B
Organizational Structure	C
Site Entitlement	D
Supplemental Need Documentation	E
Supplemental Existing Alternatives Documentation	F
Required Financial Feasibility Documentation	G
Supplemental Effects on Payors Documentation	H
Architectural Documentation	I
Required Financial Accessibility Documentation	J
Supplemental Documentation re: Relationship to Health Care Delivery System	K
Supplemental Documentation re: Efficient Utilization, Non-Resident Services, Research Projects, Assistance to Health Professional Programs, Improvements and Innovation, Needs of HMOs, Quality Standards, Resources and Provision of Underreported health services, if applicable.	L
Letters of Support	M
Required Documentation for Service-Specific Review Considerations (See Page 37 and 38 for Explanation)	N, O, etc.

☞ **NOTE:** *Supplemental documentation is documentation such as magazine articles, research papers, newspaper articles, etc., which cannot be reproduced or created in MS Word format.*

OVERVIEW OF REVIEW PROCESS

BATCHED APPLICATIONS

SEQUENCE OF CERTIFICATE OF NEED APPLICATION REVIEW ACTIVITIES



► Batching Notice issued 30 days before Letter of Intent Due

► Letter of Intent received by Department 30 days before application is submitted

► Applications submitted; deemed complete; review cycle begins

► 60-Day meeting (applicant only); deadline for receipt of opposition letter(s)

► 75th day – applicant provides additional information

► 90th day – Opposition Meeting(s) scheduled; applicant can be in attendance; opposing parties must provide written statement of opposition arguments presented to the Department via the online web portal and provide a copy to the applicant; presentation time will be limited; Department reserves the right to make additional inquiries subsequent to the 60-day meeting and following the opposition meeting.

► 100th day last day for letters of support to be submitted to the Department

► 110th day applicant deadline for submitting amended information; applicant deadline for providing written response to opposition due to Department; applicant deadline for providing written response to Department's inquiries subsequent to opposition meeting

► 120th day Decision issued (No discretion to extend)

NON-BATCHED APPLICATIONS

SEQUENCE OF CERTIFICATE OF NEED APPLICATION REVIEW ACTIVITIES

Letter of Intent

Application submitted (10 days to review for completeness)

Application deemed complete (review cycle begins)

60-Day Meeting (applicant only); deadline for receipt of opposition letter(s)

75th Day (applicant provides additional information)

90th Day (opposition meeting(s) scheduled; applicant can attend, opposing parties must provide written copy of argument)

100th Day (last day for letters of support to be submitted to Department)

110th Day (applicant provides amended information; applicant provides response to opposition)

120th Day (Department Issues decision)

150th Day (project can be extended)

► **Letter of Intent received by Department 30 days before application is submitted**

► **Application submitted (10 working days to review for completeness)**

► **Application deemed complete; 120-day review cycle begins**

► **60-day meeting (applicant only); deadline for receipt of opposition letter(s)**

► **75th day applicant provides additional information**

► **90th day – Opposition Meeting(s) scheduled; applicant can be in attendance; opposing parties must provide written statement of opposition arguments presented to the Department via the online web portal and provide a copy to the applicant; presentation time will be limited; Department reserves the right to make additional inquiries subsequent to the 60-day meeting and following the opposition meeting.**

► **100th day last day for letters of support to be submitted to the Department**

► **110th day applicant deadline for submitting amended information; applicant deadline for providing written response to opposition; applicant deadline for providing written response to Department's inquiries subsequent to opposition meeting**

► **120th day Decision issued (Department has discretion to extend to 150th day)**

Section 1: General Identifying Information

1. Enter the following information for the person or entity that will offer or develop the new institutional health service. If applicable, this information should correspond with the information submitted to the Department's Healthcare Facility Regulation Division as the "Name of the Governing Body." The contact person should be a person directly affiliated with the Applicant and not a consultant or attorney.

APPLICANT		
Applicant Legal Name: Axzons Homecare Ltd.		
d/b/a (if applicable):		
Address: 3715 Northside Parkway NW, Building 100, Suite 500		
City: Atlanta	State: GA	Zip: 30327
County: Fulton	Main Business Phone: 866-429-9677	
Parent Organization:		
CONTACT PERSON		
Name: Sandeep Kalra	Title or Position: Chief Executive Office	
Phone: 866-429-9677	Fax: 866-429-9667	
E-mail Address: skalra@axzonshomecare.com		

2. Is the name of the facility or proposed facility different than the Applicant's legal name? ☐ **YES** ☐ **NO**

If **YES** ➔ Enter the facility information below. If applicable, this information should correspond to the "Name of Facility" maintained by the Department's Healthcare Facility Regulation Division.

If **NO** ➔ Continue to the next question.

FACILITY		
Facility Name:		
Facility Address:		
City:	State:	Zip:
County:	Phone:	

3. If the facility is currently existing, is it currently licensed or permitted by the Department's Healthcare Facility Regulation Division?

☐ **YES** ☐ **NO** ☐ **Not Applicable**

If **YES** ➔ 🗁 Attach a copy of any and all licenses and permits at **APPENDIX B**.

If **NO** ➔ Continue to the next question.

If **Not Applicable** ➔ Check one of the following:
■ Not Currently Existing (Proposed Only)
☐ No License or Permit Required

4. Is the legal owner of the facility different than the Applicant? ☐ **YES** ☐ **NO**

If **YES** ➔ Identify the legal owner and all individuals or entities that own 10 percent interest or more in the facility. Include complete names, addresses, and telephone numbers.

If **NO** ➔ Continue to the next question.

OWNER #1		
Name:		
Address:		
City:	State:	Zip:
Phone:		
OWNER #2		
Name:		
Address:		
City:	State:	Zip:
Phone:		
OWNER #3		
Name:		
Address:		
City:	State:	Zip:
Phone:		

5. Check the appropriate box to indicate the type of **ownership of the Facility**. Check only **one** box.

TAX EXEMPT	☐ Not-for-Profit Corporation		
	☐ Public (Hospital Authority or Government)		
TAX PAYING	☐ General Partnership	■ Business Corporation	☐ Sole Proprietor
	☐ Limited Liability Partnership	☐ Limited Liability Corporation	

6. Will the **entire** facility be operated by an entity other than the Applicant or the legal owner?

☐ **YES** ☐ **NO**

If **YES** ➔ Identify the operator and include the complete name, address, and telephone number.

If **NO** ➔ Continue to Question 8.

OPERATOR		
Name:		
Address:		
City:	State:	Zip:
Phone:		

7. Check the appropriate box to indicate the type of **operator**. Check only **one** box.

TAX EXEMPT	☐ Not-for-Profit Corporation		
	☐ Public (Hospital Authority or Government)		
TAX PAYING	☐ General Partnership	☐ Business Corporation	☐ Sole Proprietor
	☐ Limited Liability Partnership	☐ Limited Liability Corporation	

8. Please provide documentation of the organizational and legal structure of the Applicant as indicated in the table below. 🗁 Attach this documentation as **APPENDIX C**. Please attach the documents in the order they are listed.

ORGANIZATIONAL STRUCTURE	
Not-for-Profit Corporation	☐ Name of Each Officer and Director ☐ Articles of Incorporation ☐ Certificate of Existence ☐ Bylaws ☐ Organizational Chart(s) ☐ Application/Authorization to do Business in Georgia (for Non-Resident Corporations)
Public (Hospital Authority or Government)	☐ All Governing Authority Approvals for this Application and Project ☐ Bylaws ☐ Organizational Chart(s)

ORGANIZATIONAL STRUCTURE	
Sole Proprietor	☐ County and Municipal Government Business Authorization Documents (e.g. Licenses, Permits, Etc.) ☐ Bylaws ☐ Organizational Chart(s)
General Partnership	☐ Name, Partnership Interest, and Percentage Ownership of Each Partner ☐ Partnership Agreement ☐ Certificate of Existence ☐ Bylaws ☐ Organizational Chart(s)
Limited Liability Partnership	☐ Name, Partnership Interest, and Percentage Ownership of Each Partner ☐ Partnership Agreement ☐ Certificate of Existence ☐ Certificate of Registration ☐ Articles of Organization ☐ Bylaws ☐ Organizational Chart(s)
Business Corporation	■ Name of Each Officer and Director ■ Articles of Incorporation ■ Certificate of Existence ■ Bylaws ■ Organizational Chart(s) ☐ Application/Authorization to do Business in Georgia (for Non-Resident Corporations)
Limited Liability Corporation	☐ Name of Each Officer and Director ☐ Articles of Incorporation ☐ Operating Agreement ☐ Certificate of Existence ☐ Bylaws ☐ Organizational Chart(s) ☐ Application/Authorization to do Business in Georgia (for Non-Resident Corporations)

9. If you have identified the Applicant as a Not-for-Profit Corporation, Business Corporation, or Limited Liability Corporation, explain the corporate structure and the manner in which all entities relate to the Applicant.

☞ **NOTE:** *Do not exceed the allotted space for your response.*

The applicant is a business corporation with a sister organization Axzons Homecare Corporation, operating a home healthcare agency in the state of New York. The applicant does not have any other organizations within the state of Georgia. See organizational documents in Appendix C for more detail.

10. Does the Applicant have Legal Counsel to whom legal questions regarding this application may be addressed?

■ **YES** ☐ **NO**

If **YES** ➔ Identify the lead attorney below.

If **NO** ➔ Continue to the next question.

LEGAL COUNSEL		
Name: Jeffrey Mustari, Esq.		
Firm: Southern Health Lawyers, LLC (a Sanders & Mustari Law Firm)		
Address: 3550 Lenox Road NE, 3 Alliance Center, Suite 2100		
City: Atlanta	State: Georgia	Zip: 30326
Phone: (404) 806-5575	Fax: (866) 871-2238	
Email: jmustari@southernhealthlawyers.com		

11. Did a Consultant prepare and/or provide information in this application? ☐ **YES** ☐ **NO**

If **YES** ➔ Identify the Consultant below.

If **NO** ➔ Continue to the next question.

CONSULTANT		
Name:		
Firm:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
Email:		

12. Does the Applicant wish to designate and authorize an individual other than the Applicant Contact listed in response to Question 1 to act as the representative of the Applicant for purposes of this application?

■ **YES** ☐ **NO**

If **YES** ➔ Please complete the information in the table on the next page. By doing so, the Applicant authorizes the representative to submit this CON application and make amendments thereto; to provide the Department of Community Health with all information necessary for a determination on this application; to enter into agreements with the Department of Community Health in connection with this CON; and to receive and respond, if applicable, to notices in matters relating to this CON.

If **NO** ➔ Continue to the next question.

AUTHORIZED REPRESENTATIVE		
Name: Jeffrey Mustari, Esq.		
Firm: Southern Health Lawyers, LLC (a Sanders & Mustari Law Firm)		
Address: 3550 Lenox Road NE, 3 Alliance Center, Suite 2100		
City: Atlanta	State: Georgia	Zip: 30326
Phone: (404) 806-5575	Fax: (866) 871-2238	
Email: jmustari@southernhealthlawyers.com		

☞ **NOTE:** *This authorization will remain in effect for this application until written notice of termination is sent to the Department of Community Health that references the specific CON application number. Any such termination must identify a new authorized representative. Also, if the authorized representative's contact information changes at any time, the Applicant must immediately notify the Department of Community Health of any such change.*

13. Does the Applicant have any lobbyist employed, retained, or affiliated with the Applicant directly or through its contact person or authorized representative?

☐ **YES** ☐ **NO**

If **YES** ➔ Please complete the information in the table below for each lobbyist employed, retained, or affiliated with the Applicant. Be sure to check the box indicating that the Lobbyist has been registered with the State Ethics Commission. Executive Order 10.01.03.01 and Rule 111-1-2-.03(2) require such registration.

If **NO** ➔ Continue to the next question.

LOBBYIST DISCLOSURE STATEMENT		
Name of Lobbyist	**Affiliation with Applicant**	**Registered with State Ethics Commission?**
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No
	☐ Employed ☐ Other Affiliation	☐ Yes ☐ No

Section 2: Project Description

14. Indicate the type of facility that will be involved in the project.

FACILITY TYPE	
☐ Birthing Center	☐ Hospital
☐ Continuing Care Retirement Community (CCRC)	☐ Nursing or Intermediate Care Facility
☐ Freestanding Ambulatory Surgery Center	☐ Personal Care Home
■ Home Health Agency	☐ Traumatic Brain Injury Facility
☐ Freestanding Emergency Department	
☐ Diagnostic, Treatment or Rehabilitation Center (DTRC) ☐ Freestanding Single-Modality Imaging Center ☐ Mobile Imaging ☐ Other:	☐ Freestanding Multi-Modality Imaging Center ☐ Practice-Based Imaging

15. Indicate the services that will be involved or affected by this project.

SERVICES		
ACUTE	***Hospital Inpatient***	***Diagnostic Services***
	☐ Medical/Surgical	☐ Computerized Tomography (CT) Scanner
	☐ Open Heart Surgery	☐ Magnetic Resonance Imaging (MRI)
	☐ Pediatric	☐ Positron Emission Tomography (PET)
	☐ Obstetrics	☐ Diagnostic Center, Cancer/Specialty
	☐ ICU/CCU	
	☐ Newborn, ICU/INT	***Other Outpatient Services***
	☐ Newborn/Nursery	☐ Ambulatory Surgery
	☐ Rehabilitation	☐ Birthing Center
	☐ Acute, Burn, Other Specialty	
	☐ Long Term Acute Care	***Clinical/Surgical***
	☐ Inpatient, Other	☐ Emergency Medical
	☐ Psychiatric, Adult	☐ Emergency Medical, Trauma Center
	☐ Substance Abuse, Adult	☐ Adult Cardiac Catheterization
	☐ Psychiatric, Child/Adolescent	☐ Gamma Knife
	☐ Substance Abuse, Child/Adolescent	☐ Lithotripsy
	☐ Psychiatric, Extended Care	☐ Pediatric Cardiac Catheterization
	☐ Destination Cancer Hospital	☐ Megavoltage Radiation Therapy
LONG-TERM	☐ Skilled Nursing Care	☐ Personal Care Home
	☐ Intermediate Nursing Care	☐ Traumatic Brain Injury (TBI)
	☐ Continuing Care Retirement Community (CCRC)	■ Home Health
OTHER	☐ Administrative Support	☐ Grounds/Parking
	☐ Non-Patient Care, Other	☐ Medical Office Building

16. Check the most appropriate category(ies) for this project. Check all that apply.

PROJECT CATEGORY	
Construction	***Service Change***
☐ New Facility	■ New Service
☐ Expansion of Existing Facility	☐ Expansion of Service
☐ Renovation of Existing Facility	☐ Expansion or Acquisition of Service Area
☐ Replacement of Existing Facility	☐ Consolidation of Service
Procurement of Medical Equipment	☐ Relocation of Facility
☐ Purchase	☐ Other
☐ Lease	
☐ Donation (fair market value must be used)	

17. Please provide the following site information for the facility and services identified in this application. Check the appropriate box to indicate the current status of the site acquisition. 🗁 Attach the appropriate documents that provide for the Applicant's entitlement to the site at **APPENDIX D**.

☞ **NOTE:** *If an unsigned lease is attached, include a letter documenting both parties' commitment to participate in the lease once the CON is approved, if applicable.*

PROJECT SITE INFORMATION		
Street Address: 1201 Front Avenue, Suite N		
City: Columbus	County: Muscogee	Zip: 31901
Number of Acres: .001		
Status of Site Acquisition		
☐ Purchased (attach deed)	☐ Leased (attach lease)	
■ Under Option (attach option agreement)	☐ Under Contract (attach contract or bill of sale)	
☐ Other; please specify:		
Zoning		
Is the site appropriately zoned to permit its use for the purpose stated within the application?	■ YES ☐ NO	
If NO ➔ Describe what steps have been taken to obtain the correct zoning and the anticipated date of re-zoning:		
Encumbrances		
Are there any encumbrances that may interfere with the use of the site, such as mortgages, liens, assessments, easements, rights-of-way, building restrictions, or flood plains?	☐ YES ■ NO	

18. Provide a detailed description of the proposed project including a listing of the departments (e.g. ED, ICU), services, (e.g. Home Health, Cardiac Cath), and equipment (e.g. MRI, PET, Cath) involved.

☞ **NOTE:** *If your description exceeds this blocked space, attach additional 8-½ by 11-inch pages, number the first sheet Page 9.1, the second Page 9.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 9.1, etc. behind this Page 9.*

See description on attached pages.

18. Detailed Description of Proposed Project, Home Health Services:

Axzons Homecare, Ltd., (hereafter referred to as "Axzons") is a new entity in Georgia that is seeking to establish a new home health agency in Georgia. Axzons has a sister organization (Axzons Health System Corp.) that is an existing home health agency licensed to serve 47 counties within New York State, including New York City. Axzons is seeking a Certificate of Need (CON) to establish a home health agency in State Service Delivery Region 8 (SSDR-8) Counties: Chattahoochee, Randolph, Clay, Schley, Dooly, Stewart, Harris, Sumter, Macon, Talbot, Marion, Taylor, Quitman, and Webster counties serving and providing home health care in Middle Georgia. Our administrative and professional team of home health care providers understand the needs of the communities we serve. As a healthcare provider that has been serving Medicare, Medicaid, and indigent patients in the state of New York for years, we understand the unique needs and challenges that come with serving diverse communities, including both rural and dense urban populations. In turn, we will bring the expertise of Axzons to the mostly rural population of patients in Middle Georgia.

We believe that our experience in serving diverse populations in both major metropolitan centers as well as rural counties with populations of less than 15,000 can be of great value to the patients in Middle Georgia. Our team of healthcare professionals has a deep understanding of the cultural, linguistic, and socioeconomic factors that impact the health outcomes of patients from different backgrounds.

We are committed to delivering quality care to all patients. We believe that every patient deserves access to high-quality healthcare services, and we provide that care in a culturally sensitive and patient-centered manner.

We are confident that our experience in serving diverse populations in New York can be applied to the unique needs of the patients in Middle Georgia. We are focused on providing patients with the high quality, cost effective home health care Axzons has historically provided. Axzons is a quality provider of home-based personal healthcare services in the residence of homebound patients whose physicians have prescribed professional home health care of various types. Axzons is focused on providing skilled nursing and therapy services through individualized care plans. We start the process with an in-home assessment of a patient's needs to support their overall health status. While working with the patient's physician, Axzons utilizes an individualized care plan which is continually updated during their home health episode to accommodate the patient's needs or condition. Throughout in-home treatment, Axzons continuously updates the patient's physician so that they are aware of the progression of care and any change we identify during the course of treatment.

Home health care is an intermittent medical service that is focused on a patient's recovery from an injury or illness. Axzons home health aides also assist with many daily tasks, including personal care tasks such as dressing, bathing, and grooming. We provide these services along with skilled services like nursing and occupational, physical, or speech therapy. We intend to provide services to patients in Chattahoochee, Randolph, Clay, Schley, Dooly, Stewart, Harris, Sumter, Macon, Talbot, Marion, Taylor, Quitman, and Webster counties by or before the end of this year.

AXZONS IS A COMPREHENSIVE HOME HEALTH SERVICES PROVIDER

The frequency and quantity of visits made by our home healthcare specialists are determined by the care plan that has been approved by the patient's physician. Any modifications to this personalized care plan must also receive approval from the physician. While our list of home health care services primarily includes the following, it is not necessarily limited to them:

Skilled Nursing Services:

Our medical care will be provided by licensed nurses, such as registered nurses (RNs) or licensed practical nurses (LPNs), who have received specialized training and education in providing healthcare services. Skilled nursing services may include wound care, medication management, administering injections, monitoring vital signs, tube feeding, infusion therapies, pulmonary care, central line port maintenance and providing education and support to patients and their families. These services are designed to help patients manage their medical conditions and improve their overall health and well-being.

Home Health Aide:

Our aides provide support to patients with daily living tasks until they regain their independence and recover. This service may encompass grooming, personal care, and exercises that are driven by therapy.

Personal Care:

Axzons provides assistance by a home health aide or caregiver to patients with activities of daily living (ADLs) such as bathing, dressing, grooming, toileting, and feeding. Personal care is an essential component of home health services, particularly for patients who are elderly, disabled, or recovering from an illness or injury. Home health aides are trained to provide personal care services in a safe and compassionate manner, while also respecting the patient's privacy and dignity. Personal care services can be customized to meet the unique needs of each patient and may include assistance with mobility, transferring, and positioning. The goal of personal care services is to help patients maintain their independence and improve their quality of life while living in the comfort of their own home.

Companion or Sitter:

A caregiver who provides non-medical support and companionship to patients who require assistance with daily living activities. A companion or sitter may be a family member, friend, or a professional caregiver who is trained to provide emotional support, socialization, and supervision to patients who are elderly, disabled, or recovering from an illness or injury. The role of a companion or sitter may include providing companionship, engaging in conversation, playing games, reading, and accompanying the patient on outings. They may also assist with light housekeeping, meal preparation, and medication reminders. The goal of a companion or sitter is to provide emotional and social support to patients, while also ensuring their safety and well-being. This type of home health service is particularly beneficial for patients who live alone or have limited social support. Axzons provides companions and sitters to relieve friends and family members of caregiving responsibilities and improve the quality of life and relationships between patients and their primary caregivers.

Infusion Therapy:

Infusion therapy is a type of medical treatment that involves the administration of medication or fluids directly into a patient's bloodstream through a vein. Infusion therapy will be provided by one of our licensed healthcare professionals, such as a nurse, who is trained to administer medications and monitor

the patient's response to treatment. Axzons employs qualified and experienced nurses to provide infusion therapies to those patients in need of such services and provides continuous quality improvement training to ensure the highest quality care to patients.

Medical Social Work:

Medical social work is a specialized field of social work that focuses on helping patients and their families cope with the social, emotional, and financial challenges of illness or injury. Our medical social workers provide counseling, education, and support to patients and their families, as well as assistance with accessing community resources and navigating the healthcare system.

Physical Therapy:

Our licensed physical therapists will work with patients to develop a personalized treatment plan that may include exercises, stretches, and other techniques to improve strength, flexibility, and balance.

Occupational Therapy:

Our licensed occupational therapists will work with patients to develop a personalized treatment plan that may include exercises, adaptive equipment, and modifications to the patient's home environment.

Our licensed respiratory therapists will work with patients to develop a personalized treatment plan that may include breathing exercises, medication administration, and the use of respiratory equipment.

Nutrition:

Assessment of a patient's nutritional needs and the development of a personalized nutrition plan. This may include dietary counseling, meal planning, and education on healthy eating habits. Axzons maintains a nutritional counseling program to ensure its providers are experienced and qualified to provide specialized nutritional counseling and care to its patient.

Audiology:

Assessment and treatment of hearing and balance disorders. This may include hearing tests, hearing aid fittings, and balance exercises.

Speech Language Pathology:

Assessment and treatment of speech, language, and swallowing disorders. This may include speech therapy, language therapy, and swallowing therapy.

Homemaker:

Assistance with household tasks, such as cleaning, laundry, and meal preparation. Homemakers may also provide companionship and emotional support to patients.

Housekeeper:

Assistance with cleaning and maintaining the patient's home environment. Housekeepers may also aid with laundry and other household tasks.

Axzons Visiting Nurse services will be responsible for implementing a tailored plan of care for patients. The Care Plan is based on collaboration with the patient, the doctor, and a professional Axzons Homecare nurse. Once created, our skilled nursing staff continues to monitor the home health care provided by our aides. Continuous Quality Improvement (CQI) meetings will be held regularly, to ensure that the highest level of care is given. Axzons Homecare nurses also receive continuous training and education to offer the best currently available services in the industry to our client.

Company Resources:

Axzons sister organization has been in business for years and operates in New York. We already have a proven formula and are prepared to immediately aid our Georgia operations with billing, accounting, human resources, financial, administrative, quality improvement, governmental regulatory and compliance services, as well as Medicare and Medicaid certification, including an award as a New York State Lead Fiscal Intermediary to provide Medicaid services in 47 counties in New York (including its most rural counties such as Schuyler, Lewis, and Yates), and state licensing maintenance.

Axzons professional staff have the ability and will assist Axzons services in SSDR 1 to implement strategies to immediately begin operations. Axzons will implement the following key services:

1. Implement a recruitment plan to hire and train nursing and therapy personnel on an incremental basis relative to patient and visit growth.
2. Include referral sources in service area counties with continuous marketing efforts with physicians, hospitals, and ancillary healthcare service providers such as assisted living and personal care homes.
3. Ensure Axzons has the necessary financial and management resources to support patient caseloads while providing quality and necessary nursing and therapeutic services.

Primary Patient Focused Objectives:

Axzons is guided by a philosophy that is committed to meeting the home health care needs of local communities in a caring, outcomes-driven, safe, efficient, and cost-effective manner, including those that have not been adequately addressed. To achieve this, Axzons has set the following objectives:

1. Provide compassionate service to all patients.
2. Deliver quality care that meets the highest standards of professionalism.
3. Honor all patient rights and work closely with their families to achieve maximum functional independence.
4. Reduce re-hospitalizations by providing coordinated planned care between patients, caregivers, and physicians.
5. Empower Georgians to care for their loved ones at home.
6. Offer expert and compassionate staff to support patients and their families.
7. Provide education and resources to help caregivers provide the best possible care.
8. Foster a culture of respect, empathy, and understanding for all patients and their families.
9. Continuously improve our services to meet the changing needs of our patients and their families.
10. Partner with Axzons to provide financial support to caregivers and help them care for their loved ones.

Personalized and Integrated Patient Care Services:

Axzons patients receive an individualized plan of care that is approved by the patient's physician in coordination with the patient and their family members. Home health visits are carefully planned and guided by these individualized patient care plans, which are reviewed and updated weekly at case conferences and upon a significant change in the patient's health status.

The Axzons approach reinforces and supplements care provided by family members and friends while maintaining the patient's independence by allowing them to take an active role in their care. Through experience, Axzons knows that home care is socially beneficial in fostering independence and is less costly than institutionalized care, making it the desired option in terms of the social, emotional, and mental well-being of the patient. The patient care plans are linked with community programs to meet the patient and their family's needs while fostering the importance of family, physical, emotional, and mental health, and freedom of choice.

Through coordinated home health care services, Axzons focuses on individually planned and monitored patient care plans to achieve comprehensive medical, nursing, social work, and related care to patients in their homes. This approach provides more personalized care in the home for patients than that provided in institutions, comprehensive care at a lower cost than the institutional setting, shorter hospital stays, or prevention of hospitalization or re-hospitalization of patients, improved utilization of existing health care continuum facilities, thus reducing the demand for more hospital and nursing home beds, faster recovery, prevention, or delay of disability, while maintaining personal dignity by restoring patients to normal family living and useful functional activity.

Axzons utilizes virtual and in-person patient/provider conferences to ensure that the care plans remain effective and appropriate identification of the patient's continuing care needs. Case conferences are conducted on all patients in the home health program initiated when the patient's care regimen is started. Case conferences occur weekly, at recertification, and at any significant change in condition as well as prior to discharge. Case conferences are conducted by a multidisciplinary team of health care professionals headed by a clinical manager who is responsible for assuring effective communication among all disciplines involved in the patient's care and that care is coordinated among all services and disciplines.

A multi-disciplinary team comprised of nurses and ancillary health workers maintain virtual mobile office activities from their automobiles. All professional staff utilize laptop computers and/or mobile devices such as iPads and smartphones that allow for superior communication between the office and field staff. Axzons has a proven track record of using these "point of care" devices to seamlessly manage its electronic medical record. Field staff routinely meet as required by State and Federal regulations to ensure compliance with all applicable patient care rules, regulations, and protocols.

Axzons uses the KanTime home care software application because it is one of the highest-rated Home Care software products in the country. This comprehensive user-friendly software allows staff ease of learning and effective use in the field. Field staff have immediate access to patient records from anywhere there is wireless connectivity or periodically through the day via internet access. An additional critical feature of the KanTime software is its "offline" documentation capability, which allows its field clinicians the ability to continue to document in the home even in remote areas where there is no internet access. This ability

to access and update the medical record between field (RNs, Therapists, and HH Aides) and office staff is a far superior clinical management system, thus improving the delivery of quality care.

Additionally, Axzons equips its field clinical staff with equipment (Pulse Oximeter, PT/INR monitors, Anodyne red light therapy, ultrasound, and electrical stimulation) essential to in-home comprehensive care. This equipment expense is not a billable expense for the agency but aids in achieving better clinical outcomes. All clinicians are issued "car boxes" that contain and organize necessary medical equipment and supplies.

In Axzons' current operations clinical home care staff typically reside in or near the communities being served, so that they have reasonable travel distances to their assigned patients and typically travel to the home office weekly to replenish their mobile medical supplies as well as review patient care plans and participate in case conferences to discuss the health care status and needs of each patient being served by the home health agency. Axzons utilizes tailored policies, procedures, and protocols to ensure that patient care will be effective, personalized, and centrally coordinated through secured online communications with the main office and patient's primary physician as necessary.

Axzons' Quality Improvement Program and related internal risk management protocols ensure that the care provided to its patients is consistent with specific policies, procedures, and is documented in each patient's chart. Axzons' administration recognizes the importance of continually monitoring relevant aspects of care provided to patients. Axzons' quality improvement program maintains oversight and development of quality indicators that have been proven to measure aspects of care consistently. On a quarterly basis, staff evaluates specific quality indicators. Results of the evaluation process are summarized and reported to leadership to ensure that Axzons' patients receive high-quality, effective care.

Compliance Management:

The Axzons Team has extensive experience in hiring caregivers for long-term and community care, as well as in collecting and documenting their time sheets to comply with Medicaid regulations. Additionally, the team runs a weekly payroll for its employees. To ensure that all wage payments are made in compliance with legal requirements, Axzons Team has partnered with ADP Payroll, one of the largest international payroll vendors and processing companies in the country.

Insurance:

The Axzons team's extensive experience in the healthcare industry has equipped them with a thorough understanding of the requirements for workers' compensation, disability, and unemployment insurance for employees. As part of their commitment to their personal assistants, Axzons will cover the costs of each of these statutory insurance programs, including short-term disability, workers' compensation, and unemployment insurance. The team has a proven track record of compliance with these insurance programs and is highly skilled in navigating the statutory requirements with caregivers. Axzons works closely with all caregivers to provide support and guidance on these benefits, including assistance with completing the necessary forms. All processing related to workers' compensation, disability, and unemployment insurance will be handled by Axzons to ensure compliance with all legal requirements.

Annual Heath Assessments:

The Axzons team is well-versed in the regulations that outline the health assessment requirements for home health aides. No caregiver is permitted to provide services until all state requirements are met. Axzons has established a process for evaluating the health assessments of caregivers, which will be overseen by the senior medical team with assistance from senior nursing staff. At the time of hire, caregivers are informed of the health requirements related to their employment. If an aide does not have a current health assessment, Axzons will work with them to ensure they can access a clinic or medical provider to obtain the necessary assessment. No aide will be allowed to work without an updated health assessment, and Axzons will explain this requirement to them to ensure they understand that they cannot work until the health assessment is completed and confirmed by Axzons.

To track annual health assessments, Axzons will use its EMR software, HHAExchange, to monitor the due date for each caregiver's assessment. Axzons will send reminders to caregivers to ensure they obtain an updated health assessment before the prior one expires. Nurses employed at Axzons will analyze physicals and conduct follow-up annual health assessments to ensure the health status of each caregiver.

Human Resource Record Keeping:

Axzons will be responsible for maintaining personnel records for each home health aide and medical staff. These records will be separated into three files: general personnel information, medical information, and an immigration-compliance file that contains the 1-9 paperwork. The contents of the personnel files will be collected at the time of intake and hiring of each home health aide and medical staff. Access to personnel files will be granted only to personnel who have a "need-to-know." Additionally, Axzons will collect and maintain timekeeping records and timesheets that are submitted by caregivers.

The Axzons team has extensive experience in maintaining and self-auditing personnel records of caregivers. To ensure that Axzons has all the required documentation and that it is stored in the proper manner, the corporate compliance officer will conduct periodic self-audits of the personnel records. Axzons will maintain all personnel records and will be responsible for the collection of timesheets and time records.

Patient Records Keeping:

Axzons will maintain a comprehensive file for each patient, similar to the personnel records for home health aides and medical staff. All records will be kept and updated regularly to ensure that they are accurate and up-to-date. The contents of each patient file will include general patient information, medical information, and any necessary immigration-compliance documentation. Access to patient files will be granted only to personnel who have a "need-to-know." Axzons will be responsible for maintaining all patient records and ensuring that they are stored in the proper manner.

Section 3: General Review Considerations

All Certificate of Need applications are evaluated to determine their compliance with the general review considerations contained in Rule 111-2-2-.09. Please document how the proposed project conforms with the following general review considerations.

Rule 111-2-2-.09(1)(a): Consistency with State Health Plan

The proposed new institutional health service is reasonably consistent with the relevant general goals and objectives of the State Health Plan.

19. Explain how the project is consistent with the State Health Plan or why it does not apply. Also explain how the application is consistent with the Applicant's own long range plans.

☞ **NOTE:** *If your explanation exceeds this blocked space, attach additional 8-½ by 11-inch pages, number the first sheet Page 10.1, the second Page 10.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 10.1, etc. behind this Page 10.*

See description on attached pages.

19. Rule 111-2-2-.09(1)(a): Consistency with State Health Plan

A. GOAL: To ensure that Georgia citizens have access to cost- effective, efficient, and quality home health services.

B. OBJECTIVES:

1. **Provide compassionate service to all patients**: This objective emphasizes the importance of providing compassionate care to all patients, regardless of their condition or circumstances. It highlights the need for caregivers to be empathetic and understanding towards patients, and to provide care that is focused on their individual needs. Axzons maintains policies and procedures as well as training to all Axzons providers and caregivers to ensure patients receive compassionate care.

2. **Deliver quality care that meets the highest standards of professionalism**: This objective emphasizes the importance of delivering high-quality care that meets the highest standards of professionalism. It highlights the need for caregivers to be knowledgeable, skilled, and competent in their work, and to provide care that is evidence-based and effective. Axzons maintains a continuous quality improvement program to ensure its employees maintain the highest standards of professionalism and experience in providing services to its patients.

3. **Honor all patient rights and work closely with their families to achieve maximum functional independence**: This objective emphasizes the importance of honoring patient rights and working closely with their families to achieve maximum functional independence. It highlights the need for caregivers to respect patients' autonomy and to involve them and their families in the care planning process. Services provided by Axzons specifically contemplate collaboration with a patient's family and friends who are the primary caregivers, to encourage positive relationships and quality of life.

4**. Reduce re-hospitalizations by providing coordinated planned care between patients, caregivers, and physicians**: This objective emphasizes the importance of reducing re-hospitalizations by providing coordinated planned care between patients, caregivers, and physicians. It highlights the need for caregivers to work closely with physicians to develop care plans that are tailored to the patient's needs and to ensure that patients receive the appropriate care in a timely manner. Axzons services are designed to minimize re-hospitalization and improve coordination of care between patients, caregivers, and the patient's physicians to ensure the patient has the highest possible quality of life.

5**. Empower Georgians to care for their loved ones at home**: This objective emphasizes the importance of empowering Georgians to care for their loved ones at home. It highlights the need for caregivers to provide education and resources to help families provide the best possible care for their loved ones. As noted previously, Axzons supports its patients and their primary care givers, encouraging and supporting strong relationships between patients and their primary caregivers.

6. **Offer expert and compassionate staff to support patients and their families**: This objective emphasizes the importance of offering expert and compassionate staff to support patients and their families. It highlights the need for caregivers to be knowledgeable, skilled, and

compassionate in their work, and to provide care that is focused on the patient's individual needs. Axzons' recruitment and retention policies, as well as its continuous quality improvement program ensures its employees are experienced and qualified to provide a high caliber of patient care and compassion.

7. **Provide education and resources to help caregivers provide the best possible care**: This objective emphasizes the importance of providing education and resources to help caregivers provide the best possible care. It highlights the need for caregivers to be knowledgeable about the latest research and best practices in their field, and to have access to resources that can help them provide high-quality care. As noted previously, Axzons' continuous quality improvement program ensures that its employees are highly trained and up-to-date on the latest research and best practices in the field of home healthcare.

8. **Foster a culture of respect, empathy, and understanding for all patients and their families**: This objective emphasizes the importance of fostering a culture of respect, empathy, and understanding for all patients and their families. It highlights the need for caregivers to be respectful, empathetic, and understanding towards patients and their families, and to provide care that is culturally sensitive and responsive to their needs. Axzons' policies and procedures ensure its employees bring a high level of care and compassion to patient care and ensuring patients and their primary care givers have the necessary resources to ensure the highest quality of life for the patient.

9. **Continuously improve our services to meet the changing needs of our patients and their families**: This objective emphasizes the importance of continuously improving services to meet the changing needs of patients and their families. It highlights the need for caregivers to be responsive to the changing needs of patients and their families, and to continuously evaluate and improve the quality of care they provide. Axzons' continuous quality improvement program specifically ensures its employees maintain the highest level of care by fostering an environment of continuous improvement and learning.

10. **Partnership between Axzons and caregivers to help them care for their loved one**s: This objective emphasizes the importance of partnering with Axzons and caregivers to help them care for their loved ones. It highlights the need for caregivers to have access to financial resources that can help them provide high-quality care, and to have the support they need to care for their loved ones. Axzons will partner with community partners in the proposed services area to ensure that patients and their primary caregivers have access to resources to ensure the patient has the highest quality of life.

Rule 111-2-2-.09(1)(b): Need

The population residing in the area served, or to be served, by the new institutional health service has a need for such services.

20. Please explain the need for your particular project or service. For services for which a need methodology exists in the State Health Plan, please use the said methodology. In submitting information to explain the need for your project, please also use the following guidelines:

- For any population projections, the official projections of the Office of Planning and Budget should be utilized;
- Include maps that clearly define both the primary and secondary service areas and identify all other providers of the proposed service that lie within the primary and secondary service area on such maps;
- Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients, visitors, and employees; and
- For services that already have documented utilization rates, include such historical utilization data, and projections for future utilization.

☞ **NOTE:** *If your explanation exceeds this blocked space, attach additional 8-½ by 11-inch pages, number the first sheet Page 11.1, the second Page 11.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 11.1, etc. behind this Page 11.*

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that supports the need for your project into **APPENDIX E**. All documents such as tables, charts, and maps that support your need analysis and that are able to be inserted or created in MS Word format should be inserted following this page according to instructions in the note above.

See description on attached pages.

20. **Need**

The Office of Health Planning ("OHP") has identified a projected "unmet need" for additional home health services in fourteen (14) SSDR- 8 counties, including Chattahoochee, Randolph, Clay, Schley, Dooly, Stewart, Harris, Sumter, Macon, Talbot, Marion, Taylor, Quitman, and Webster counties with a total identified un-met numerical need of 600 within SSDR-8.

SSDR-8 is comprised of 16 rural to suburban counties, with populations ranging from just over 2,000 in Quitman County to just over 196,000 in Muscogee County.

Axzons proposes to offer home health services Chattahoochee, Randolph, Clay, Schley, Dooly, Stewart, Harris, Sumter, Macon, Talbot, Marion, Taylor, Quitman, and Webster Counties as identified by the Department in its Batching Notice. Axzons does not currently offer services in the identified counties and is submitting this application pursuant to OHP's identification of unmet need for each county.

While Axzons does not currently provides home health services in the identified counties, it provides similar services in the State of New York, along with related healthcare services, in forty seven (47) New York counties. Axzons has substantial experience providing high quality, cost-effective home health services and will bring this experience and expertise to the provision of home health services to patients in Chattahoochee, Randolph, Clay, Schley, Dooly, Stewart, Harris, Sumter, Macon, Talbot, Marion, Taylor, Quitman, and Webster Counties.

Axzons' sister organization currently provides its services in forty seven (47) New York counties, including both its most populous counties as well as its least populated counties such as Lewis, Schuyler, and Yates counties which all have populations under 25,000. This breadth of service area with diverse population densities mirror the populations and demands of SSDR-8 which has rural counties as well as some higher density suburban counties.

Axzons will serve all patients regardless of race, ethnicity, religion, income or insurance status and will make an indigent and charity care commitment of one percent (1%).

Axzons currently serves Medicare, Medicaid, Third Party, and other governmental payer insured patients in New York, and will similarly offer services to those patient populations in Georgia's SSDR-8.

RELATIONSHIPS WITH LOCAL SUPPORT SERVICES

Axzons will develop relationships with local services including transportation, meal support, other healthcare providers, and similar third party services to ensure that Axzons patients will have access to a wide array of ancillary services to ensure high quality care and quality of life is maintained by patients and their families.

AXZONS PROPOSED LOCATION WITHIN SSDR-8

Should Axzons obtain approval, it will maintain a location in SSDR-8. While Axzons will maintain a location within SSDR-8, its health care professionals will be distributed and easily accessible in each of the identified counties to ensure continuous coverage for services provided to patients.

AXZONS' WIDE RANGE OF HOME HEALTH SERVICES PROVIDED

Services offered by Axzons to its home health care patients will include general home health care services, live-in care, respite care, cardiological care, companion care, nutritional services, nursing services, and other specialized care services particular to home health care services, all services which it's sister organization currently provides in New York. Axzons will provide each of these services to meet the identified need for additional home health services in SSDR-8 in a high quality, cost-effective manner to ensure its patients and applicable payors receive the best value for the high quality services rendered by Axzons.

HOME HEALTHCARE SERVICES

Axzons provides a broad range of skilled and aide based services to patients living in their own homes and in assisted living facilities. Axzons emphasizes the promotion and maintenance of a high quality standard of living for patients experiencing illness and disability.

LIVE-IN CARE

Axzons provides fully trained caregivers to live with patients in their homes. Live-in caregivers support the specific needs of patients to keep them comfortable and independent in their own homes. Axzons will provide two or more caregivers who will work in rotation to provide 24/7 live-in support for patients suffering from chronic conditions who live along or are unable to conduct the activities required for daily living as needed.

RESPITE CARE

Axzons provides respite care to its patients and their families for emergency temporary care, planned short-term, and time-limited breaks for families and other unpaid care givers of children with a developmental delay, children with behavioral problems, adults with an intellectual disability, and adults with cognitive loss in order to support and maintain the primary care giving relationship. Axzons' respite care program allows primary care givers to maintain positive relationships with their loved ones and maintain long term primary care relationships.

COMPANION CARE

Axzons provides companion care and sitter care through a team of highly trained and experienced caregivers who have extensive skills, knowledge, and experience to provide personalized companion and sitter services to meet the unique needs of each individual patient. Axzons' team of companion caregivers assist with daily living activities, medication reminders, transportation, light housekeeping, and companionship to ensure patients have the best possible quality of life.

NUTRITIONAL COUNSELLING

Axzons maintains a comprehensive nutritional counseling program, training its caregivers with the necessary skills and knowledge base to assist its patients with maintaining appropriate nutrition to address the patient's specific needs. Axzons caregivers assist patients with preparing grocery lists, meal preparation, cleanup and storage of prepared foods, coordinate with Meals on Wheels programs, dietary and actual consumption of meals monitoring, and preparation and assistance with following disease specific dietary requirements.

NURSING SERVICES

Axzons provides nursing services to patients to support its home health services personnel where nursing care has been ordered by a patient's physician. Axzons visiting nurses provide care to all Axzons patients where ordered for those patients with long term needs or short term needs. This service provides a convenient alternative to patients needing to travel to an outpatient healthcare facility for treatment.

Axzons nurses provide initial client assessment, pre and post-operative care, routine monitoring of vitals, catheter care and change assistance, trach and vent care, pain management, injections, infusion and IV therapies, lab draws, wound care, tube feeding assistance , pulmonary care, medication management, and central line and port maintenance.

Axzons maintains a Continuous Quality Improvement program to ensure Axzons staff have the necessary skills, training, and continuing education to always improve and provide high quality care to patients.

SPECIALIZED CARE

In support of each of its services, Axzons provides specialized care for patients with Alzheimer's and Dementia, Parkinson's, respite care, developmental and intellectual difference care, stroke recovery support, chronic obstructive pulmonary disease support, and recuperative care.

CONCLUSIONS

Axzons plans to operate a diverse and wide range of general and specialized services specifically to ensure it provides the highest quality care for its patients. Axzons maintains several programs to support these services, including quality control and improvement for its health care providers and relationships with third party community partners to ensure patient access to the widest possible range of services. Axzons' experience providing home health care services in rural counties in New York will translate appropriately to the similarly situated populations of Georgia's SSDR-8.

Axzons will bring this depth of experience and service to Georgia's SSDR-8, providing high quality care, community partnerships, and participation to ensure the identified need in Georgia's SSDR-8 is met.

Rule 111-2-2-.09(1)(c): Existing Alternatives

Existing alternatives for providing services in the service area the same as the new institutional health service proposed are neither currently available, implemented, similarly utilized, nor capable of providing a less costly alternative, or no Certificate of Need to provide such alternative services has been issued by the Department and is currently valid.

21. Identify existing health care facilities and services and those approved for development in the service or planning area. Describe how your service differs in terms of population served from the existing and approved services. Describe how the proposed project will enhance service delivery in the service or planning area. Also, explain the internal organizational alternatives that the Applicant considered.

☞ **NOTE:** *If your explanation exceeds this blocked space, attach additional 8-½ by 11-inch pages, number the first sheet Page 12.1, the second Page 12.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 12.1, etc. behind this Page 12.*

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of existing alternatives into **APPENDIX F**. All documents such as tables, charts, and maps that you wish to use to analyze the existing alternatives and that are able to be inserted or created in MS Word format should be inserted following this page according to instructions in the note above.

See description on attached page.

21 **EXISTING ALTERNATIVES**

The Office of Health Planning ("OHP") has identified a projected "unmet need" for additional home health services in fourteen (14) SSDR-8 counties, including Chattahoochee, Clay, Dooly, Harris, Macon, Marion, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor and Webster counties. This identification by OHP acknowledges that existing home health agencies are currently unable to meet the need for services, requiring additional services to be provided.

Of the nine (9) agencies currently serving counties, Chattahoochee, Clay, Dooly, Harris, Macon, Marion, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor and Webster counties there currently no agencies serving more than three (300) patients.

Agency	Number of Patients													
	Chattahoochee	Clay	Dooly	Harris	Macon	Marion	Quitman	Randolph	Schley	Stewart	Sumter	Talbot	Taylor	Webster
CareSouth - An Affiliate of Crisp Regional Hospital	-	-	206	-	62	-	-	-	-	-	20	-	-	-
Encompass Health Home	29	-	-	111	-	39	-	-	-	24	-	33	61	22
Georgia Home Health	-	-	-	51	-	-	-	-	-	-	-	-	-	-
Kindred at Home - Columbus	25	-	-	129	-	56	-	-	-	-	-	96	-	-
Ultra Care of Georgia	24	-	-	188	-	-	-	-	-	-	-	-	-	-
West Georgia Home Care	-	-	-	77	-	-	-	-	-	-	-	-	-	-
Amedisys Home Health of	-	-	-	-	-	-	-	-	-	-	1	-	-	-
Amicita Home Health	-	4	-	-	-	-	-	42	-	-	-	-	-	-
Phoebe Home Health	-	14	-	-	-	-	20	94	-	8	119	-	-	15

Axzons' sister organization in New York already provides a wide range of home health services to thousands of patients in New York. Axzons is well positioned to expand into Georgia and provide high quality, cost-effective care to the patients of SSDR-8.

Axzons will provide a wide range of comprehensive home health services to patients in order to meet the identified need and support the existing health care services already serving SSDR-8.

Rule 111-2-2-.09(1)(d): Financial Feasibility

The project can be adequately financed and is, in the immediate and long-term, financially feasible.

22. Provide project cost estimates for the following categories. *Enter in whole dollar amounts except Cost / Sq. Ft.*

PROJECT COST ESTIMATES				
Type of Cost	**Amount**	**Sq. Ft.**	**Cost / Sq. Ft.**	
COSTS APPLICABLE TO FILING FEE				
Construction				
(1) New Facility Costs				
(2) Expansion Costs				
(3) Renovation Costs				
(4) Architectural and Engineering Fees				
(5) Subtotal Construction	0.00			← *Add Lines 1 through 4*
Equipment				
(6) Fixed Equipment (not in construction contract)				Attach Purchase Orders or Quotes for All Major Medical Equipment at **APPENDIX G**.
(7) Moveable Equipment	35,000.00			
(8) Subtotal Equipment	35,000.00			← *Add Lines 6 through 7*
Other				
(9) Contingency	45,000.00			
(10) Legal and Administrative Fees	5,000.00			
(11) Interim Financing				
(12) Underwriting Costs				
(13) Building and Fire Code Compliance				
(14) Other:				
(15) Subtotal Other	50,000.00			← *Add Lines 9 through 14*
(16) TOTAL COST APPLICABLE TO FILING FEE	85,000.00			← *Add Lines 5, 8 and 15*
COSTS EXCLUDED FROM FILING FEE				
(17) Site Acquisition Cost				
(18) Predevelopment Costs				
(a) Preparation of Site				
(b) Development and Preparation of CON Application	15,000.00			
(19) Subtotal Predevelopment	15,000			← *Add Lines 18a and 18b*
(20) Escrow for Debt Service				
(21) TOTAL COST EXCLUDED FROM FILING FEE	15,000			← *Add Lines 17, 19, and 20*
(22) GRAND TOTAL ESTIMATED PROJECT COST	100,000			← *Add Lines 16 and 21*

☞ **NOTE:** *Enter the Amount of Line 16 on the Cover Page at Item 2 of the Submission Table.*

☞ **NOTE:** *Use the amount of Line 22 for all responses throughout this application except for calculating the filing fee.*

23. Indicate the anticipated sources of **funds** for the proposed capital expenditures if any. Specify the amount received from each source. Round to whole dollar amounts. 🗁 Attach documentation indicating the current availability of grants, private contributions, and unrestricted reserves, if any, at **Appendix G**.

Fund Sources	
Source	**Amount**
DEBT	
(1) Revenue Certificates (Bonds)	
(2) General Obligation Bonds	
(3) Commercial Loans	
(4) Government Loans	
EQUITY	
(5) Grants	
(6) Private Contributions (Philanthropy)	
(7) Public Campaign	
(8) Unrestricted Reserves on Hand (Cash)	100,000.00
(9) Other (please specify):	
(10) TOTAL ESTIMATED FUNDS	

← *Add Lines 1 through 9*

🗁 If you enter debt financing sources, provide the following in **APPENDIX G**:

1. Contingency letters of commitment from a bank or other reputable lending institution(s) indicating its interest in financing the project if a Certificate of Need is issued to the Applicant that states the anticipated terms, including the interest rate, frequency of payments, total amount to be borrowed, and the duration of the financial obligation.
2. Amortization schedules including the interest, principal, depreciation and amortization by year.

☞ **NOTE:** *The amount of Line 10 should equal the amount of Line 22 of Question 22 above.*

24. Does the Applicant undergo annual financial audits? ■ **YES** ☐ **NO**

If **YES** ➔ 🗁 Attach the most recent financial audit at **APPENDIX G**.

If **NO** ➔ Please provide Balance Sheets, Bank Statements, Tax Returns, or other financial statements verifying income. 🗁 Attach this documentation in **APPENDIX G**.

25. Provide pro forma income and expense projections for the first two years of operation following the anticipated completion of the project. Identify all the assumptions used to develop the pro forma statement. Indicate the period covered for the first and second years.

Pro Forma Income and Expense Projections			
	Type of Income or Expense	**First Year** (mm/yy)	**Second Year** (mm/yy)
	Period Covered (Month and Year)	*to*	*to*
	(1) Number of Beds/Rooms/Procedures/Patients	300	600
	(2) Projected Percent Occupied or Utilized	50 %	100 %
	REVENUES		
	(3) Inpatient Revenues		
	(4) Outpatient Revenues	$806,659.00	$1,613,319.00
Add Lines 3 and 4	(5) Patient Revenues	$806,659.00	$1,613,319.00
	(6) Other Revenues		
Add Lines 5 and 6	**(7) GROSS REVENUES**	$806,659.00	$1,613,319.00
	Deductions From Revenues		
	(8) Indigent and Charity Care	$8,066.00	$16,133.00
	(9) Bad Debt	$10,399.00	$20,798.00
	(10) Contractual Adjustments		
	Medicaid	$126,697.00	$253,395.00
	Medicare	$99.538.00	$199,077.00
	Other	$19,907.00	$39,815.00
	(11) Other Free Care		
Add Lines 8, 9, 10 & 11	**(12) TOTAL DEDUCTIONS**	$264,607.00	$529,218.00
Subtract Line 12 from Line 7	**(13) NET REVENUES**	$542,052.00	$1,084,101
	EXPENSES		
	Direct Expenses		
	(14) Salaries and Benefits	$360,981.00	$721,962.00
	(15) Supplies	$14,491.00	$28,982.00
	(16) Other	$26,376	$52,752.00
Add Lines 14 through 16	**(17) DIRECT EXPENSES**	$401,848.00	$803,696.00
	Indirect Expenses		
	(18) Depreciation	10,000.00	25,000.00
	(19) Amortization		
	(20) Interest		

Pro Forma Income and Expense Projections		
Type of Income or Expense	**First Year** (mm/yy)	**Second Year** (mm/yy)
Period Covered (Month and Year)	*to*	*to*
(21) Other		
Add Lines 18 through 21 **(22) INDIRECT EXPENSES**	10,000.00	25,000.00
Add Lines 17 & 22 **(23) TOTAL EXPENSES**	$411,848.00	$828,696.00
INCOME / (LOSS)		
Subtract Line 23 from Line 13 **(24) Income / (Loss)**	$130,204.00	$255,405.00
(25) Income Taxes	0.00	0.00
Subtract Line 25 from Line 24 **(26) NET INCOME / (LOSS)**	$130,204.00	$255,405.00
GROSS PATIENT REVENUE BY SOURCE		
Government		
(27) Medicare	$330,730.00	$661,460.00
(28) Medicaid	$411,396.00	$822,792.00
(29) Other Government		
Add Lines 27 through 29 **(30) Government**	$742,126.00	$1,484,252.00
Nongovernmental		
(31) Third Party Payors	$48,399.00	$96,798.00
(32) Self-Pay	$16,134.00	$32,269.00
(33) Other Nongovernmental		
Add Lines 31 through 33 **(34) Nongovernmental**	$64,532.00	129,067.00
Add Lines 30 and 34 **(35) TOTAL, ALL SOURCES**	$806,659.00	$1,613,319.00

☞ **NOTE:** These amounts must equal *"Patient Revenues"* under line 5 on Page 15

Briefly outline the assumptions made for each line item of statistics entered in the Pro Forma Income and Expense Projections above.

PRO FORMA ASSUMPTIONS
(1) Number of Beds/Rooms/Procedures/Patients: The statistic used by applicant is "patients" served, with one half of the patient need allocated in year one and the total unmet need allocated in year 2.
(2) Projected Percent Occupied or Utilized: Not applicable.
(3) Inpatient Revenues: Not applicable as the services provided are outpatient services only.
(4) Outpatient Revenues: All revenue is associated with skilled intermittent home health services.
(6) Other Revenues: Not applicable.
(8) Indigent and Charity Care: Equal to one percent (1%) of adjusted gross revenue.
(9) Bad Debt: Based on historical experience of applicant's sister organization.

PRO FORMA ASSUMPTIONS

(10) Contractual Adjustments:
Based on historical experience of applicant's sister organization.

(11) Other Free Care:
Not Applicable.

(14) Salaries and Benefits:
Based on historical experience of applicant's sister organization.

(15) Supplies:
Based on historical experience of applicant's sister organization.

(16) Other:
Based on historical experience of applicant's sister organization.

(18) Depreciation:
Based on a standard straight line method.

(19) Amortization:
Not applicable.

(20) Interest:
Not applicable.

PRO FORMA ASSUMPTIONS

(21) Other Indirect Expense:
No other indirect expenses anticipated.

(25) Income Taxes:
Not applicable.

(27) Medicare:
Based on an estimation that Medicare patients will equal 41% of applicant's patient base.

(28) Medicaid:
Based on an estimation that Medicaid patients will equal 51% of applicant's patient base.

(29) Other Government:
0

(31) Third Party Payors:
Based on an estimation that third party payor patients will equal 6% of applicant's patient base.

(32) Self-Pay:
Based on an estimation that self-pay patients will equal 2% of applicant's patient base.

26. Provide details of the Applicant's total existing indebtedness in the following table:

Lender Name	Origination Date	Due Date	Outstanding Principal	Interest Rate	Associated Capital Project CON/LNR # (if applicable)
No indebtedness				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	
				%	

27. Please provide the following information about staffing levels. Indicate the number of existing and proposed employees for the second operating year following the project's completion. Please express in full-time equivalents.

Staffing Levels (Full-Time Equivalents)			
Position	**Existing**	**Proposed**	**Total**
Registered Nurse		1.5	1.5
Licensed Practical Nurse		1.0	1.0
Licensed Nurse Practitioner or Other Advanced Practice Nurse			
Nurse Midwife			
Nursing Assistant			
Physician			
Pharmacist			
Dentist			
Social Worker		1.0	1.0
Certified Addiction Counselor			
Audiologist		1.00	1.00
Radiological Technician			
Surgical Technician			
Physical Therapist		1.0	1.0
Respiratory Therapist		0.5	0.5
Occupational Therapist		1.0	1.0
Psychologist			
Speech - Language Pathologist		1.0	1.0
Medical Laboratory Technologist			
Personal Care Aide		2.5	2.5
Home Health Aide		2.5	2.5
Total Other Staff		2.0	2.0

28. Describe plans for securing the services of professional, administrative, and paramedical personnel. Describe the current availability of staff as well as plans for training and recruiting the required personnel. Include institutional agreements and other supporting documents. Do not exceed the space provided.

1. Assess the current availability of staff including Registered Nurses, Administrators, Therapists, Medical Social workers, and Home Health Aides.

2. Develop a recruitment strategy: Based on the assessment of current staff availability, Axzons will develop a recruitment strategy to attract and hire additional medical staff and caregivers in advance of patient volume increases. This will include having direct contact with certified home health aide, nursing, physical therapy, occupational therapy, and speech therapy training programs to continue identifying candidates for future employment. Axzons will also place sponsored ads in appropriate media outlets, host recruiting events at libraries and churches, and create relationships with medical institutions in the service area.

3. Utilize job boards and social media: Axzons will also use job boards and various other social media companies to advertise job openings and attract potential candidates.

4. Provide training and support: Once new staff members are hired, Axzons will provide training and support to ensure they have the skills and knowledge necessary to provide high-quality care. This may include on-the-job training, continuing education opportunities, and mentorship programs.

5. Evaluate and adjust recruitment strategy: Axzons will continuously evaluate the effectiveness of its recruitment strategy and adjust it as needed to ensure that it is attracting the best possible candidates for open positions.

By implementing these plans, Axzons aims to secure the services of professional, administrative, and paramedical personnel to provide high-quality care to its patients.

Rule 111-2-2-.09(1)(e): Effects on Payors

The effects of the new institutional health service on payors for health services, including governmental payors, are reasonable.

29. Provide data to show the trend in **current** and **projected** charges under the facility's existing operations. For proposed new facilities or services, provide data to show the trend in charges at other facilities that are owned and/or operated by the Applicant, if applicable.

☞ **NOTE:** *If your explanation exceeds this blocked space or you need to attach tables or graphs, attach additional 8-½ by 11-inch pages, number the first sheet Page 23.1, the second Page 23.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 23.1, etc. behind this Page 23.*

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of the effect on payors of your project into **APPENDIX H**. All documents such as tables, charts, and maps that you wish to use to analyze the effect on payors and that are able to be inserted or created in MS Word format should be inserted following this page according to instructions in the note above.

See on attached page.

29. **Rule 111- 2-2-.09(1)(e): Effects on Payors**

The Applicant proposes to charge the following actual and projected rates:

Projected Average Charge Per Discipline Visit						
Year	**Skilled Nursing**	**Physical Therapy**	**Home Health Aide**	**Occupational Therapy**	**Medical Social Work**	**Speech Therapy**
2023	$162	$188	$92	$188	$162	$162
2024	$166	$193	$94	$193	$166	$166
2025	$170	$198	$96	$198	$170	$170
2026	$174	$203	$98	$203	$174	$174
2027	$178	$208	$100	$208	$178	$178
2028	$182	$213	$102	$213	$182	$182
Source: Internal Projection Data						

These rates and projections are consistent with other home health agencies providing the same services at competitive and low costs within the proposed service area.

Additionally, as noted elsewhere in this application, Axzons is designated a Lead Fiscal Intermediary in the State of New York's Medicaid program demonstrating its commitment to providing high quality services at a cost-effective rate. This designation makes Axzons one in a much smaller select group of providers designated to provide home health services to Medicaid patients in New York. Axzons will bring its leadership and experience serving Medicaid patients to its operations in the proposed service area and by doing so, exhibit fiscal responsibility with all payors within proposed service area.

Rule 111-2-2-.09(1)(f): Construction Methods and Costs

The costs and methods of a proposed construction project, including the costs and methods of energy provision and conservation, are reasonable and adequate for quality health care.

30. Provide the following information about the architect or engineer who has been engaged to design this project. Include documentation of the architect or engineer's registration in Georgia.

CHIEF ARCHITECT/ENGINEER		
Name: Not applicable		
Firm:		
Address:		
City:	State:	Zip:
Phone:		
Registration Number:		

31. Project Completion Forecast. Complete the following project completion forecast. It is important that you supply feasible and well-planned dates because if you do not complete your project or implement your project in a timely fashion, your Certificate of Need will be subject to revocation. For projects that do not involve construction, enter days and dates for those events that are applicable; for example, Equipment Installed and Final Progress Report Submitted.

PROJECT COMPLETION FORECAST		
Event	**Days Required to Complete**	**Proposed Completion Date**
1. Final Architectural Plans and Specifications		
2. Plans approved by State Architect		
3. Enforceable Construction Contract Signed		
4. Building Permit Secured		
5. Materials on Site		
6. Site Preparation Completed		
7. Construction 25% Complete		
8. Construction 50% Complete		
9. Construction 75% Complete		
10. Equipment Installed (If Applicable)		
11. Construction 100% Complete		
12. License Obtained from DCH's Healthcare Facility Regulation Division	60	11/30/2023
13. New Institutional Health Service Offered	1	12/1/2023
14. Final Progress Report Submitted	30	12/30/2023

In addition to the table above, if major components of the proposed project will be completed and become operational prior to the overall completion of the project (for example department or services will be developed in phases) indicate below the anticipated date of completion for each component.

Will major components of the proposed project be developed in phases? ☐ **YES** ☐ **NO**

If **YES** ➔ Complete the following table. ☞ **NOTE:** *If your components or phases exceed the number of rows in the table, attach an additional 8-½ by 11-inch sheet containing a replica of this table, number the first sheet Page 25.1, the second Page 25.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 25.1, etc. behind this Page 25.*

If **NO** ➔ Continue to the next question.

COMPONENT/PHASED COMPLETION FORECAST		
Component, Department, or Phase	**Days Required to Complete**	**Proposed Completion Date**

☞ **NOTE:** *If litigation regarding this application, and approval thereof, occurs, the completion forecast will be adjusted at the time of the final resolution to reflect the actual effective date, if the final resolution is in favor of the application.*

32. Please provide the information in the chart below if your project involves any construction or remodeling. 🗁 Attach the requested information in **APPENDIX I** in the order listed in the chart below.

Architectural Documents	
1. Architect Certification	Provide a letter from the architect certifying the construction and/or renovation costs for the project. The letter must include the total square footage, the total cost of construction, the cost per square foot for construction, and the cost per square foot for renovations. These amounts should match the amounts shown on Lines 1 through 5 of Question 22. ***This letter must be prepared within 60 days of submission of the application.***
2. Schematic Plans	Provide schematic plans for the project and include at least the following information: • Plans for each floor that clearly show the relationship between departments and services and the room arrangements for each. Indicate the function of each room or space. • Proposed roads, walkways, service courts, entrance courts, parking, and orientation should be shown on either a plot plan or the first floor plan. • Provide a cross-sectional diagram that indicates the type of construction and building materials. • If the proposed construction is an addition or if it is otherwise related to existing buildings on the site, the schematic plans should show the facilities and the general arrangement of those buildings. ☞ **NOTE:** *These plans should be provided on paper no larger than 8 ½- in. by 11-in. If such plans cannot be reproduced legibly at this size, the plans must be submitted as a high-resolution PDF document included with the application.*
3. Plot Plan	Provide a plot plan of the site including at least the following: dimensions of the property lines; the locations of major structures, easements, rights-of-way, and encroachments; the location of the proposed facility or expansion; and the relationship of the facility to additional structures, if any, on the campus.

Rule 111-2-2-.09(1)(g): Financial Accessibility

The new institutional health service proposed is reasonably financially and physically accessible to the residents of the proposed service area and will not discriminate by virtue of race, age, sex, handicap, color, creed or ethnic affiliation.

33. In order for the Department to evaluate the extent to which each Applicant proposes to provide, or has provided, health care services for those unable to pay, address each of the following review considerations concerning such financial accessibility by providing written narrative as well as documentation:

a. The Applicant should have policies and directives related to the acceptance of financially indigent, medically indigent, Medicaid, PeachCare, and Medicare patients for necessary treatment. Explain how the Applicant meets this requirement. Limit your response to the space provided.

> The Applicant has a history (through its sister organization) of providing high quality services to all patients, including indigent, Medicaid and Medicare patients in high numbers. The non-discriminatory practices of Applicant are provided in more detail in the various policies attached herein.
>
> Appendix J includes each of the following policies:
>
> 1. Client/ Consumer Rights Policy-addresses patient acceptance and nondiscriminatory practices.
> 2. Admittance & Re-Admittance of Clients
> 3. Provision of Information

🗁 Attach the requested policies and directives as **APPENDIX J**.

b. The Applicant should have policies ensuring that medical staff privileges allow a reasonable acceptance of referrals of Medicaid patients, PeachCare patients, and all other patients who are unable to pay all or a portion of their health care costs. Explain how the Applicant meets this requirement. Limit your response to the space provided.

> Not applicable: Because home health agencies do not address medical staff privileges. With that said, the Applicant has extensive experience working within the Medicaid prgoram and accepting and caring for Medicaid patients. As part of its commitment to providing high-quality care to patients, Axzons will be enrolled in Medicare and Medicaid and will provide care to Medicaid, Medicare and PeachCare patients in significant numbers if approved.
>
> The applicant's policies allow for the reasonable acceptance of referrals for Medicaid patients, PeachCare patients, and all other patients who are unable to pay all or a portion of their healthcare costs.

🗁 Attach the requested policies and directives as **APPENDIX J**.

c. The Applicant must provide evidence of specific efforts made to provide information to patients regarding arrangements for satisfying incurred health care charges. Explain how the Applicant meets this requirement. Limit your response to the space provided.

Axzons' team has extensive experience working with patients and is well-versed in providing quality care. If approved, Applicant will apply for Medicare and Medicaid. In accordance with the Provision of Information policy and procedures, prospective patients will receive an information package detailing the types of insurance accepted, including financially and medically indigent, Medicaid, PeachCare, Medicare, private pay, and other commercial insurances. As part of the admission packet, Axzons will provide patients with information on who will be responsible for satisfying the incurred healthc are charges for all services rendered. Axzons will have administrative staff to assist patients with any inquiries related to charges and payment responsibility.

d. The Applicant should, if applicable, have documented records of funds received from the county, city, philanthropic agencies, donations, and any other source of funds (other than from direct operations) for the provision of health care services to indigent, Medicaid, and PeachCare patients. Explain how the Applicant meets this requirement. Limit your response to the space provided.

Not applicable. As the applicant is a for profit corporation, it will likely not qualify for these categories of funds in support of its home health operations.

e. The Applicant should have documented records as evidence of the Applicant's commitment to participate in the Medicaid, Medicare, and PeachCare programs, as well as the Applicant's commitment to provide health care services to all presenters regardless of race, gender, disability, or ability to pay, and the Applicant's commitment to providing charity care. Explain how the Applicant meets this requirement. Limit your response to the space provided.

Axzons' sister organization has extensive experience working with Medicare and Medicaid patients and is well-versed in providing quality care. If approved, Applicant will apply for Medicare and Medicaid with an expectation to provide a significant number of services to those patient populations. Additionally, Axzons has provided a written commitment to participate in the Medicare, Medicaid, and PeachCare for Kids programs, as well as any other state health benefits. They have also committed to providing healthcare services to all patients regardless of race, gender, disability, or ability to pay, and to offer charity care.

f. The Applicant should have documented records as evidence that the levels of health care provided correspond to a reasonable proportion of those persons who are medically indigent and those who are eligible for Medicare, Medicaid or PeachCare within the service area. Attached records of care provided to patients unable to pay should include Medicare and Medicaid adjustments, PeachCare, other indigent care, and other itemized deductions from revenue, including bad debt. Explain how the Applicant meets this requirement. Limit your response to the space provided.

The proposed homecare agency of Axzons is committed to providing healthcare services that are proportionate to the number of medically indigent individuals and those eligible for Medicare, Medicaid, or PeachCare within the service area. Although healthcare services have not yet been provided, Axzons is dedicated to fulfilling this commitment. While we are currently unable to provide documentary records as evidence, we assure you that our commitment to providing quality healthcare services remains steadfast. Axzons sister organization can demonstrate the high levels of care provided to these patient populations and our patient revenue projections are based largely on Medicare and Medicaid patients, along with the indigent and charity care commitment.

🗁 Attach any evidence directly supporting your explanation as **APPENDIX J**.

34. Has the Applicant made any previous indigent and charity care commitments associated with a **previous** Certificate of Need application?

☐ **YES** ☐ **NO**

If **YES** ➔ Complete the following table. Specify the information requested for each applicable facility and/or service. Also, attach sheets to indicate how the amount of the commitment was determined.

If **NO** ➔ Continue to the next question.

Previous Indigent/Charity Care Commitments				
Facility/Service	**Project Number**	**Date of Approval**	**Percent of Adjusted Gross Revenue**	**Outcome**
			%	☐Met ☐Not Met
			%	☐Met ☐Not Met
			%	☐Met ☐Not Met
			%	☐Met ☐Not Met
			%	☐Met ☐Not Met
			%	☐Met ☐Not Met

35. Is the Applicant making an indigent and charity care commitment for **this** project?

■ **YES** ☐ **NO**

If **YES** ➔ Complete the information requested below. Note that failure to meet an indigent and charity care commitment could result in fines and constitute grounds for an adverse ruling on a future Certificate of Need application.

If **NO** ➔ Continue to the next question.

Is the commitment voluntary, or is it required by a specific Certificate of Need rule?

☐ Voluntary ■ Mandatory

Is the commitment service-specific or hospital-wide?

■ Service-Specific ☐ Hospital-Wide

In the space provided below, describe the commitment and include its amount and effective date(s). Indicate what percentage of adjusted gross revenues the commitment represents.

Axzons will commit to make an indigent and charity care commitment for this project of one percent (1%) of adjusted gross revenue. In making this indigent and charity care commitment, it is worth noting that Axzons has extensive experience working with Medicare and Medicaid patients through its sister organization's current operations in New York, as well as charity care provided in that organization. As such, they are well-equipped to support an influx of indigent and charity care patients through these programs. It is important to recognize that the need for such care has already been established, and Axzons has a proven track record of providing high quality care to these patient populations. Therefore, Axzons' experience and expertise in caring for medically indigent patients is a testament to their dedication to providing high quality healthcare services to all individuals, regardless of their ability to pay.

Rule 111-2-2-.09(1)(h): Relationship to Health Care Delivery System

The proposed new institutional health service has a positive relationship to the existing health care delivery system in the service area.

36. In the space provided below, explain how the proposed new institutional health service will complement existing services, provide services for which there is a target population, provide an alternative to existing services, or provide services for which there is an unmet need. You may wish to list referral arrangements and working relationships with other providers.

☞ **NOTE:** *If your explanation exceeds this blocked space, attach additional 8-½ by 11-inch pages, number the first sheet Page 31.1, the second Page 31.2 and so on. Do not alter the main page numbers of this application. Once printed, insert your additional pages 31.1, etc. behind this Page 31.*

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of the relationship of your project to the health care delivery system into **APPENDIX K**. All documents such as tables, charts, and maps that you wish to use to analyze the relationship with the health care delivery system and that are able to be inserted or created in MS Word format should be inserted following this page according to instructions in the note above.

Axzons' team has extensive experience working with Medicaid, Medicare and private pay patients, and is well-versed in providing high quality care. The Applicant is committed to meeting the unmet needs of the proposed service areas. We will work closely with hospitals, rehabs, and other institutions to ensure safe patient discharge and provide a continuum of care for patients in need. Additionally, Axzons will partner with community-based organizations to support their members' home health requirements. With years of experience in creating, nurturing, and expanding relationships with relevant medical institutions, Axzons is dedicated to providing quality home health to those in need. We will use this experience to foster referral arrangements and working relationships with area medical institutions and other service providers. In short, Axzons will complement existing home health services and provide an alternative to current offerings. Our commitment to providing quality care and fostering strong relationships with medical institutions and service providers sets them apart as a reliable and dedicated home health agency. In addition, the Applicant projects hiring more home health aides and personal care aides than typical applicants that demonstrate its committment to providing high quality and cost effective care when large numbers of patients will not necessarily need physical therapists or higher cost home health services. Community Linkage Plan ---See Appendix K

Rule 111-2-2-.09(1)(i): Efficient Utilization

The proposed new institutional health service encourages more efficient utilization of the health care facility proposing such service.

37. State how your proposed project will enhance delivery of the services within your facility. Do not exceed the space provided for your response.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of the effect your project on utilization into **APPENDIX L**.

Applicant's sister organization in New York has a proven track record of providing home health services in largely rural counties of upstate New York, which include rural areas comparable to those in Georgia's SSDR-8. Applicant's sister organization was awarded a Lead Financial Intermediary, a distinguished award under New York's Medicaid program, which shows that New York's Medicaid program recognizes applicant's sister organization's experience and expertise in providing high quality, cost-effective care to these vulnerable patient populations who receive care through the program. Applicant will bring that same experience and expertise to its operations in Georgia.

Because applicant can bring the resources and experience of a large organization to its operations in Georgia, it will generate efficiencies in utilization of services, the use of a single HIPAA compliant EHR system, and staff which would be duplicated if multiple organizations were providing the same services.

Rule 111-2-2-.09(1)(j): Non-Resident Services

The proposed new institutional health service provides, or would provide a substantial portion of its services to individuals not residing in its defined service area or the adjacent service area.

38. State how your proposed project provides or will provide a substantial portion of the proposed services to individuals not residing in the defined service area or the adjacent service area. Limit your response to the space provided. If this consideration is not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you wish to use to demonstrate how your project conforms to this rule into **APPENDIX L**.

Not Applicable.

Rule 111-2-2-.09(1)(k): Research Projects

The proposed new institutional health service conducts biomedical or behavioral research projects or a new service development, which is designed to meet a national, regional, or statewide need.

39. State how your proposed project includes research projects or develops new services that will meet a national, regional, or statewide need. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you wish to use to demonstrate how your project conforms with this rule on research projects into **APPENDIX L**.

Not applicable: Axzons will not conduct biomedical or behavioral research or represents a new service development designed to meet a national, regional, or statewide need.

Rule 111-2-2-.09(1)(l): Assistance to Health Professional Programs

The proposed new institutional health service meets the clinical needs of health professional training programs.

40. State how your proposed project will meet the clinical needs of health professional programs, which request assistance. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of how your project addresses the needs of health professional programs into **APPENDIX L**.

The applicant is committed to participating in field training students in the areas of home health services as requested and the students would be placed with an experienced staff person during their training period.

Rule 111-2-2-.09(1)(m): Improvements and Innovation

The proposed new institutional health service fosters improvements or innovations in the financing or delivery of health services; promotes health care quality assurance that can be documented with outcomes greater than those which are generally in keeping with accepted clinical guidelines, peer review programs and comparable state rates for similar populations; promotes cost effectiveness; or fosters improvements or innovations in the financing or delivery of health services; or fosters competition that is shown to result in lower patient costs without a significant deterioration in the quality of care;

41. State how your proposed project fosters improvements or innovations in the financing or delivery of health services, promotes health care quality assurance or cost effectiveness, or fosters competition. Limit your response to the space provided.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize to demonstrate your projects compliance with this rule consideration into **APPENDIX L**.

The proposed Axzons home health agency is committed to holding regular Quality Assurance meetings in accordance with its policies and procedures. Axzons' state-of-the-art healthcare delivery systems will facilitate improvements and innovations in the seamless delivery of health services. These meetings will monitor and improve all aspects of agency operations, including financial, technical, and medical aspects. Axzons' goal is not only to adhere to accepted clinical guidelines but to exceed them in the care provided to patients. Additionally, Axzons will focus on reducing the rate of patient rehospitalization, which will contribute to cost-effectiveness and positively impact state health budgets. By prioritizing quality care and continuous improvement, Axzons is dedicated to providing the best possible healthcare services to its patients.

Rule 111-2-2-.09(1)(n): Needs of HMOs

The proposed new institutional health service fosters the special needs and circumstances of Health Maintenance Organizations.

42. State how your proposed project fosters the special needs of HMOs. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis of the effect of your project on the needs of HMOs into **APPENDIX L**.

Axzons' team has extensive experience working with HMOs and is well-versed in complying with all HMO rules. They are committed to working with all HMOs to provide quality care to their members. During the COVID-19 pandemic, Axzons' sister company helped Managed Long Term Care plans in New York provide services to members who had not received home health services for months. This experience has given Axzons' team a deep understanding of the complications and issues that can arise when working with HMO members. Applicant is dedicated to fostering the special needs of HMOs. By prioritizing the needs of HMO members and complying with regulations, Axzons is committed to providing quality care to all individuals in need of home health services.

Rule 111-2-2-.09(1)(o): Minimum Quality Standards

The proposed new institutional health service meets the Department's minimum quality standards, including, but not limited to, standards relating to accreditation, minimum volumes, quality improvements, assurance practices, and utilization review procedures.

43. State how your proposed new institutional health service meets the department's minimum quality standards. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis into **APPENDIX L**.

The applicant, if approved, intends to obtain Medicare and Medicaid certification, along with Joint Commission accreditation like its sister organization. Applicant also intends to seek accreditation with the Community Health Accreditation Program, Inc. (CHAP), as is recommended for home health agencies in the service specific considerations. In addition, the applicant also maintains various policies and procedures to ensure it provides high quality, cost efficient care to all patients in need of service including the following: 1) Continuous Quality Improvement Program; 2) Admittance policy; 3) Consumer Rights Policy; 4) Charity Care and Indigent Care policy; 5) Cultural diversity policy; 6) Equal opportunity employment plans; 7) Provision of information policy; 8) Solicitation and Distribution policy; and 9) Annual & Quarterly Quality Improvement Evaluations to ensure all policies are being followed and identify areas of policy improvement across the whole agency.

Rule 111-2-2-.09(1)(p): Necessary Resources

The proposed new institutional health service can obtain the necessary resources, including health care management personnel.

44. State how your proposed new institutional health service meets the department's requirement to be able to obtain the necessary resources. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis into **APPENDIX L**.

Axzons is well-equipped with the necessary resources, including personnel, to begin operations. Axzons has already hired an Administrator, Nurse, Social Worker, and a few caregivers in preparation for receiving State approval. Office staff is also available to begin providing services. In addition to personnel, Axzons has access to necessary software systems, a payroll provider, training resources, and marketing materials. With these resources in place, Axzons is ready to hit the ground running and provide quality home health services to those in need. Their commitment to being fully prepared and equipped demonstrates their dedication to providing reliable and efficient services to their patients.

Rule 111-2-2-.09(1)(q): Underrepresented Health Service

The proposed new institutional health service is an underrepresented health service, as determined annually by the Department. The Department shall, by rule, provide for an advantage to equally qualified applicants that agree to provide an underrepresented service in addition to the services for which the application was originally submitted.

45. State how your proposed new institutional health service meets the department's requirement regarding provision of an underrepresented health service. Limit your response to the space provided. If not applicable, so state.

🗁 Attach any documentation, such as magazine articles, research papers, or any other document that cannot be reproduced or created in MS Word format and that you utilize in your analysis into **APPENDIX L**.

Not applicable.

Rule 111-2-2-.09(2): Destination Cancer Hospital

46. State how your proposed new institutional health service meets the department's requirements for a destination cancer hospital under the rule cited above. Include your response in **Appendix L.**

Rule 111-2-2-.09(4): Basic Perinatal Services

47. State how your proposed new institutional health service meets the department's requirements for Basic Perinatal Services under the rule cited above. Include your response in **Appendix L.**

Section 4: Service-Specific Review Considerations

48. The following table documents the service-specific review considerations currently utilized by the Department.

a) Carefully review this table and place a checkmark in the box provided for any and all service-specific review considerations that apply to your project.

SERVICE-SPECIFIC CONSIDERATIONS				
	Service	**Rule Number**	**Check if Applicable & Included**	**Appendix Letter** See instructions at (d) on next page
ACUTE CARE	Short Stay General Hospital Services	111-2-2-.20	☐	
	Adult Cardiac Catheterization Services	111-2-2-.21	☐	
	Open Heart Surgical Services	111-2-2-.22	☐	
	Pediatric Cardiac Catheterization and Open Heart Services	111-2-2-.23	☐	
	Perinatal Services	111-2-2-.24	☐	
	Freestanding Birthing Center Services	111-2-2-.25	☐	
	Psychiatric and Substance Abuse Inpatient Services	111-2-2-.26	☐	
LONG-TERM CARE	Skilled Nursing and Intermediate Care Facility Services	111-2-2-.30	☐	
	Personal Care Home Services	111-2-2-.31	☐	
	Home Health Services	111-2-2-.32	■	
	Life Plan Community Sheltered Nursing Facilities	111-2-2-.33	☐	
	Traumatic Brain Injury Services	111-2-2-.34	☐	
	Comprehensive Inpatient Physical Rehabilitation Services	111-2-2-.35	☐	
OTHER	Ambulatory Surgical Services	111-2-2-.40	☐	
	Positron Emission Tomography Services	111-2-2-.41	☐	
	MegaVoltage Radiation Therapy Services/Units	111-2-2-.42	☐	

CONTINUED ON NEXT PAGE

111-2-2-.32 Specific Rule Considerations for Home Health Services

(1) **Applicability**. A Certificate of Need for a home health agency will be required prior to the establishment of a new home health agency or the expansion of the3 geographic service area of an existing home health agency unless such expansion is a result of a non-reviewable acquisition of another existing home health agency.

(2) **Definitions**.

(a) "Home health agency" means a public agency or private organization, or subdivision of such an agency or organization, which is primarily engaged in providing to individuals who are under a written plan of care of a physician, on a visiting basis in the place of residence used as such individual's home, part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse, and one or more of the following services: physical therapy, occupational therapy, speech therapy, medical social services under the direction of a physician, or part-time or intermittent services of a home health aide.

(b) "Horizon year" means the last year of the three-year projection period for need determinations for a new or expanded home health agency.

(c) "Geographic service area" means a grouping of specific counties within a planning area for which the home health agency is authorized to provide services to individuals residing in the specific counties pursuant to an existing or future certificate of need. For purposes of establishing a service area for a new home health agency, the geographic service area shall consist of any individual county or combination of contiguous counties which have an unmet need as determined through the numerical need formula or the exception. For purposes of an expansion of an existing agency, the geographic service area shall consist of an individual county or any combination of counties which have an unmet need and which are within any planning area in which the home health agency already provides service; however, in no case may an existing home health agency apply to provide services outside the health planning areas in which its current geographic service area is located.

(d) "Nursing care" means such services provided by or under the supervision of a licensed registered professional nurse in accordance with a written plan of medical care by a physician. Such services shall be provided in accordance with the scope of nursing practice laws and associated Rules.

(e) "Planning area" for all home agencies means the geographic regions in Georgia defined in the State Health Plan or Component Plan.

(3) Standards.

(a) The need for a new or expanded home health agency shall be determined through application of a numerical need method and an assessment of the projected number of patients to be served by existing agencies.

1. The numerical need for a new or expanded home health agency in any planning area in the horizon year shall be based on the estimated number of annual home health patients within each health planning area as determined by a population-based formula which is a sum of the following for each county within the health planning area:

   (i) a ratio of 4 patients per 1,000 projected horizon year Resident population age 17 or younger;
   (ii) a ratio of 5 patients per 1,000 projected horizon year Resident population age 18 through 64;
   (iii) a ratio of 45 patients per 1,000 projected horizon year Resident population age 65 through 79; and
   (iv) a ratio of 185 patients per 1,000 projected horizon year Resident population age 80 and older.

2. The net numerical unmet need for home health services shall be determined by subtracting the projected number of patients for the current calendar year from the projected need for services as calculated in (3)(a)1. The projected number of patients for the current calendar year is determined by multiplying the number of patients having received services in each county, as reported in the most recent survey year, by the county population change factor. The county population change factor is the percent change in total population between the most recent survey year and the current calendar year.

(b) 1. The Division shall accept applications for review as enumerated below:

   (i) If the net numerical unmet need in a given planning area is 250 patients or more, the Division shall authorize the submission of applications for an expanded home health agency; or

   (ii) If the net numerical unmet need in a given planning area is 500 patients or more, the Division shall authorize the submission of applications for a new home health agency as well as an expanded home health agency.

2. An applicant must propose to provide service only within a county or group of counties, each of which reflects a numerical unmet need, and contained within the given planning area for which the Division has authorized the submission of applications.

3. The Department shall only approve applications in which the applicant has applied to serve all of the unmet numerical need in any one county in which need

is projected. The need within counties shall not be divided or shared between any two or more applicants.

RESPONSE: The Office of Health Planning ("OHP") has identified an unmet need of 600 within SSDR-8 in the following counties: Chattahoochee, Randolph, Clay, Schley, Dooly, Stewart, Harris, Sumter, Macon, Talbot, Marion, Taylor, Quitman, and Webster, authorizing OHP to review the submission of new applications to provide home health services. Axzons proposes to offer new home health services in each identified county to all patients.

(c) The Division may authorize an exception to 111-2-2-.32(3)(a) if:

1. The applicant for a new or expanded home health agency can show that there is limited access in the proposed geographic service area for special groups such as, but not limited to, medically fragile children, newborns and their mothers, and HIV/AIDS patients. For purposes of this exception, an applicant shall be required to document, using population, service, special needs and/or disease incidence rates, a projected need for services in the planning area of at least 200 patients within a defined geographic service area. A successful applicant applying under this section will be restricted to serving the special group or groups identified in the application within the county or counties stipulated in the application; or

2. A particular county is served by no more than two (2) home health agencies and either of the following conditions exists:

(1) less than one percent of the county's population has received home health service, or

(2) one of the two home health agencies has demonstrated a failure to adequately serve Medicaid patients as evidenced by a level of service to such individuals that is less than the statewide average within each of the past two years as reported on the Annual Home Health Services survey. For purposes of this exception, "served by" shall mean the agency(ies) are licensed to serve the county by the Healthcare Facility Regulation Division of the Georgia Department of Community Health.

RESPONSE: Not applicable. Axzons is not seeking approval pursuant to an exception as OHP has determined there is an unmet need for home health services in the identified counties of Chattahoochee, Randolph, Clay, Schley, Dooly, Stewart, Harris, Sumter, Macon, Talbot, Marion, Taylor, Quitman, and Webster in SSDR-8.

(d) An applicant for a new or expanded home health agency shall provide a community linkage plan which demonstrates factors such as, but not limited to, referral arrangements with appropriate services of the healthcare system and working agreements with other related community services assuring continuity of care focusing

on coordinated, integrated systems which promote continuity rather than acute, episodic care. Working agreements with other related community services may include the ability to streamline referrals to other appropriate services and to participate in the development of cross-continuum care plans with other providers.

RESPONSE: Axzons' sister organization has a long established history of providing services in forty seven (47) New York counties and has maintained substantial relationships with partners in those counties to ensure high quality care and continuity of care to its patients. Axzons is implementing similar plans to establish relationships within the communities where it proposes to provide services. See Community Linkage Plan attached in **Appendix N**.

(e) An applicant for a new or expanded home health agency shall provide a written statement of its intent to comply with all appropriate licensure requirements and operational procedures required by the Healthcare Facility Regulation Division of the Georgia Department of Community Health.

RESPONSE: As a proposed new home health service in Georgia, Axzons shall comply with all appropriate licensure in the state of Georgia and will appropriate licensure with the Healthcare Facility Regulation Division.

(f) An applicant for a new or expanded home health agency or agency(ies) owned and/or operated by the applicant or its parent organization shall have no history of uncorrected or repeated conditional level violations or uncorrected standard deficiencies as identified by licensure inspections or equivalent deficiencies as noted from Medicare or Medicaid audits.

RESPONSE: Axzons' sister organization has serviced Medicare and Medicaid patients in the state of New York and was selected as a Lead Fiscal Intermediary for the New York Department of Health to provide services to New York's Medicaid beneficiaries in forty seven (47) New York counties. While the Applicant is a new entity expanding into Georgia, its sister organization has no history of conditional level violations or uncorrected standard deficiencies in this provision of services to Medicare and Medicaid patients.

(g) An applicant for a new or expanded home health agency or agency(ies) owned and/or operated by the applicant or its parent organization shall have no previous conviction of Medicaid or Medicare fraud.

RESPONSE: Axzons and its affiliates have no previous conviction of Medicaid or Medicare fraud.

(h) An applicant for a new or expanded home health agency shall provide a written plan which demonstrates the intent and ability to recruit, hire and retain the appropriate numbers of qualified personnel to meet the requirements of the services proposed to

be provided and that such personnel are available in the proposed geographic service area.

RESPONSE: Axzons maintains a robust roster of providers and support personnel to ensure quality and continuity of care for its home health patients. Axzons will bring its substantial operational resources and experience to implement plans to maintain appropriate staff and healthcare providers to provide 24-7 care to its patients in the proposed service area. See Human Resource Plan and Cultural Diversity Policy, both attached in Appendix N.

(i) An applicant for a new home health agency shall provide evidence of the intent to meet the appropriate accreditation requirements of The Joint Commission (TJC), the Community Health Accreditation Program, Inc. (CHAP), and/or other appropriate accrediting agencies.

RESPONSE: Axzons' sister organization is currently accredited by The Joint Commission and if the project is approved, the Applicant intends to seek accreditation from the Community Health Accreditation Program, Inc. (CHAP) or similar accrediting agencies.

(j) An applicant for an expanded home health agency shall provide documentation that they are fully accredited by The Joint Commission (TJC), the Community Health Accreditation Program, Inc. (CHAP), and/or other appropriate accrediting agency.

RESPONSE: Not applicable, as Applicant is a new home health agency.

(k) An applicant for a new or expanded home health agency shall provide its existing or proposed plan for a comprehensive quality improvement program.

RESPONSE: Axzons maintains a Continuous Quality Improvement program to ensure Axzons providers have the necessary skills, training, and continuing education to always improve and provide high quality care to patients. See Continuous Quality Improvement Policy attached in **Appendix N**.

(l) An applicant for a new or expanded home health agency shall assure access to services to individuals unable to pay and to all individuals regardless of payment source or circumstances by:

1. providing evidence of written administrative policies that prohibit the exclusion of services to any patient on the basis of age, disability, gender, race, or ability to pay;

2. providing a written commitment that services for indigent and charity patients will be offered at a standard which meets or exceeds one percent of annual, adjusted gross revenues for the home health agency or, in the case of an applicant providing

other health services, the applicant may request that the Division allow the commitment for services to indigent and charity patients to be applied to the entire facility;

RESPONSE: Axzons provides care to its patients regardless of age, disability, gender, race, or ability to pay. Axzons has long provided substantial care through New York's Medicaid and Medicare programs and is committed to an indigent and charity care policy of one percent (1%). See Indigent Charity Care Policy and Client/Consumer Rights Policy **Appendix N**.

3. providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to Medicare, Medicaid, and indigent and charity patients;

RESPONSE: As a new home health service in Georgia, Axzons does not currently have any other Georgia owned facilities providing services to Georgia patients. However, Axzons' sister organization provides Medicaid and Medicare services as well as indigent and charity care to its New York patients and commits to providing appropriate documentation evidencing its meeting this requirement with its Georgia operations as required following its approval.

4. providing a written commitment to participate in the Medicare, Medicaid and PeachCare for Kids programs; and

RESPONSE: Axzons commits to participating in Georgia's Medicare, Medicaid and PeachCare for Kids programs and to provide high quality care to patients of those programs just as it's sister organization does for New York Medicare and Medicaid patients with its current operations.

5. providing a written commitment to participate in any other state health benefits insurance programs for which the home health service is eligible.

RESPONSE: Axzons commits to participate in other Georgia state health benefits insurance programs for which home health service is an eligible benefit.

(m) An applicant for a new or expanded home health agency shall demonstrate that their proposed charges compare favorably with the charges of existing home health agencies in the same geographic service area.

RESPONSE: Axzons has researched other similar home health services in the service area and proposes to offer its services at or below the rates of other home health agencies in the service area.   consistent with those of other home health services. See Table titled: Financial Average Charges Per Agency Visit in **Appendix N**.

(n) An applicant for a new or expanded home health agency shall document an agreement to provide Division requested information and statistical data related to the operation and provision of home health services and to report that data to the Division in the time frame and format requested by the Department.

RESPONSE: Axzons commits to providing the necessary home health services information and statistical data to the Department as required.

(o) The department may authorize an existing home health agency to transfer one county or several counties to another existing home health agency without either agency being required to apply for a new or expanded Certificate of Need, provided the following conditions are met:

1. The two agencies agree to the transfer and submit such agreement and a joint request to transfer in writing to the department at least thirty (30) days prior to the proposed effective date of the transfer;

2. The two agencies document within the written request that the transfer would result in increased and improved services for the residents of the county or counties including Medicare and Medicaid patients;

3. The agency to which the county or counties are being transferred currently offers services in at least one contiguous county or within the health planning area(s) in which county or counties are located; and

4. The two agencies are in compliance with all other requirements of these Rules; such compliance to be evaluated with the written transfer request. No such transfer shall become effective without written approval from the department.

RESPONSE: Not applicable. Axzons is proposing to provide new home health services and is not seeking a transfer from one or multiple counties to another.

b) After reviewing the table above and indicating the applicable considerations by placing a check mark in the appropriate rows, obtain a copy of each set of service-specific review considerations that apply to this Certificate of Need application and project. These considerations are available on the Department's website at www.dch.georgia.gov.

c) After obtaining the service-specific review considerations, the Applicant should document the project's compliance with each of the applicable rule standards. Attach the applicable considerations to this document. Number the pages of your service-specific considerations starting at Page 38.1, 38.2, etc. and insert them once printed behind this Page 38. If more than one set of service-specific considerations is applicable to your project include them behind this Page starting at Page 38.1 in the order that the considerations appear in the table above. Clearly label each new set of service-specific considerations at the top of page.

d) 🗁 Attach all substantiating documents and supplemental information required by a set of service-specific review considerations in **APPENDIX N**. If addressing more than one set of service-specific considerations place the substantiating documents in response to the first set of service-specific considerations in **APPENDIX N**, documents relating to the second set in **APPENDIX O**, and so forth until each applicable set of service-specific considerations has its own appendix for substantiating documents and supplemental information. Enter the corresponding letter in the Appendix Letter column in the table on the previous page. Within each Appendix, place the documents and supplemental information in the order in which such items are asked for in the applicable service-specific review standards.

   NOTE: The Appendices described in (d) above should only be utilized for substantiating documents and supplemental information required by the service-specific review considerations that cannot be reproduced or created as an MS Word document, e.g. QA Policies, Referral Agreements, etc. All documents such as tables, charts, and maps that you wish to use to utilize in your analysis of particular service-specific review considerations that are able to be inserted or created in MS Word format should be inserted following this page according to instructions in (c) above.

THE REMAINDER OF THIS PAGE LEFT BLANK.

CERTIFICATION OF APPLICANT

By signing below,

a) I hereby certify that the contained statements and all addenda, appendices, or attachments hereto are true and complete to the best of my knowledge and belief and that I possess the authority to submit this application and bind the Applicant to promises made herein;

b) I understand that a representative of the Office of Health Planning may make a direct request of me for additional information in order to deem this application complete;

c) I further understand that if awarded a Certificate of Need, information must be provided to the Office of Health Planning regarding the progress, scope, and costs associated with the project. Consequently, I agree and certify that the Applicant will submit progress reports as required by Rule 111-2-2-.04(2), which specifies the frequency and the content of the progress reports. I understand that failure to comply with these reporting requirements may result in penalties, up to and including revocation of the Certificate of Need;

d) I further understand that if issued a Certificate of Need, the Applicant is bound to any representations that have been made within this application and any and all supplemental information; and

e) I certify that the Applicant will accept a condition or conditions on the award of a Certificate of Need based upon any representation of intent contained herein.

APPLICANT CERTIFICATION	
Signature of Authorized Signatory (BLUE INK ONLY):	
Name: Sandeep Kalra	
Title: Chief Executive Officer	Date: 5/30/2023

APPENDIX A

1. Proof of Submission to the County Commission

2. Notice of Compliance for Survey and Indigent and Charity Care Commitment Requirements

Brian P. Kemp, Governor **Caylee Noggle, Commissioner**

2 Martin Luther King Jr. Drive SE, East Tower | Atlanta, GA 30334 | 404-656-4507 | www.dch.georgia.gov

VIA EMAIL

To: Sandeep Kalra, Chief Executive Officer
Axzons Homecare Ltd.
3715 Northside Pkwy NW, Building 100, Suite 500
Atlanta, GA 30327
skalra@axzonshomecare.com

NOTICE OF COMPLIANCE FOR SURVEY AND INDIGENT AND CHARITY CARE COMMITMENT REQUIREMENTS

As of the date below, the following proposed applicant or organization **HAS MET** the requirements for submission and completeness of all surveys and has fulfilled active indigent and charity care commitments or other required data appropriate to the filing of the Certificate of Need Project described below and pursuant to DCH Rules 111-2-2-.06(5)(b)4 and 111-2-2-.06(5)(b)10:

Applicant or Organization: ***Axzons Homecare Ltd.***

Letter of Intent Number: ***LOI2023-026***

Project Description: ***Establishment of Home Health Services – SSDR 8***

Note: An individual Notice of Compliance must be included in each application filed for the current batching cycle. Applications must be filed no later than 12:00 P.M. on Tuesday May 30, 2023.

Certified By:

Karesha B. Laing,
Interim Executive Director,
Office of Health Planning

Date Certified: **May 15, 2023**

May 30, 2023

VIA EMAIL:
(davis.sandra@columbusga.org)

Sandra T. Davis
Clerk of Council
Board of Commissioners
P.O. Box 1340
Columbus, GA 31901

RE: Certificate of Need Application: Axzons Homecare Ltd.
Home Health Agency, Spring 2023 Batching Cycle, SSDR #8
Columbus, Muscogee County, Georgia

Dear Ms. Davis,

Enclosed please find a copy of Certificate of Need application filed by Axzons Homecare Ltd. which proposes to develop offer home health services in SSDR 8, including Chattahoochi, Randolph, Clay, Dooly, Harris, Macon, Marion, Quitman, Schley, Stewart, Sumter, Talbot, Taylor and Webster Counties. This copy is being filed pursuant to State Certificate of Need regulations, which require that a copy of such an application be filed with the office of the County Commission in the county in which the Certificate of Need project is proposed.

Should you have any questions, please feel free to call me at (404) 806-5575.

Sincerely,

SOUTHERN HEALTH LAWYERS, LLC

Jeffrey Mustari

Enclosure

3 Alliance Center
3550 Lenox Road NE, Suite 2100
Atlanta, Georgia 30326
Phone: (404) 806-5575
Fax: (866) 871-2238
E-Mail: jmustari@southernhealthlawyers.com
Web: www.southernhealthlawyers.com

APPENDIX B

Permits and Licenses

Not Applicable

APPENDIX C

ORGANIZATIONAL STRUCTURE

1. Name of Each Officer and Director
2. Articles of Incorporation
3. Certificate of Existence
4. Bylaws
5. Organizational Chart

APPENDIX C

ORGANIZATIONAL STRUCTURE

Name of Each Officer and Director

APPENDIX C – 1		
AXZONS HOMECARE LTD.		
Officer Name	**Title**	**Address**
Sandeep Kalra	President	3715 Northside Parkway, NW Building 100 Suite 500 Atlanta, Georgia 30327
John M. Chacko, MD	Clinical Director	3715 Northside Parkway, NW Building 100 Suite 500 Atlanta, Georgia 30327
Vidhu Saini	Secretary	3715 Northside Parkway, NW Building 100 Suite 500 Atlanta, Georgia 30327

APPENDIX C

ORGANIZATIONAL STRUCTURE

2. Articles of Organization

Control Number : 22205111

STATE OF GEORGIA

Secretary of State

Corporations Division
313 West Tower
2 Martin Luther King, Jr. Dr.
Atlanta, Georgia 30334-1530

CERTIFIED COPY

I, **Brad Raffensperger**, the Secretary of State of the State of Georgia, do hereby certify under the seal of my office that the attached documents are true and correct copies of documents filed with the Corporations Division of the Office of the Secretary of State of Georgia under the name of

Axzons Homecare Ltd.
a Domestic Profit Corporation

This certificate is issued pursuant to Title 14 of the Official Code of Georgia Annotated and is prima-facie evidence of the existence or nonexistence of the facts stated herein.

Docket Number	:	25205052
Date Inc/Auth/Filed	:	09/19/2022
Jurisdiction	:	Georgia
Print Date	:	05/23/2023
Form Number	:	215

Brad Raffensperger
Secretary of State

Control Number : 22205111

STATE OF GEORGIA

Secretary of State

Corporations Division
313 West Tower
2 Martin Luther King, Jr. Dr.
Atlanta, Georgia 30334-1530

CERTIFICATE OF INCORPORATION

I, **Brad Raffensperger**, the Secretary of State and the Corporation Commissioner of the State of Georgia, hereby certify under the seal of my office that

Axzons Homecare Ltd.
a **Domestic Profit Corporation**

has been duly incorporated under the laws of the State of Georgia on **09/19/2022** by the filing of articles of incorporation in the Office of the Secretary of State and by the paying of fees as provided by Title 14 of the Official Code of Georgia Annotated.

WITNESS my hand and official seal in the City of Atlanta and the State of Georgia on **09/28/2022**.

Brad Raffensperger

Brad Raffensperger
Secretary of State

ARTICLES OF INCORPORATION

Electronically Filed
Secretary of State
Filing Date: 9/19/2022 12:47:52 PM

BUSINESS INFORMATION

CONTROL NUMBER	22205111
BUSINESS NAME	Axzons Homecare Ltd.
BUSINESS TYPE	Domestic Profit Corporation
EFFECTIVE DATE	09/19/2022
SHARES	100

PRINCIPAL OFFICE ADDRESS

ADDRESS	70 E Sunrise Highway, Ste # 500, Valley Stream, NY, 11581, USA

REGISTERED AGENT

NAME	ADDRESS	COUNTY
JOHN M CHACKO	2700 PINETREE RD, NE, UNIT # 1112, ATLANTA, GA, 30324, USA	Fulton

INCORPORATOR(S)

NAME	TITLE	ADDRESS
Sandeep Kalra	INCORPORATOR	70 E Sunrise Highway, Suite # 500, Valley Stream, NY, 11581, USA

OPTIONAL PROVISIONS

Home Care, Hospice, Pharmacy, Dispensary

AUTHORIZER INFORMATION

AUTHORIZER SIGNATURE	Sandeep Kalra
AUTHORIZER TITLE	Incorporator

STATE OF GEORGIA

Secretary of State

Corporations Division
313 West Tower
2 Martin Luther King, Jr. Dr.
Atlanta, Georgia 30334-1530

Annual Registration

Electronically Filed
Secretary of State
Filing Date: 01/05/2023 22:30:15

BUSINESS INFORMATION		
BUSINESS NAME	:	Axzons Homecare Ltd.
CONTROL NUMBER	:	22205111
BUSINESS TYPE	:	Domestic Profit Corporation
ANNUAL REGISTRATION PERIOD	:	2023

BUSINESS INFORMATION CURRENTLY ON FILE		
PRINCIPAL OFFICE ADDRESS	:	70 E Sunrise Highway, Ste # 500, Valley Stream, NY, 11581, USA
REGISTERED AGENT NAME	:	JOHN M CHACKO
REGISTERED OFFICE ADDRESS	:	2700 PINETREE RD, NE, UNIT # 1112, ATLANTA, GA, 30324, USA
REGISTERED OFFICE COUNTY	:	Fulton

UPDATES TO ABOVE BUSINESS INFORMATION		
PRINCIPAL OFFICE ADDRESS	:	70 E Sunrise Highway, Ste # 500, Valley Stream, NY, 11581, USA
REGISTERED AGENT NAME	:	JOHN M CHACKO
REGISTERED OFFICE ADDRESS	:	2700 PINETREE RD, NE, UNIT # 1112, ATLANTA, GA, 30324, USA
REGISTERED OFFICE COUNTY	:	Fulton

OFFICER	TITLE	ADDRESS
SANDEEP KALRA	Secretary	70 E SUNRISE HIGHWAY, STE 500, VALLEY STREAM, NY, 11580, USA
SANDEEP KALRA	CEO	70 E SUNRISE HIGHWAY, STE 500, VALLEY STREAM, NY, 11580, USA
SANDEEP KALRA	CFO	70 E SUNRISE HIGHWAY STE 500, VALLEY STREAM, NY, 11580, USA

AUTHORIZER INFORMATION		
AUTHORIZER SIGNATURE	:	SANDEEP KALRA
AUTHORIZER TITLE	:	Officer

APPENDIX C

ORGANIZATIONAL STRUCTURE

3. Certificate of Existence

Control Number : 22205111

STATE OF GEORGIA

Secretary of State

Corporations Division
313 West Tower
2 Martin Luther King, Jr. Dr.
Atlanta, Georgia 30334-1530

CERTIFICATE OF EXISTENCE

I, **Brad Raffensperger**, the Secretary of State of the State of Georgia, do hereby certify under the seal of my office that

Axzons Homecare Ltd.
a **Domestic Profit Corporation**

was formed in the jurisdiction stated below or was authorized to transact business in Georgia on the below date. Said entity is in compliance with the applicable filing and annual registration provisions of Title 14 of the Official Code of Georgia Annotated and has not filed articles of dissolution, certificate of cancellation or any other similar document with the office of the Secretary of State.

This certificate relates only to the legal existence of the above-named entity as of the date issued. It does not certify whether or not a notice of intent to dissolve, an application for withdrawal, a statement of commencement of winding up or any other similar document has been filed or is pending with the Secretary of State.

This certificate is issued pursuant to Title 14 of the Official Code of Georgia Annotated and is prima-facie evidence that said entity is in existence or is authorized to transact business in this state.

Docket Number : 25202230
Date Inc/Auth/Filed : 09/19/2022
Jurisdiction : Georgia
Print Date : 05/22/2023
Form Number : 211

Brad Raffensperger
Secretary of State

APPENDIX C

ORGANIZATIONAL STRUCTURE

4. Corporate Bylaws

CORPORATE BYLAWS OF

<u>AXZONS HOMECARE LTD.</u>

INCORPORATED IN THE STATE OF GEORGIA

ARTICLE I – CORPORATE AUTHORITY

Section 1. *Incorporation*: **Axzons Homecare LTD**., (the "Corporation") is a duly organized corporation authorized to do business in the State of

Pennsylvania by the filing of Articles of [Organization] [Incorporation] on September 19th, 2022

Section 2. *State law:* The Corporation is organized under **Title 14 of the Georgia Code** and except as otherwise provided herein, the Statutes shall apply to the governance of the Corporation

ARTICLE II - OFFICES

Section 1. *Registered Office and Registered Agent*: The registered office of the Corporation in the State of Georgia, shall be 2700 PINE TREE RD, NE, UNIT # 1112, ATLANTA, GA 30324, The registered agent of the Corporation shall be John M Chacko.

Section 2. *Other Offices*: The Corporation may also have offices at such other places, both within and without the State of Georgia, as the Board of Directors may from time to time determine or the business of the Corporation may require.

ARTICLE III – MEETINGS OF SHAREHOLDERS

Section 1. *Place of Meetings*: Meetings of shareholders shall be held at the principal office of the Corporation or at such place as may be determined from time to time by the Board of Directors of the Corporation.

Section 2. *Annual Meetings*: Each year, the Corporation shall hold an annual meeting of shareholders on such date and at such time as shall be determined from time to time by the Board of Directors, at which meeting shareholders shall elect a Board of Directors and transact any other business as may properly be brought before the meeting.

Section 3. *Special Meetings*: Special meetings of the shareholders, for any purpose or purposes, may be called at any time by the President of the Corporation, or the Board of Directors, or shareholders holding at least ten percent (10%) of the issued and outstanding voting stock of the Corporation. Business transacted at any special meeting shall be confined to the purpose or purposes set forth in the notice of the special meting.

Section 4. *Notice of Meetings*: Whenever shareholders are required to permitted to take any action at a meeting, a written notice of the meeting shall be provided to each shareholder of record entitled to vote at or entitled to notice of the meeting, which shall state the place, date, and hour of the meeting, and, in the case of a special meting, the purpose or purposes for which the meeting is called. Unless otherwise provided by law, written notice of any meeting shall be given not less than ten nor more than sixty days before the date of the meeting to each shareholder entitled to vote at such meeting.

Section 5. *Quorum at Meetings:* Shareholders may take action on a matter at a meeting only if a quorum exists with respect to that matter. Except as otherwise provided by law, a majority of the outstanding shares of the Corporation entitled to vote, represented in person or by proxy, shall constitute a quorum at a meeting of shareholders. Once a share is represented for an purpose at a meeting (other than solely to object to the holding of the meeting), it is deemed present for quorum purposes for the remainder of the meeting and the shareholders present at a duly organized meeting may continue to transact business until adjournment, notwithstanding the withdrawal of sufficient shareholders to leave less than a quorum. The holders of a majority of the outstanding shares represented at a meeting, whether or not a quorum is present, may adjourn the meeting from time to time.

Section 6. *Proxies:* Each shareholder entitled to vote at a meeting of shareholders or to express consent or dissent to corporate action in writing without a meeting may authorize another person or persons to vote for him or her by proxy, but no such proxy shall be voted or acted upon after one year from its date, unless the proxy provides for a longer period. A duly executed proxy shall be irrevocable if it states that it is irrevocable and if, and only as long as, it is coupled with an interest sufficient in law to support an irrevocable power. Except as otherwise provided herein or by law, every proxy is revocable at the pleasure of the shareholder executing it by communicating such revocation, in writing, to the Secretary of the Corporation.

Section 7. *Voting at Meetings*: If a quorum exists, action on a matter (other than the election of directors) is approved if the votes cast favoring the action exceed the votes cast opposing the action. Directors shall be elected by a plurality of the votes cast by the shares entitled to vote in the election (provided a quorum exists). Unless otherwise provided by law or in the Corporation's Articles of Incorporation, and subject to other provisions of these Bylaws, each shareholder

shall be entitled to one vote on each matter, in person or by proxy, for each share of the Corporation's capital stock that has voting power and that is held by such shareholder. Voting need not be by written ballot.

Section 8. *List of Shareholders:* The officer of the Corporation who has charge of the stock ledger of the Corporation shall prepare and make, at least ten days before any meeting of shareholders, a complete list of the shareholders entitled to vote at the meeting, arranged alphabetically, and showing the address of each shareholder and the number of shares held by each shareholder. The list shall be open to the examination of any shareholder for any purpose germane to the meeting, during ordinary business hours, for a period of at least ten days before the meeting, either at a place in the city where the meeting is to be held, which place must be specified in the notice of the meeting, or at the place where the meeting is to be held. The list shall also be produced and kept available at the time and place of the meeting, for the entire duration of the meeting, and may be inspected by any shareholder present at the meeting.

Section 9. *Consent in Lieu of Meetings:* Any action required to be taken or which may be taken at any meeting of shareholders, whether annual or special, may be taken without a meeting, without prior notice, and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by the holders of outstanding shares having not less than the minimum number of votes that would be necessary to take such action at a meeting at which all shareholders entitled to vote were present and voted. The action must be evidenced by one or more written consents, describing the action taken, signed and dated by the shareholders entitled to take action without a meeting, and delivered to the Corporation at its registered office or to the officer having charge of the Corporation's minute book.

No consent shall be effective to take the corporate action referred to in the consent unless the number of consents required to take action are delivered to the Corporation or to the officer having charge of its minute book within sixty days of the delivery of the earliest-dated consent.

Prompt notice of the taking of the corporate action without a meeting by less than unanimous vote shall be given to those shareholders who have not consented in writing.

Section 10. *Conference Call*: One or more shareholders may participate in a meeting of shareholders by means of conference telephone, videoconferencing, or similar communications equipment by means of which all persons participating in the meeting can hear each other. Participation in this manner shall constitute presence in person at such meeting.

Section 11. *Annual Statement:* The President and the Board of Directors shall present at each annual meeting a full and complete statement of the business and affairs of the corporation for the preceding year.

ARTICLE IV – DIRECTORS

Section 1. *Powers of Directors*: The business and affairs of the Corporation shall be managed by or under the direction of the Board of Directors, which may exercise all such powers of the Corporation and do all lawful acts and things, subject to any limitations set forth in these Bylaws or the Articles of Incorporation for the corporation

Section 2. *Number, Qualification and Election*: The number of directors shall be set at _2____________. Each director shall be at least 18 years of age. The directors need not be residents of the state of incorporation. The directors shall be elected by the shareholders at the annual meeting of shareholders by the vote of shareholders holding of record in the aggregate at least a plurality of the shares of stock of the Corporation present in person or by proxy and entitled to vote at the annual meeting of shareholders. Each director shall be elected for a term of __4____ year(s), and until his or her successor shall be elected and shall qualify or until his or her earlier resignation or removal.

Section 3. *Nomination of Directors*: The Board of Directors shall nominate candidates to stand for election as directors; and other candidates may also be nominated by any shareholder of the Corporation, provided such nomination is submitted in writing to the Corporation's Secretary no later than 30 days prior to the meeting of shareholders at which such directors are to be elected, together with the identity of the nominator and the number of shares of the stock of the Corporation owned by the nominator.

Section 4. *Vacancies*: Except as otherwise provided by law, any vacancy in the Board of Directors occurring by reason of an increase in the authorized number of directors or by reason of the death, withdrawal, removal, disqualification, inability to act, or resignation of a director shall be filled by the majority of directors then in office. The successor shall serve the unexpired portion of the term of his or her predecessor. Any director may resign at any time by giving written notice to the Board or the Secretary.

Section 5. *Meetings*:

a. Regular Meetings: Regular meetings of the Board of Directors shall be held at least __1_ times per year without notice and at such time and place as determined by the Board.

b. Special Meetings: Special meetings of the Board may be called by the Chairperson or the President on two days' notice to each

director, either personally or by telephone, express delivery service, email, or facsimile transmission, and on four days' notice by mail (effective upon deposit of such notice in the mail). The notice need not specify the purpose of a special meeting.

Section 6. *Quorum and Voting at Meetings*: A majority of the total number of authorized directors shall constitute a quorum for transaction of business. The act of a majority of directors present at any meeting at which a quorum is present shall be the act of the Board of Directors, except as provided by law, the Articles of Incorporation, or these Bylaws. Each director present shall have one vote, irrespective of the number of shares of stock, if any, he or she may hold.

Section 7. *Committees of Directors*. The Board of Directors, by resolution, may create one or more committees, each consisting of one or more Directors. Each such committee shall serve at the pleasure of the Board. All provisions under the Statutes and these Bylaws relating to meetings, action without meetings, notice, and waiver of notice, quorum, and voting requirements of the Board of Directors shall apply to such committees and their members.

Section 8. *Consent in Lieu of Meetings*: Any action required or permitted to be taken at any meeting of the Board of Directors or of any committee thereof, may be taken without a meeting of all members of the Board or committee, as the case may be, consent thereto in writing, such writing or writings to be filed with the minutes or proceedings of the Board or committee.

Section 9. *Conference Call*: One or more directors may participate in meetings of the Board or a committee of the Board by any communication, including videoconference, by means of which all participating directors can simultaneously hear each other during the meeting. Participation in this manner shall constitute presence in person at such meeting.

Section 10. *Compensation:* The Board of Directors shall have the authority to fix the compensation of Directors. A fixed sum and expenses of attendance may be allowed for attendance at each regular or special meeting of the Board. No such payment shall preclude any director from serving the Corporation in any other capacity and receiving compensation therefor.

Section 11. *Removal of Directors:* Any director or the entire Board of Directors may be removed, with or without cause, by the holders of a majority of the shares then entitled to vote at an election of directors.

ARTICLE V -- OFFICERS

Section 1. *Positions:* The officers of the Corporation shall be a Chairperson, a President, a Secretary, and a Treasurer, and such other officers as the Board may from time to time appoint, including one or more Vice Presidents and such

other officers as it deems advisable. Each such officer shall exercise such powers and perform such duties as shall be set forth herein and such other powers and duties as may be specified from time to time by the Board of Directors. The officers of the Corporation shall be elected by the Board of Directors. Each of the Chairperson, President, and/or any Vice Presidents may execute bonds, mortgages, and other documents under the seal of the Corporation, except where required or permitted by law to be otherwise executed and except where execution thereof shall be expressly delegated by the Board to some other officer or agent of the Corporation.

Section 2. *Chairperson*: The Chairperson shall have overall responsibility and authority for management and operations of the Corporation, shall preside at all meetings of the Board of Directors and shareholders, and shall ensure that all orders and resolutions of the Board of Directors and shareholders are implemented.

Section 3. *President*: The President shall be the chief operating officer of the Corporation and shall have full responsibility and authority for management of the day-to-day operations of the Corporation. The President shall be an ex-officio member of all committees and shall have the general powers and duties of management and supervision usually vested in the office of president of a corporation.

Section 4. *Secretary*: The Secretary shall attend all meetings of the Board and all meetings of the shareholders and shall act as clerk thereof, and record all the votes of the Corporation and the minutes of all its transactions in a book to be kept for that purpose, and shall perform like duties for all committees of the Board of Directors when required. The Secretary shall give, or cause to be given, notice of all meetings of the shareholders and special meetings of the Board of Directors, and shall perform such other duties as may be prescribed by the Board of Directors or President, and under whose supervision the Secretary shall be. The Secretary shall maintain the records, minutes, and seal of the Corporation and may attest any instruments signed by any other officer of the Corporation.

Section 5. *Treasurer*: The Treasurer shall be the chief financial officer of the Corporation, shall have responsibility for the custody of the corporate funds and securities, shall keep full and accurate records and accounts of receipts and disbursements in books belonging to the Corporation, and shall keep the monies of the Corporation in a separate account in the name of the Corporation. The Treasurer shall provide to the President and directors, at the regular meetings of the Board, or whenever requested by the Board, an account of all financial transactions and of the financial condition of the Corporation.

Section 6. *Term of Office*: The officers of the Corporation shall hold office until their successors are chosen and have qualified or until their earlier resignation or removal. Any officer or agent elected or appointed by the Board may be

removed at any time, with or without cause, by the affirmative vote of a majority of the Board of Directors. Any vacancy occurring in any office as a result of death, resignation, removal, or otherwise, shall be filled for the unexpired portion of the term by a majority vote of the Board of Directors.

Section 7. *Compensation*: The compensation of officers of the Corporation shall be fixed by the Board of Directors.

ARTICLE VI – CAPITAL STOCK

Section 1. *Stock Certificates*: The shares of the Corporation shall be represented by certificates, provided that the Board of Directors may provide by resolution that some or all of any or all classes or series of the stock of the Corporation shall be uncertificated shares. Notwithstanding the adoption of such a resolution by the Board of Directors, every holder of stock represented by certificates and, upon request, every holder of uncertificated shares, shall be entitled to have a certificate signed in the name of the Corporation, by the Chairperson, president or any Vice President, and by the Treasurer or Secretary. Any or all of the signatures on the certificate may be by facsimile. The stock certificates of the Corporation shall be numbered and registered in the share ledger and transfer books of the Corporation as they are issued and shall bear the corporate seal.

Section 2. *Lost Certificates*: The Corporation may issue a new certificate of stock in place of any certificate theretofor issued and alleged to have been lost, stolen, or destroyed, and the Corporation may require the owner of the lost, stolen or destroyed certificate, or his or her legal representative, to make an affidavit of that fact, and the Corporation may require indemnity against any claim that may be made against the Corporation on account of the alleged loss, theft, or destruction of any such certificate or the issuance of such new certificate.

Section 3. *Transfers*: Transfers of shares shall be made on the books of the Corporation upon surrender and cancellation of the certificates therefore, endorsed by the person named in the certificate or by his or her legal representative. No transfer shall be made which is inconsistent with any provision of law, the Articles of Incorporation for the Corporation, or these Bylaws.

Section 4. *Record Date*: In order that the Corporation may determine the shareholders entitled to notice of or to vote at any meeting of shareholders, or any adjournment thereof, or to take action without a meeting, or to receive payment of any dividend or other distribution, or to exercise any rights in respect of any change, conversion, or exchange of stock, or for the purpose of any other lawful action, the Board of Directors may fix a record date, which record date shall not precede the date upon which the resolution fixing the record date is

adopted by the Board of Directors and shall not be less than ten nor more than fifty days before the meeting or action requiring a determination of shareholders.

If no record date is fixed by the Board of Directors:

a. for determining shareholders entitled to notice of or to vote at a meeting, the record date shall be at the close of business on the day next preceding the day on which notice is given, or, if notice is waived, at the close of business on the day next preceding the day on which the meeting is held or other action taken;
b. For determining shareholders entitled to consent to corporate action without a meeting, the record date shall be the day on which the first written consent is delivered to the Corporation in accordance with these Bylaws; and
c. For determining shareholders for any other purpose, the record date shall be at the close of business on the day on which the Board of Directors adopts the resolution relating thereto.

ARTICLE VII -- DIVIDENDS

Section 1. *Dividends*: The Board of Directors may declare and pay dividends upon the outstanding shares of the Corporation, from time to time and to such extent as the Board deems advisable, in the manner and upon the terms and conditions provided by law and the Articles of Incorporation of the Corporation.

Section 2. *Reserves*: The Board of Directors may set apart, out of the funds of the Corporation available for dividends, said sum as the directors, from time to time, in their absolute discretion, think proper as a reserve fund for any proper purpose. The Board of Directors may abolish any such reserve in the manner it was created.

ARTICLE VIII – GENERAL PROVISIONS

Section 1. *Insurance and Indemnity:* The Corporation may purchase and maintain insurance in a reasonable amount on behalf of any person who is or was a director, officer, agent, or employee of the Corporation against liability asserted against or incurred by such person in such capacity or arising from such person's status as such.

Subject to applicable statute, any person made or threatened to be made a party to any action, suit, or proceeding, by reason of the fact that he or she, his or her testator or intestate representative, is or was a director, officer, agent, or employee of the Corporation, shall be indemnified by the Corporation against the reasonable expenses, including attorney's fees, actually and necessarily incurred by him or her in connection with such an action, suit, or proceeding. Notwithstanding the foregoing, no indemnification shall be made by the Corporation of judgment or other final determination establishes that the potential

indemnificatee's acts were committed in bad faith or were the result of active or deliberate fraud or dishonesty or clear and gross negligence.

Section 2. *Corporate Records*: Any shareholder of record, in person or by attorney or other agent, shall, upon written demand under oath stating the purpose thereof, have the right during the usual hours for business to inspect for any proper purpose the Corporation's stock ledger, a list of its shareholders, and its other books and records, and to make copies or extracts therefrom. A proper purpose shall mean a purpose reasonably related to such person's interest as a shareholder. In every instance in which an attorney or other agent shall be the person seeking the right to inspection, the demand under oath shall be accompanied by a power of attorney or such other writing authorizing the attorney or other agent to so act on behalf of the shareholder.

The demand under oath shall be directed to the Corporation at its registered office or its principal place of business.

Section 3. *Fiscal Year:* The fiscal year of the Corporation shall be the calendar year.

Section 4. *Seal:* The corporate seal shall be in such form as the Board of Directors shall approve. The seal may be used by causing it or a facsimile thereof to be impressed, affixed, or otherwise reproduced.

Section 5. *Execution of Instruments*: All contracts, checks, drafts, or demands for money and notes and other instruments or rights of any nature of the Corporation shall be signed by such officer or officers as the Board of Directors may from time to time designate.

Section 6. *Notice*: Whenever written notice is required to be given to any person, it may be given to such person, either personally or by sending a copy thereof through the United States mail, or by email, or facsimile, charges prepaid, to his or her address appearing in the books of the Corporation, or supplied by him or her to the Corporation for the purpose of notice. If the notice is sent by mail it shall be deemed to have been given to the person entitled thereto when deposited in the United States mail. If the notice is sent by facsimile, it shall be deemed to have been given at the date and time shown on a written confirmation of the transmission of such facsimile communication. If such notice is related to a meeting, the notice shall specify the place, day, and hour of the meeting, and, in the case of a special meeting of shareholders, the purpose of and general nature of the business to be transacted at such special meeting.

Section 7. *Waiver of Notice*: Whenever any written notice is required by law, or by the Articles of Incorporation or by these Bylaws, a waiver thereof in writing, signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

Except in the case of a special meeting of shareholders, neither the business to be conducted at nor the purpose of the meeting need be specified in the waiver of notice of the meeting. Attendance of a person either in person or by proxy, at any meeting, shall constitute a waiver of notice of such meeting, except where a person attends a meeting for the express purpose of objecting to the transaction of any business because the meeting was not lawfully convened or called.

Section 8. *Amendments*: The Board of Directors shall have the power to make, adopt, alter, amend, and repeal from time to time the Bylaws of the Corporation except that the adoption, amendment, or repeal of any Bylaw regulating the election of directors shall be subject to the vote of shareholders entitled to cast at least a majority of the votes which all shareholders are entitled to cast at any regular or special meeting of the shareholders, duly convened after notice to the shareholders of that purpose.

The foregoing Bylaws were adopted by the Board of Directors on September 19th 2022.

SECRETARY'S SIGNATURE

Vidhu Saini

SECRETARY (PRINT)

VIDHU SAINI

SHAREHOLDER'S NAME	**NUMBER (#) OF SHARES**
Sandeep Kalra	100

APPENDIX C

ORGANIZATIONAL STRUCTURE

5. Organizational Charts

Axzons Homecare Ltd. Organizational Chart

- BOARD
  - Executive Administrator
    - Director of Patient Services
      - Registered Nurse
      - Registered Nurse
      - Registered Nurse
    - Clinical Operations Lead
      - Manager Quality Assurance
        - Quality Assurance Lead
        - Monitoring Supervisor
  - Chief Operations Officer
    - Director of IT Deployment
      - Office operations Associate
        - Office operations Associate
    - Director Human Resources
      - Human Resource Manager
      - Human Resource Lead
        - Human Resource Lead
    - Director Marketing
      - Public Relations Manager
      - Market Analysis Lead

APPENDIX D

SITE ENTITLEMENT

Applicant has performed a diligent search to obtain leased office space in SSDR-8. Upon CON approval, applicant will execute a lease and maintain an office within SSDR-8 to support its provision of home health services to patients. See Lease Terms attached in Appendix D.

DIRECT DRAFT AUTHORIZATION FORM

CUSTOMER INFORMATION

NAME: ____
(Please Print or Type)

Customer Number: ____________________________

I hereby authorize: **CoWork Columbus/ WC Bradley Real Estate**

To initiate: [ ] debit / drafts

To my: [ ] checking account [ ] savings account

I understand that, if necessary, an adjusting debit or credit entry may be made to correct an error.

I also authorize the financial institution named below to credit and/or debit my account for the correcting entries. I duly certify that I am an authorized signer of said account and have the right to enter into this agreement.

ACCOUNT INFORMATION

NAME OF BANK: ____

CITY / STATE: ____

BANK ROUTING NUMBER: ____

ACCOUNT NAME: ____

ACCOUNT NUMBER: ____

This authority will remain in full force and effect until such time as: **CoWork Columbus / WC Bradley Real Estate** has received written notification from me that the draft authorization has been revoked. It is further provided that written notification of termination, by either party, shall be provided in such time and manner as to afford either party reasonable opportunity to act on it.

Membership Payments will be drafted on the 1st day of each month. If the 1st falls on a weekend, payment will be drafted the following business day.

____ ____________________
Signature of account owner Date

Please attach a voided check.

COMPARISON SHEET

	FLEX SEATS $200 monthly	DEDICATED DESKS $300 monthly	PRIVATE OFFICE $650 – $1,175 monthly*	TRADITIONAL OFFICE $812.50 a Month Average Rent (650 sq ft)
24 Hour Access	✓	✓	✓	Maybe
Beverage & Snack Bar	✓	✓	✓	$60 a Month
Fully Furnished	✓	✓	✓	$140 a Month
Onsite Membership Director	✓	✓	✓	Not Included
Daily Use Lockers	✓	✓	✓	Not Included
High Speed, Fiber Optic-Driven Wi-Fi	✓	✓	✓	$85 a month
Networking Opportunities	✓	✓	✓	Not Included
Conference Room Time	2 Hours a Month Included	6 Hours a Month Included	8 Hours a Month Included	Not Included
Color Copies	25 Included Monthly $0.75 After That	✓	✓	Print Shop is $0.89 per side
B&W Copies	100 Included Monthly $0.15 After That	✓	✓	Print Shop is $0.08 per side
Mail	$15.00 Monthly	✓	✓	P.O. Box $19 Monthly
Parcel Receipt	✓	✓	✓	Not Included

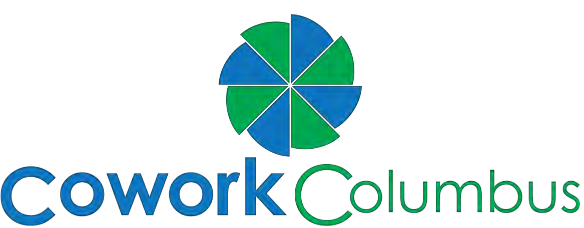
NOTE: Office pricing based on single occupancy, additional occupants are $300 per month.

WHERE YOU WORK

706.571.3400 | CoWork-Columbus.com

Leasing and Management by

Owner/Manager reserves the right to make changes in their sole discretion without notice. Prices, terms and use are subject to change.
Membership is not guaranteed and is subject to application and approval.



Membership Terms and Conditions

CoWork Columbus is excited to welcome you as a member. These terms and conditions (these "Terms and Conditions") in conjunction with your membership application ("Application", and together with these Terms and Conditions, the "Agreement") describe your rights and obligations in connection the services you elected in your Application and certain other related services and features available to members (the "Services"). If you have any questions about the Agreement, please contact Cherie Sanders, csanders@wcbradley.com. By using the Services, you are agreeing to abide by and be bound by the Agreement.

Services, the Work Space and Access

"We" or "us" and similar words means CoWork Columbus. We reserve the right to change the legal entity that charges you for, and/or provides, the Services. References to "you" or "your" and similar words refer to the individual or entity registering for any Services through an Application. You agree to immediately update your Application in the event of any changes to your contact information. If you are entering these Terms and Conditions on behalf of an entity, you represent and warrant that you have all necessary right, authority and consent to bind such entity. In the event your relationship with the entity changes or ends, you agree to promptly update your Application to reflect this. If your membership is provided by an entity, you may lose access to the Services upon termination or change in status of your relationship with such entity (and you agree we may rely upon any communication from an executive officer of such entity in this regard). You agree to indemnify us for any loss we may suffer as a result of any breach of these warranties and representations.

We will make the space, including any private areas, described in your Application (the "Work Space") available to you at the time and in the condition described in your Application. Basic office amenities ("Basic Amenities"), as generally provided to our members, are a part of your membership and include, without limitation, daily cleaning services, electricity for normal office use, internet access as specified in your Application, heating and air conditioning during Business Hours, water, pantry access/amenities such as tea and coffee, basic kitchen and bathroom supplies, and any other Basic Amenities indicated in your Application. Unless otherwise provided in your Application, Basic Amenities do not include computer, printer, copier, or phone line access. Additional Services as described in your Application or as may otherwise be agreed-to between you and us ("Additional Services") shall be provided in the manner, and for the additional costs (if any), indicated in your Application or in a separate agreement governing such Additional Services, and any additional terms governing such Additional Services, shall be integrated into these Terms and Conditions.

Unless specified otherwise in your Application, the Work Space does not include additional storage spaces or non-exclusive, private areas. To the extent we make any space generally

available to our members and/or the public, you will also have access to such space on a nonexclusive basis and on the same terms as are generally offered, subject to any rules, regulations, capacity and/or access restrictions imposed by us for such space ("Community Guidelines").

You may access the Work Space (i) during the normal operating hours (as initially defined in your Application), which may be updated from time to time by written notice to you ("Business Hours"), with the exception of U.S. federal holidays, when Business Hours may end earlier, and (ii) outside Business Hours if you have been provided a key. Any such access outside Business Hours may be subject to applicable fees and Community Guidelines.

You (and if we permit, your guests and invitees) may be required to present a valid, government issued photo identification in order to gain access to the Work Space. For security purposes, we may have security cameras onsite, which may record certain areas of the Work Space. We may review footage to investigate incidents, including turning over any such footage to applicable law enforcement authorities. We are entitled to access the Work Space, including any exclusive, private areas, with or without notice for maintenance, safety or emergency purposes

The availability and scope of the Services are subject to change from time to time in our sole discretion. From time to time, we may also make modifications, deletions or additions to these Terms and Conditions and will provide you with notice of such changes via the contact information we have on file for you. Most changes will be effective immediately upon notice. Your continued use of the Services following notice of any such changes, constitutes your agreement to such changes. If you do not agree to the changes, you may cancel your membership, but note that there are no refunds for early cancellation.

Membership Fee and Refundable Deposits
Unless otherwise set forth in your Application or other agreement for Additional Services, your membership fees and, to the extent applicable, any additional payment obligations (collectively, the "Payments") shall be paid in advance, on the first day of each month during the Term, unless we notify you otherwise (the "Payment Date"). By providing your payment information, if you elect an automatic payment option, you agree to pay us the recurring or nonrecurring fees associated with the Services you are purchasing, per your Application or other agreement for Additional Services, or as updated by us from time to time upon notice to you. You acknowledge and agree that the payment method provided by you will be automatically charged the fees and any other amounts you may incur or be liable for (including for damages caused to the Work Space) in connection with the Services. You must keep your payment information up-to-date and accurate. Payments that are not paid by the applicable Payment Date will be subject to late charges and administrative fees (with a minimum of $25 per instance) and accruing finance fees at the highest rate allowed by law or $50 per day, whichever is lower.

You agree that you shall pay a refundable deposit as security, to the extent applicable, according to your Application. In the event you breach your Agreement (including failure to make any Payment when timely due) or take any other actions or omissions resulting in any claims, losses, damages, payments (including legal fees), fines or penalties or other damage to us ("Damages"), we may use all or any portion of any refundable deposit to cure such breach or for the payment of any such Damages. If we do use all or any portion of any refundable deposit in respect of such Damages, you shall promptly (but no later than ten (10) days of our notice to you) restore the refundable deposit to an amount equal to its original sum. For the avoidance of doubt, you will be

held liable (and do hereby authorize us to charge you) for the repair cost for all Damage caused by you (and, if permitted, your guests and invitees). Provided you have made all required Payments in accordance with the Agreement, there are no deductions pursuant to this paragraph and you have vacated the Work Space in good condition with all furniture and fixtures in place, you will receive a return of any refundable deposit. We will not be required to keep any refundable deposit separate from our general accounts and shall have no obligation or liability for payment of interest.

Your use of the Services may be immediately suspended, and eventually terminated, if we are unable to charge your Payment for any reason. When we receive funds from you, we will first apply the funds to any balances which are in arrears and to the earliest month due first. Once past balances are satisfied, any remaining portion of the funds will be applied to current fees due. The fees applicable to your membership may be subject to modification from time to time (including annual increases every year), and such modifications will become effective upon your following Payment Date. Your continued use of the Services following notice of any such modifications, and through the following Payment Date, constitutes your agreement to such modified fees. You may at any time cancel your membership if you do not agree to any modified fees.

All fees are non-refundable. Note that there are no refunds for early cancellation.

Term and Termination

The term of your membership (the "Term") is as described in your Application. The Term may be terminated (such date, the "Termination Date") by us immediately (i) in the event of a material breach of the Agreement; (ii) if you cease your business operations or become the subject of a petition in bankruptcy or any other proceeding relating to insolvency, receivership, administration, liquidation, or assignment for the benefit of creditors; (iii) in connection with the termination of an underlying lease for the Work Space; or (iv) if you continue to use the Work Space or otherwise receive Services beyond the Term. In the event of a termination of the Term, on or before the Termination Date, (x) you shall vacate and cease use of the Work Space in all respects and (y) you shall pay all Payments due and payable for Services as of the Termination Date.

Community Guidelines

The Work Space has a set of Community Guidelines its members (and to the extent permitted by us, your guests and invitees) must comply with while using Services. The Community Guidelines are hereby incorporated into these Terms and Conditions. Community Guidelines may be revised from time to time and are available by contacting us at csanders@wcbradley.com.

In general, we expect that you will not perform any activity that is reasonably likely to be disruptive, damaging or dangerous to us, our employees or agents, other members, any guests, invitees or any other third or property of any of the foregoing.

Other Legal Terms

Not a Lease. You acknowledge that this is a revocable license for a limited use, and nothing in the Agreement shall constitute a leasehold interest or tenancy or conveyance of any exclusive possessory interest in the Work Space, including any private areas. Accordingly, we may exercise self-help to regain exclusive control of the Work Space, including, without limitation, locking up

the Work Space. You understand and agree that no prior or subsequent court order or approval shall be necessary in connection with such self-help or lock-out.

Construction Activities. From time to time it may be necessary for us to make certain modifications, improvements and alterations to the Work Space for maintenance or other reasons ("Improvements"). We will give you prior notice to any such Improvements, which shall be executed in a manner that minimizes interference with the conduct of your business.

Relocation. You acknowledge and agree that we have the right to relocate you within the Work Space to a comparable area (a "Relocation") upon prior notice. In the event of any Relocation, your Application shall be updated to reflect such relocated area.

Attornment. If any applicable landlord (or a designee thereof) succeeds to our rights under any lease and continues to provide the Services in a reasonably comparable manner, then at the request of such landlord, you will attorn to the successor under these Terms and conditions and sign, acknowledge and deliver any instrument that the successor requests to evidence the attornment. Upon such attornment, your Agreement will continue in full force and effect as a direct arrangement between the successor and you.

No Third-Party Liability. We do not control and are not responsible for the actions of other individuals using the Services or at the Work Space. You should be aware that other users or members may not be who they claim to be. We do not perform background checks on our members. We do not endorse, support or verify the facts, opinions or recommendations of our members.

No Liability for Third-Party Products / Services. The Services may provide you with access to third-party products or services. In no event will we be liable, directly or indirectly, to anyone for any damage or loss relating to any use of such products, services or other materials provided by a third-party and not under our control, such as third-party internet providers. You agree that our making available access to or discounts for any third-party services does not constitute provision or warranty of such third-party services by us, and you will look solely to the applicable third-party for provision of the applicable third-party services and for compensation for any claims, damages, liabilities or losses you may incur in connection with such third-party services.

Waiver and Release of Claims. To the fullest extent permitted by law, you, on your own behalf and on behalf of your guests and invitees, waive any and all claims and rights against us and our affiliates, parents, and successors and each of our and their employees, assignees, officers, managers, independent contractors, agents and directors (collectively, the "CoWork Columbus Parties") resulting from injury or damage to, or destruction, theft, or loss of, any property, or person (collectively, "Claims") and release the CoWork Columbus Parties from any such Claims.

Indemnification. You will indemnify, defend and hold harmless the CoWork Columbus Parties from and against any and all claims, liabilities, damages and expenses, including reasonable attorneys' fees, resulting from any breach of the Agreement by you or your guests or invitees or from the acts or omissions of you or your guests or invitees. You are responsible for the actions of all damages caused by all persons that you or your guests or invitees invite to enter the Work Space. You shall not make any settlement that requires a material act or admission by any of the CoWork Columbus Parties, imposes any obligation upon any of the Co Work Columbus Parties or does

not contain a full and unconditional release of the CoWork Columbus Parties, without our written consent. None of the CoWork Columbus Parties shall be liable for any settlement made without its prior written consent.

Cooperation. From time to time, we may investigate any actual, alleged or potential violations of these Terms and Conditions. You agree to cooperate fully in any of these inquiries. You waive all rights against the CoWork Columbus Parties and agree to hold them harmless in connection with any claims relating to any action taken by us as part of our investigation.

Limitation of Liability; Insurance. To the extent permitted by law, the aggregate monetary liability of any of the CoWork Columbus Parties to you or your guests or invitees for any reason and for all causes of action, whether in contract, tort, breach of statutory duty, or other legal or equitable theory will not exceed the actual, total amounts paid by you to us under the Agreement for the product or service from which the claim arose in the three (3) months prior to the claim arising. None of the CoWork Columbus Parties will be liable under any cause of action, for any indirect, special, incidental, consequential, reliance or punitive damages, including loss of profits or business interruption, or for the cost of any substitute goods, services or technology. You acknowledge and agree that you may not commence any action or proceeding against any of the CoWork Columbus Parties, whether in contract, tort, breach of statutory duty, or other legal or equitable theory, unless the action, suit, or proceeding is commenced within one (1) year of the cause of action's accrual.

Disclaimer of Warranties and Implied Terms. The Services are provided "AS IS". To the extent permitted by law, we disclaim all warranties and terms, express or implied, with respect to the Services, including warranties, terms or representations as to the availability, operation, performance and/or use of our Services, or any other materials on or accessed via the Services, including any warranties or terms of merchantability, fitness for a particular purpose, title, non-infringement and any implied warranties, terms or indemnification arising from course of dealing, course of performance or usage in trade. In addition to the forgoing, we will not be liable for failure to perform our Service obligations if the failure results from an act of nature, the act of a national, federal, state or local government authority, fire, explosion, accident, industrial dispute or any other event beyond our reasonable control. Some jurisdictions do not allow the exclusion of certain warranties or the exclusion or limitation of liability for consequential or incidental damages, so the exclusions and limitations above may not apply to you. In such event, such exclusions and limitations shall apply to the maximum extent allowed under applicable law.

Entire Agreement. The Agreement and any terms or rules that may be posted or provided to you constitute the entire agreement between us regarding the Services and supersedes any prior proposals, understandings and contemporaneous communications you may have entered into with us regarding your membership and the Work Space.

Severability. If any provision of the Agreement and terms or rules that may be posted or provided to you are held to be unenforceable, then that provision is to be interpreted either by modifying it to the minimum extent necessary to make it enforceable (if permitted by law) or disregarding it (if not). If an unenforceable provision is modified or disregarded in accordance with this paragraph, the rest of the Agreement and any terms or rules that may be posted or provided to you are to remain in effect as written, and the unenforceable provision is to remain as written in any circumstances other than those in which the provision is held to be unenforceable.

No Waiver. Our failure to enforce its rights under the Agreement at any time for any period will not be construed as a waiver of such rights, and the exercise of one right or remedy will not be deemed a waiver of any other right or remedy.

Survival. You will remain liable for past due Payments, and we may exercise our rights to collect due Payment, despite termination of the Term. You agree to reimburse our reasonable attorneys' fees and other fees to enforce our rights to Payments. This paragraph together with the section entitled "Membership Fee and Refundable Deposits", the Community Guidelines, and any other provision which by its nature must survive to effectuate its purpose shall survive any termination or expiration of the Agreement.

Community Guidelines
Current as of: January 1, 2019

Contact and Payment Information
You must promptly (but in no even later than 5 days) notify us to update any changes to your contact information and payment information.

Prohibited Activities You
may not:

- use the Work Space to conduct any illegal activities or activities that are generally regarded as offensive as we may determine in our sole discretion;
- bring any pets or animals into the Work Space;
- directly or indirectly take, copy or use any information or intellectual property belonging to other members or any of their guests, including without limitation personal names, likenesses, voices, business names, trademarks, service marks, logos, trade dress, other identifiers or other intellectual property, or modified or altered versions of the same;
- use the Work Space to conduct retail or medical activities or otherwise involving frequent visits by non-members to the public areas of the Work Space;
- perform any modifications, improvements or alterations in or to the Work Space without our prior written consent which consent may be withheld in our sole and absolute discretion;
- bring weapons, drugs, or other objectionable material into the Work Space; or
- use, take or copy the trademarks, service marks, logos, trade dress or business name of COWORK COLUMBUS or other identifiers, including modified or altered, or use pictures or illustrations of the Work Space in any advertising, publicity or other purpose without our prior written consent.

Keys
Depending on your membership, you may receive an electronic key ("key") to access the Work Space. You cannot transfer your key to anyone else, and you are responsible for maintaining the security of your key. You must promptly notify us if you suspect your key has been compromised or if your key has been lost. Electronic Keys remain our property, and you must return them immediately upon termination or expiration of your membership. You shall under no circumstances duplicate any keys issued by us, and any such duplication shall immediately result in your forfeiting the key deposit in its entirety (to the extent one was paid) and having any such

key privileges revoked. You may be charged a replacement fee for any lost or damaged keys, including our withholding all or any portion of your key deposit or other refundable deposits. We reserve the right to alter or change your key at any time upon reasonable notice. If you paid a key deposit, upon the return of such keys, the key deposit shall be returned to you in a timely manner upon (i) the expiration of the Term and your vacating and ceasing use of the Work Space and (ii) your return of all keys issued.

Guests

To the extent we permit, you may invite guests to the public areas of the Work Space from time to time. Guests may access Common Spaces (and Conference Rooms when they are reserved for meetings with you). Guests must be accompanied by you at all times and you are responsible for the actions of your permitted guests while they are in the Work Space. Note that guests are not permitted to access private and other space designated for reserved use by our other members without permission from the reserving member. You may not accept any payment or other remuneration from a guest in exchange for any guest’s access to the Work Space.

We may require all guests and invitees to be registered with us prior to entering the Work Space.

Common Spaces and Conference Rooms

Public areas of the Work Space available for general member use (“Common Spaces”) are to be enjoyed by our members (and to the extent we permit, your guests) and are for temporary use and not as a place for continuous, everyday work.

Rooms and other space designated for reserved, private use by our members (“Conference Rooms”) are available by reservation only and upon payment of any applicable fee and are to be accessed by you (and to the extent we permit, your guests) starting from the time immediately prior to your reserved time and ending at the time immediately following your reserved time.

You are expected to clean up after yourself after use of Common Spaces and Conference Rooms, including disposal of trash, removal of dishes, glasses and cutlery, and, with respect to Conference Rooms, wiping the surface of conference tables of crumbs, spills and stains. If we incur excess cleaning charges for your failure to properly clean a Conference Room, the cost of such cleaning will be passed down to you.

Common Spaces and Conference Rooms are first come first serve and subject to availability.

Mail

Subject to our written approval, you may elect to receive mail and packages at the Work Space during Business Hours. While we may accept mail and deliveries on your behalf, we shall not be responsible for the safeguarding or handling of any mail or deliveries. We have no obligation to store such mail or packages for more than thirty (30) days of our receipt or if we receive mail or packages after termination of your membership. This amenity is meant to allow you to accept business correspondence from time to time. It is not meant for an address for the receipt of merchandise or personal goods, and we have no obligation to accept bulk or oversized mail or packages.

Signage, Fixtures, and Furniture
You may not display signage anywhere within the Work Space without our prior written permission nor may you attach or affix any items to the walls, install antennas, telecommunications lines or devices or bring additional furniture or fixtures into the Work Space without our prior written approval.

Technology Release
You agree that we (i) are not responsible for any damage to any of your electronic equipment or systems related your use of the Work Space; (ii) do not assume any liability or warranty in the event that any manufacturer warranties are voided; and (iii) do not offer any verbal or written warranty, either expressed or implied, regarding the success of any technical support. Furthermore, you acknowledge that you have no expectation of privacy with respect to our internet connection (and, if applicable, networks, telecommunications systems or information processing systems (including any stored computer files, email messages and voice messages)), and your activity and any files or messages on or using any of those devices or systems may be monitored at any time without notice, including for security reasons and to ensure compliance with our policies, regardless of whether such activity occurs on equipment owned by you or us.

If we deem it reasonably necessary, we may disclose information about you to satisfy applicable law, rule, regulation, legal process or government request, or to protect us, our members, or other individuals, or any of our or their property. It is your obligation to notify any of your guests about this policy.

You and Other Members
We do not control and are not responsible for the actions of other members or any other third parties. If a dispute arises between members or their invitees or guests, we shall have no responsibility or obligation to participate, mediate or indemnify any party.

Not Responsible for Personal Property
We are not responsible for any property you leave behind in the Work Space. It is your responsibility to ensure that you have retrieved all of your personal items prior to leaving. In any event, you must remove all of your property from the Work Space at the end of your membership. After providing you with notice, we will be entitled to dispose of any property remaining in the Work Space, and you waive any claims or demands regarding such property or our handling of such property. You will be responsible for paying any fees reasonably incurred by us regarding such removal.

Damages
Normal wear and tear excepted, you will be responsible for the cost of all repairs or replacements to furniture, fixtures and equipment (including, by way of example and not limitation, workstations, pantry equipment and Conference Room furniture) in the Work Space or otherwise used by you or your guests to the extent such repair or replacement is the result of damages caused by your or your guest’s misuse, negligence or willful misconduct.

Internet
Your access to the connection is at our discretion. Your access may be blocked, suspended or terminated at any time and for any reason, including violation of Community Guidelines, disruption of access to other members, or to otherwise protect us, our users, or other third parties.

The connection is available to your device only when it is within wireless range of our access points or through an ethernet cable to a data network port. The connection is generally subject to unavailability, including by reason of emergencies, service failures, transmission, equipment or network problems or limitations, interference, signal strength, and maintenance and repair. We are not responsible for any interruptions or performance issues with the connection, or the underlying network(s), transmission equipment and systems. Network speed will vary based on your device configuration, location, compression, network congestion and other factors. You are solely responsible for any devices, software, or other materials necessary for use of the connection.

You agree not to, and are prohibited from, accessing or using (or attempting to access or use) the connection or taking any action online that violates any applicable law or regulation or that could harm us or any third party or interfere with the operation of the data network to others. For example, among other items, you may not:

- share the internet password or access;
- upload or transmit through the connection any (i) computer viruses, worms, spam or anything else designed to interfere with or disrupt the normal operating procedures of a computer or network; or (ii) any material which is defamatory, offensive, or of an obscene nature; or
- take any action that imposes an unreasonable or disproportionately large load on our network or infrastructure or that violates or threatens or system or network security or that of our users or any third parties.

You acknowledge that no data network and internet-based communication is 100% secure, such communications could be intercepted by equipment and software and no such communication should be considered private or protected. We also have the right, but not the obligation, to monitor, intercept and review, and disclose, without further notice, any transmissions over or use of our connection to comply with lawful process, orders, warrants or subpoenas, or to protect our rights, property and members.

Our Marketing

From time to time we may want to photograph, video or otherwise record the Work Space to support our marketing initiatives. In connection therewith, you grant us the right and permission to film, tape, record and photograph your area at reasonable times, and with reasonable prior notice. We agree to coordinate with you in order to account for any scheduling or privacy concerns.

Flex Seats vs Desk/Cube

Flex Seats – members have the ability to work at any available desk or workspace, rather than be assigned a permanent desk. – See attached for pricing

Desk/Cube – members have their own fixed desk with lockable cabinet and ergonomic chair. – See attached for pricing

MEMBERSHIP APPLICATION

Please select a Membership Plan

PRIVATE OFFICE	DEDICATED DESKS	FLEX SEATS
Private Office (See Pricing Matrix Attached) Minimum One Year Commitment	With Membership Term: ______ Month to Month ______ 6 Month ______ 1 Year	With Membership Term: ______ Month to Month ______ 6 Month ______ 1 Year

Please provide the following contact information:

First Name________________________________ Last Name ___________________________________

Company____

Owner/Principal of Company ____

Job Title ____

Home Address ____

City__________________________ State _____________ Zip Code _________________________

Phone Number _________________________ ☐ (Cell) or ☐ (Home) or ☐ (Work)

Email ____

Please initial here if it is OK for us to publish name, industry, title and company website on our Member Directory and on our website. (www.co-workcolumbus.com)
*** We will keep your phone number, address and email private.*

I agree to a term of _______ (month(s) / days(s)) of membership with CoWork Columbus, which will allow me access to CoWork Columbus resources as outlined in this document at the rate of $ ______ (per month) / (per day). Memberships are billed the first of the month. If your membership starts in the middle of the month we will prorate that month's dues.
Nonrefundable One Time Administrative Fee $ 40.00
Electronic Key Deposit $ 10.00
All payments will be AutoDraft and paid in advance – (see attached form).

Please initial here that you have read and understand the CoWork Membership Plan Rates and by providing my payment information, I agree to pay the nonrecurring rate and fees associated with this Application.

Please initial here that you have read and agree to the terms of Use (attached) This document is expressly incorporated herein, and made a part hereof, and shall be a part of our Agreement.

By using Internet or network services (collectively, "Technology") provided by CoWork Columbus, you agree that (a) you are an active Member of CoWork Columbus, (b) your use of the Technology is subject to and in compliance with your Member contract and Privacy Policy (as each may be updated from time to time), (c) we may monitor the health and operation of the Technology, and (d) the Technology is provided "as is" with no guarantee of privacy or suitability for purpose. You agree not to use the Technology without agreeing to all of the foregoing.

Please initial here that you have read and agree to the CoWork Columbus Community Guidelines (attached) which serves as the guideline to being part of CoWork Columbus. I acknowledge and understand the community guidelines may be revised from time to time.

How did you hear about us? ____

I declare that the information I have provided is accurate. I authorize COWORK COLUMBUS or its agent to review and investigate the accuracy of the information contained in this application and consent to a background check if applicable, using the information I have provided in this application.

SIGNATURE ______________________________ DATE ________________

(PRINT) NAME ____

COWORK COLUMBUS ACCETANCE ____________________ DATE ________________

COWORK COLUMBUS STAFF MEMBER ______________________________

NOTES:

APPENDIX E

SUPPLEMENTAL NEED DOCUMENTATION

Not Applicable.

APPENDIX F

SUPPLEMENTAL EXISTING ALTERNATIVES DOCUMENTATION

(NOT APPLICABLE)

APPENDIX G

FINANCIAL FEASIBILITY DOCUMENTATION

1. Financial Feasibility Letter
2. Statement Re: Financial Statements

3715 Northside Pkwy, NW.
Bldg. 100 – Suite 500
Atlanta, GA 30327

axzonshomecare.com

May 23, 2023

Ms. Caylee Noggle
Commissioner
Georgia Department of Community Health
Office of Health Planning
2 Martin Luther King Jr. Drive SE
East Tower, 16th Floor
Atlanta, GA 30334

Re: **Axzons Homecare Ltd.**
Home Health – 2023 Spring Batching
Planning Area: SSDR #8
Proposed Project Site Location: 1201 Front Avenue, Suite N
Columbus, GA 31901
Projected Cost: $100,000.00

Dear Ms. Noggle:

This letter confirms that Axzons Homecare Ltd. has adequate cash reserves on hand to fund the above-referenced project. The cost of the project is $100,000. This capital expenditure will be funded through unrestricted cash reserves of Axzons Homecare Ltd.

Please accept this letter as written confirmation that Axzons Homecare Ltd. currently has the necessary funds in order to provide a full spectrum of home health services in SSDR #8 including Chattahooc, Randolph, Clay, Dooly, Harris, Macon, Marion, Quitman, Schley, Stewart, Sumter, Talbot, Taylor, and Webster Counties, as evidenced by the un-audited financial statements included in Appendix G.

Please let me know if you require any additional information or documentation in this regard.

Sincerely,

Sandeep Kalra
Chief Executive Officer

Axzons Homecare Ltd. Statement on Financial Audits

As a new entity formed for the purpose of providing home health services in Georgia should it receive CON approval, applicant intends to undergo annual financial audits after it receives approval and begins providing services.

APPENDIX H

Supplemental Effects on Payors

Documentation

Not Applicable.

APPENDIX I

Architectural Plans

Not Applicable

APPENDIX J

Client Consumer Rights Policy

Admittance and Readmittance of Clients Policy

Provision of Information Policy

Indigent and Charity Care Policy

Axzons Client Consumer Rights Policy

PURPOSE
1. To ensure clients are aware of their rights;
2. To ensure compliance with applicable laws; and,
3. To ensure that staff are educated about and respectful of client's rights when delivering services.

APPLICATION
This policy applies to Clients/ Consumers of Axzons Homecare Ltd. and defines their rights.

DEFINITIONS

Client
For purposes of this policy a client is a consumer or other individual or entity who uses services delivered by Axzons Homecare Ltd.

POLICY
Pursuant to Ga. Comp. R. & Regs.111-2-2-.32(3)(2)(l)(1) Axzons Homecare Ltd. has established written policies regarding the rights of the patient and developed procedures implementing such These rights, policies and procedures afford each patient the right to:

(1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record;
(2) be given a statement of the services available by the agency and related charges;
(3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient.
(i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change.
(ii) All information required by this paragraph shall be provided to the patient both orally and in writing;
(4) **be informed that the agency prohibits the exclusion of services to any patient on the basis of age, disability, gender, race, or ability to pay.**
(5) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services;
(6) participate in the planning of his or her care and be advised in advance of any changes to

the plan of care;

(7) refuse care and treatment after being fully informed of and understanding the consequences of such actions;
(8) be informed of the procedures for submitting patient complaints;
(9) voice complaints and recommend changes in policies and services to agency staff, the Georgia State Department of Community Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal;
(10) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints in accordance with the provisions.
The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Community Health's Office of Health Systems Management;
(11) be treated with consideration, respect and full recognition of his/her dignity and individuality; and
(12) privacy, including confidential treatment of patient records, and to refuse release of records to any individual outside the agency except in the case of the patient's transfer to a health care facility, or as required by law or third-party payment contract.
(b) The governing authority shall make all personnel providing patient care services on behalf of the agency aware of the rights of patients and the responsibility of personnel to protect and promote the exercise of such rights.
(c) If a patient lacks capacity to exercise these rights, the rights shall be exercised by an individual, guardian or entity legally authorized to represent the patient.

PROCEDURES

1. Supervisor/Alternate and client/client's representative shall review the Rights & Responsibilities of Client & Agency with the client/client's representative during the initial assessment and obtain the required signatures.
2. A copy of the signed *Rights & Responsibilities of Client & Agency* form shall be given to the client prior to the commencement of services. The original shall be placed in the client's file.
3. Supervisor shall make a notation in the client's record that:
   a. the *Rights & Responsibilities of Client & Agency* form was reviewed with the client/client's representative;
   b. the required signatures were obtained;
   c. a copy of the *Rights & Responsibilities of Client & Agency* form was left in the client's home; and,

4. Should the client not understand his/her "*Rights*" the Supervisor/alternate shall document the lack of understanding in the client's record and give the reason why it was not understood. If the client's representative or someone else is in the home is able to comprehend the details, the Supervisor/Alternate shall document this information.

Client Rights

The Agency's form (*Rights & Responsibilities of Client & Agency*) shall include the following client rights. i.e. The client's rights to:

1. be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record;
2. be given a statement of the services available by the Agency and related charges;
3. **be informed that the agency accepts all patients including financially indigent, medically indigent, Medicaid, PeachCare and Medicare Patients.**
4. **be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors (private pay, Commercial insurance as well as Medicaid, PeachCare and Medicare) and the extent to which payment may be required from the patient.**
   (i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change.
   (ii) All information required by this paragraph shall be provided to the patient both orally and in writing;
5. be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services;
6. participate in the planning of his or her care and be advised in advance of any changes to the plan of care;
7. refuse care and treatment after being fully informed of and understanding the consequences of such actions;
8. be informed of the procedures for submitting patient complaints;
9. voice complaints and recommend changes in policies and services to agency staff, the Georgia State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal;
10. submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints.

11. Be notified if the patient is not satisfied by the response the patient may complain to the Department of Community Health's Office of Health Systems Management;
12. The address for the complaints to DCH to be provided to patients is

13.

Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303
800-657-6442

14. be treated with consideration, respect and full recognition of his/her dignity and individuality; and
15. privacy, including confidential treatment of patient records, and to refuse release of records to any individual outside the agency except in the case of the patient's transfer to a health care facility, or as required by law or third-party payment contract.
16. **Prohibit exclusion of service and be dealt with without regard to race, color, age, sex, sexual orientation, creed, religion, disability and familial/cultural factors, or ability to pay.**
17. receive complete information about his/her health and recommended treatments, as developed jointly with this Agency;
18. provided with information on alternative services that may be available;
19. participate in a referral to another service provider or a health care institution;
20. refuse to participate in experimental research;
21. receive reasonable notice of any changes in their service, within an agreed upon amount of time, prior to the changes place
22. be informed of the cost of services and procedures and to be informed of all changes in services, procedures and fees, as they occur;
23. refuse services or treatment and be informed of the consequences of that refusal;
24. be free from mental, verbal, sexual and physical abuse, neglect, involuntary seclusion and exploitation;
25. receive privacy and confidentiality with regard to their health, social, and financial circumstances and what takes place in their homes, in accordance with laws and Agency policies;
26. receive confidential treatment of their personal and medical records;
27. approve or refuse the release of their personal or medical records to any individual/entity other than the Agency except when client records are transferred to another service provider or a health facility or as otherwise authorized by law;
28. make suggestions or complaints or present grievances to the Agency, government agencies or other entities or individuals without fear of the threat of retaliation.
29. receive a prompt response, through an established complaint or grievance procedure, to any complaints, suggestions or grievances they may have;

30. access procedures for making complaints to the:
    a. authority responsible for health quality;
    b. Adult Protective Services Program of the local Department of Social Services, if the client is an adult:
    c. The Child Protective Services Program of the local Department of Social Services, if the client is a child.
31. cared for by qualified, competent and trained personnel;
32. be taught the procedures used to provide care required, to enhance the client's ability to provide as much self-care as possible;
33. designate an individual of the client's choice , to receive instruction on care procedures, which are provided to the client, in order that the designated individual can assist the client as much as possible;
34. have full access to the information regarding their health condition and their care records maintained by this Agency, to the extent required by law;
35. be spoken to or communicated with in a manner or language they can understand;
36. speak freely without fear;
37. have their homes and property treated with respect;
38. be free from involuntary confinement, and from physical or chemical restraints;
39. be free from any actions that would be interpreted as being abusive. e.g. intimidation, physical/sexual/verbal/mental/emotional/material or financial abuse, etc.;
40. report all instances of potential abuse, neglect, exploitation, involving any employee of the Agency, to the *Elder Abuse Hotline*;
41. express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of the Agency;
42. be informed of procedures for initiating complaints about the delivery of service or resolving conflict, without fear of reprisal or retaliation;
43. be informed of the laws, regulations and policies of the Agency including:
    a. *Code of Ethics;*
    b. *Unstable Health Conditions;*
    c. *Withdrawal/Termination of Services*; AND,
    d. others, as required/requested.
44. be provided with the name, certification and staff position of all persons supplying, staffing or supervising the care and services you receive;
45. be informed of where ownership lies for any equipment/supplies provided in the provision of services;
46. receive written information on the care plan, including the names of Care Aide(s), & Supervisor assigned and the Agency's phone number;

47. provide input on which Care Aide they want and request a change of Care Aide, if desired;
48. be briefed on any procedure/treatment before it is carried out in order that they can give informed consent;
49. receive regular nursing supervision of the |Care Aide, if medically-related personal care is needed;
50. be given written documentation on the Agency's Advance Directives Policy;
51. to die with dignity;
52. be informed, within a reasonable amount of time, of the Agency's plans to terminate the care or service and/or their intention to transfer their care to another agency; and,
53. have their family or legal representative exercise the client's rights when the legal representative is legally authorized to do so

CROSS-POLICY REFERENCES

1. Client & Agency Responsibilities
2. Advance Directives
3. Standards of Conduct & Work Ethics
4. Complaints/Compliments
5. Unstable Health Conditions
6. Withdrawal/Termination of Services
7. Service Plan
8. Service Agreement
9. Privacy & Confidentiality

REGULATORY REFERENCE

This policy has a regulatory reference to Ga. Comp. R. & Regs.111-2-2-.32(3)(2)(l)(1)

RESPONSIBLE PARTY

1. Supervisor Client's services is responsible for adhering to this policy's directives.
2. Manager Client's Services

FORMS

1. Rights & Responsibilities of Client & Agency of Client & Agency

Axzons Admittance and

Readmittance of Clients Policy

PURPOSE

1. To ensure that the Agency only admits clients whose care needs can be met safely at home, as determined primarily through an in-home assessment.
2. To outline the conditions and process for admitting individuals, as clients of the Agency.
3. To outline conditions and criteria for re-admitting clients who have been discharged pr transferred from the Agency.

POLICY for ADMITTING CLIENTS

Axzons Homecare Ltd. utilizes the following standards for accepting individuals as clients:

1. The Agency shall accept referrals from almost any source including, but not limited to individuals, families, neighbors, hospitals, community organizations, home health agencies, physicians, third party payors, Veterans Organizations and Social Services
2. **The Agency's medical staff should have privileges allowing a reasonable acceptance of referrals of Medicaid patients, PeachCare patients, and all other patients who are unable to pay all or a portion of their healthcare costs.**
3. Referral sources shall provide the following information when making a referral to this Agency:
   a. potential client's name, address and telephone number;
   b. physician's name and address;
   c. medical diagnosis;
   d. type of level of service needed;
   e. referral source's name, title and phone number; and,
   f. name and telephone number of primary caregiver and emergency contact, if other that the primary caregiver.
4. The Agency shall conduct an assessment before accepting individuals as clients.
5. The Agency shall not discriminate on the basis of religion, race, color, creed, sex, age, handicap, sexual orientation, communicable disease or place of national origin, in its admittance of individuals as clients.
6. The Agency shall be qualified and/or licensed to provide the services required in a safe, efficient and responsible manner.
7. The Agency shall have a sufficient number of qualified personnel and resources to meet a potential client's requested/needed services.
8. The services requested/needed fall within the Agency's scope of services.
9. The Agency may contract services out to qualified individuals and/or other agencies.

10. Clients shall reside within the geographical area served by the Agency.
11. The potential client's home environment shall be adequate for safe and effective care.
12. The potential client shall be willing and able to function at home with required services in place.

13. The potential client's family/caregiver(s)/pertinent other(s) shall be willing to accept in-home services and be willing, able and available to participate in the care.
14. Potential clients with medical problems shall be under the care of a physician or shall be willing to seek care from a physician for medical supervision purposes.
15. Individuals, diagnosed with active pulmonary tuberculosis shall be evaluated for admittance only if the following conditions are met prior to the assessment:
    a. The infected individual has been on an anti-tuberculin regime for at least 2 weeks.
    b. The infected individual shows clinical improvement.
    c. The infected individual has had 3 consecutive samples that are AFB negative.
16. The potential client shall have the financial means to pay for services, either through state/federal assistance programs, private insurance or personal assets.
17. The Agency shall reserve the right to refuse service to anyone who does not meet the admittance criteria.
18. The potential client/representative shall be given the opportunity to either accept or refuse services.
19. The potential client/representative shall sign the required forms indicating acceptance of services.
20. Refusal of any or all identified service needs shall be documented on the assessment form and recorded in a service refusal log.

PROCEDURES for ADMITTING CLIENTS

1. In-home evaluations shall be conducted in a timely fashion following a request for service.
2. Supervisor shall evaluate a potential client's/representative's request for services prior to accepting an individual as a client.
3. The evaluation shall be comprehensive enough to determine the ability of the Agency to meet the requests and needs based on the Agency's overall service capability.
4. The identified needs/problems shall be reviewed with the potential client/ representative to determine the services required and the ability of the Agency to meet the potential client's requests/needs.
5. If the Agency can provide the services, the potential client/representative shall be provided with all the necessary information/material in order to make an informed decision.
6. Supervisor shall document that the above information has been given to the potential client/representative.
7. The potential client/representative, after review, shall be given the opportunity to either accept or refuse services.

8. If a potential client is accepted for service, a *Service Plan* shall be developed jointly with the potential client/representative and a written *Service Agreement* shall be signed by the potential client/representative and the Supervisor.
9. A copy of the *Service Plan* and the *Service Agreement* shall be given to the client and the originals shall be placed in the client's record.

POLICY for RE-ADMITTING CLIENTS

It is the policy of Axzons Health System Corporation to determine if individuals may be re-admitted as Agency clients and if service to them may be reinstated by conducting one or more of the following:

1. the completion of another General Needs Assessment;
2. a review of the Progress Summary Notes; or,
3. an update of the Service Plan/Care Plan which shall:
   a. show new or revised goals and interventions; and,
   b. specify a timeline for follow-up and evaluation.

PROCEDURES FOR RE-ADMITTING CLIENTS

1. Supervisor shall review the reasons client was discharged or transferred initially and determine what changes have occurred, which may justify re-admittance.
2. Supervisor shall conduct another General Needs Assessment and determine if the Agency can meet current needs.
3. Supervisor shall develop Service Plan/Care Plan with input from the client/client's representative/family.
4. Supervisor shall apply the policies and procedures, which are addressed in the *Agency's Service Delivery Process* section, in respect to managing the case and completing the required forms.

SCOPE

This policy applies to all members of the Agency workforce including, but not limited to, employees, medical staff, volunteers, students, physician office staff, and other persons performing work for or at Agency.

CROSS POLICY REFERENCES

1. Provision of Information
2. Service Plan
3. Service Agreement

FORMS

1. Service Plan
2. Service Agreement

Axzons Provision of Information Policy

PURPOSE

To ensure that potential and/or existing clients/clients' representatives are able to make informed decisions on the suitability of the Agency to meet their specific care needs.

POLICY

Axzons Homecare Ltd.ensures that current and potential clients/ clients' representatives have access to comprehensive information, which will enable them to make informed decisions on whether or not the Agency can meet their specific requests and needs.

PROCEDURES

An up-to-date information package shall be provided prior to the initiation of services. The information shall be presented in a clear and easily understood manner and include:

1. a list of the home care services that the Direct Care Worker will be providing;
2. types of services offered and their limitations;
3. **Types of Insurances accepted for financially indigent, medically indigent, Medicaid, PeachCare, Medicare besides Private pay, other commercial insurances.**
4. process for developing the Service Plan;
5. terms and conditions as set out in the Service Agreement;
6. address and contact details for the office;
7. hours of operation and statutory holidays observed by the Agency;
8. details of license and insurance coverage;
9. the name of the Direct Care Worker(s) who will deliver the services;
10. the days and times that services will be delivered;
11. the hourly or weekly fees and total costs for services to be provided,
12. the name of a Departmental Representative(s) they can contact for information about:
    i. licensing criteria for home care agencies or registries; and,
    ii. the Agency's responsibilities and adherence to the rules and regulations established for home care agencies.
13. The telephone number of the Ombudsman Program located with the local Area Agency on Aging (AAA).
14. The hiring and competency requirements for direct care workers to be acceptable for employment or referral by this Agency.
15. A disclosure, prepared in Departmental format, which specifies:
    a. whether the individuals, who provide the services to the client/consumer, are Agency employees or are independent /third party contractors affiliated with the Agency; and,
    b. which taxes, insurances and other obligations the Agency and/or clients/consumers

are responsible to handle.

Axzons Indigent and Charity Care Policy

<table>
<tr><td>Axzons HomeCare
Policies and Procedures</td><td rowspan="2">Axzons HomeCare</td></tr>
<tr><td>Section 4: Patient Access Services</td></tr>
<tr><td rowspan="5">Policy Title: Indigent and Charity Care</td><td>Policy Number:</td></tr>
<tr><td>Effective Date:</td></tr>
<tr><td>Revision Date:</td></tr>
<tr><td>Approved By: Director</td></tr>
<tr><td>Page Number: Page 1 of 10</td></tr>
</table>

PURPOSE:

The purpose of this policy is to establish guidelines for Charity Care for patients of Axzons Health System Corporation ("**AXZONS**") who incur significant financial burden as a result of the amount they are expected to owe "out-of-pocket" for acute care health care services.

In addition, this policy provides administrative and accounting guidelines for the identification, classification and reporting of patients as Charity Care as distinguished from Bad Debts.

POLICY STATEMENT:

Charity Care is provided to a patient with a demonstrated inability to pay. Charity adjustments may only be granted to patients receiving non-elective care. A patient is eligible for Charity Care consideration based upon meeting certain income eligibility criteria as established by the Federal Poverty Income Guideline Sliding Scale. Charity Care represents health care services that are/were provided but never expected to result in payments. As a result, Charity Care does not qualify for recognition as receivable or net patient revenue in the financial statements.

Charity Care may include unpaid coinsurance and deductibles. Bad Debt is payment not received for service rendered for which payment was anticipated and services were provided in good faith. Bad Debt patients do not meet the criteria for Charity Care, that is, they are considered able to pay but unwilling to satisfy their outstanding obligations.

Charity Care data reporting for services provided is based on charges incurred during the patients visit/encounter.

AXZONS proactively makes reasonable efforts to determine whether a patient is eligible for financial assistance before engaging in any collection activities. AXZONS has established respectful and effective procedures for addressing the needs of those persons who are unable to pay for all or most of their care. In order to preserve the dignity of these persons and to facilitate the process of securing necessary information, AXZONS performs financial screening upon scheduling for diagnostic imaging procedures. Patients who represent

increased financial risk as a result of the amount they are expected to owe “out-of-pocket” are referred to a Financial Counselor for assistance in applying for alternative payment programs (e.g., Medical Assistance) determining Charity Care eligibility, establishing payment plans or other financing arrangements.

Patients with insurance should not have their patient liability unpaid balance, coinsurance, deductible or non-covered service written-off to Charity Care unless financial hardship can be proven.

The need for Charity Care is a sensitive and personal issue for recipients and needs to be addressed with reverence for those who are in need. Confidentiality of information and individual dignity shall be maintained for all that seek charitable services.

AXZONS provides medically necessary care to all regardless of ability to pay. Partial and/or full Charity Care is based on the individual’s ability to pay.

PROCEDURE:

1. **Eligibility Criteria:** Excluded from coverage are any third parties who may be liable for payment for services.
   - 1.1. **Charity Care Application: (See <u>Exhibit B</u>)**
     - 1.1.1. Any individual who indicates the financial inability to pay a bill for a medically necessary service shall be evaluated for Charity Care assistance.
     - 1.1.2. The Statement of Financial Condition (<u>Exhibit B</u>) is used to document each patient’s overall financial situation. This application should be available in the primary language(s) of the service area.
     - 1.1.3. Credit reports may be used, when appropriate, to verify an individual’s financial circumstances.
     - 1.1.4. A patient’s employment status and earning capacity is taken into consideration when evaluating a Charity Care request.
     - 1.1.5. The data used in making a determination concerning eligibility for Charity Care should be verified.
     - 1.1.6. Once a determination has been made a notification form is provided to each applicant advising them of the decision.
   - 1.2. **Full Charity Care: 100% Discount**
     - 1.2.1. A patient whose household income (as calculated on the Statement of Financial Condition) is equal to or less than 200% of the most recent Federal Poverty Guidelines (FPG) qualifies for a Full Charity Care discount.
     - 1.2.2. For the purposes of State reporting, a patient whose household income is equal to or less than 125% of the most recent FPG is categorized as Indigent Care.
   - 1.3. **Partial Charity Care:**
     - 1.3.1. A patient whose household income is greater than 200% and less than 400% of the most recent FPG qualifies for a Partial Charity Care discount and are determined each year by the Accounting department.
     - 1.3.2. Flexible, interest-free payment plans are available (e.g., extended payment terms), as appropriate.

1.4. **Catastrophic Charity Care:**

1.4.1. In order to qualify for Catastrophic Charity Care Circumstances, the patient's Allowable Medical Expenses must exceed 40% of household income as described below:

1.4.2. AXZONS multiplies the household income as defined in Section L by 40%

1.4.3. AXZONS determines the patient's Allowable Medical Expenses.

1.4.4. AXZONS compares 40% of the household income as defined in Section L to the total amount of the patient's Allowable Medical expenses. If the total of the Allowable Medical Expenses is greater than 40% of the household income and/or assets, then the patient meets the Catastrophic Charity Care qualification. AXZONS subtracts 40% of the household income and/or assets from the Allowable Medical Expenses to determine the amount by which the Allowable Medical Expenses exceed the available income and/or assets; this amount is then eligible for a Charity Care write-off.

1.5. **Special Circumstances:**

1.5.1. Deceased patients without an estate or third party coverage are eligible for Charity Care.

1.6. **Governmental Assistance:**

1.6.1. In determining whether each individual qualifies for Charity Care, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medicaid, Healthy Families Program, Victims of Crime, State Children Services, etc.

1.6.2. Persons eligible for programs such as Medicaid but whose eligibility status is not established for the period during which the medical services were rendered, should be granted Charity Care for those services. AXZONS will make the granting of charity contingent upon applying for governmental assistance. Patients are required to complete a Medicaid application.

1.7. **AXZONS Collection Efforts:**

1.7.1. Accounts with applications pending for Charity Care or other assistance programs are held until the outcome of the application. A "pending charity approval" is defined as an application that has been fully completed by the patient, submitted and is in the process of being determined for eligibility.

1.7.2. It is acceptable (but not preferable) to take an account through the full collection cycle and later reclassify it as Charity Care, as long as a consistent process is followed and a legitimate basis exists that the patient is unable to pay. For example, self-pay accounts written-off and sent to Bad Debt, reclassifying the account to Charity Care may be considered on the basis of all of the following factors:

1.7.3. No third party coverage or inadequate coverage exists

1.7.4. No payments are recorded on the account

1.7.5. The patient/guarantor was billed a minimum of 4 times

1.7.6. Verifiable income and/or assets are provided by the patient and include all household adults.

1.8. **Collection Agency:**

1.8.1. In some cases, a patient eligible for Charity Care may not have been identified prior to initiating external collection action. Accordingly, each collection agency engaged should be made aware of the policy on Charity Care. This allows the agency to report amounts that they have determined to be uncollectible due to the inability to pay in accordance with the Charity Care eligibility guidelines.

1.8.2. Collection agencies shall not, in dealing with the uninsured patients at or below the 400% Federal Poverty Level, use or threaten to use wage garnishments or liens on primary residences as a means of collecting on unpaid AXZONS bills. AXZONS must specifically authorize institutional litigation. This does not preclude agencies from pursuing reimbursement from third-party liability settlements.

1.8.3. If a collection agency identifies special circumstances demonstrating a particular patient as being unable (versus unwilling) to pay their bill, their liability may be considered Charity Care, even if they were originally classified as a Bad Debt. The patient should be reclassified to Charity Care.

1.9. **Eligibility Period:**

1.9.1. The eligibility period is the year in which financial statements provided from patients meet charity care guidelines and care was received. If financial income or insurance status changes for the year the services incurred, the patient may become ineligible for charity as the guidelines may not be met.

1.10. **Time Requirements for Determination:**

1.10.1. While it is desirable to determine the amount of Charity Care for which a patient is eligible as close to the time of service as possible, there is no rigid limit on the time when the determination is made. In some cases, eligibility is readily apparent and a determination can be made before, on, or soon after the date of service. In other cases, it can take investigation to determine eligibility, particularly when the patient has limited ability or willingness to provide needed information. Every effort should be made to determine a patient's eligibility for Charity Care at the earliest reasonable date.

1.11. **Definition of Income:**

1.11.1. Annual earnings and cash benefits from all sources before taxes, less payments made for alimony and child support. Proof of earnings may be determined by annualizing pay at current earning rates. Bank Accounts and open available lines of credit are considered income.

2. **Accounting for Charity Care:**

2.1.1. Charity Care write-offs are accounted for in separate Deduction from Revenue general ledger accounts. One account should be used to track Charity Care given under the Full and Partial Charity Care provision; the other account should be used to track Charity Care given under the catastrophic coverage component. This allows tracking and monitoring of the amount and type of Charity Care being granted. The transaction codes used for accounting for Charity Care and their mapping to the General Ledger must be reviewed annually to ensure accuracy.

3. **Roles and Responsibilities:**

3.1.1. A collaborative review between the Vice President and the Chief Financial Officer shall be made of this policy annually. Approval and reporting to the local Board occurs to ensure oversight and accountability.

3.1.2. It shall be the responsibility of Patient Financial Services for the day-to-day administration of this policy.

4. **Recordkeeping:**

4.1.1. Records relating to potential Charity Care patients must be readily obtainable. Consideration should be given to maintaining a central file of the Statement of Financial Condition and other Charity Care summary forms if they are otherwise not readily accessible.

4.1.2. In addition, notes relating to the Charity Care application and approval or denial should be entered on the patient's account.

5. **Public Notice and Posting:**

5.1. Public notice of the availability of assistance through this policy is made through each of the following means:

5.2. Posting notices in a visible manner in locations where there is a high volume of patient traffic, such as billing offices, admitting offices, and AXZONS outpatient service settings.

5.3. Including language on patient liability statements sent to patients indicating:

5.3.1. AXZONS contact name and phone number that patients may call in order to gain information on AXZONS's Charity Care, reduced payment, and other financial assistance policies.

5.4. Posting notice of the availability of assistance and contact names and phone numbers on AXZONS's web site and notices.

5.5. Upon request, a full text copy of the Charity Care policy should be made available.

5.6. Posting annually on the website or otherwise make available to the public on a reasonable basis:

5.6.1. The costs of charity care provided.

5.7. Internally this policy shall be made available to all AXZONS Employees by being posted on AXZONS's Intranet under Administrative Policies.

5.8. Posted notices (as listed above) shall be in the primary language(s) of the service area and in a manner consistent with all applicable federal and state laws and regulations.

EXHIBIT: B

Financial Assistance Application Form

To be considered for financial assistance you **must provide** the following*:

- **A completed and signed Financial Assistance Application.**
- **Proof of Income:** (Please provide each of the following or an explanation of why not provided)
  - Federal Income Tax return(s) for your household for the most recent calendar year.
  - Bank Statements for all bank accounts for the last 2 months
  - Two (2) most recent pay stubs or a statement from your employer regarding your income.
    - ***If self employed***, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.
    - Unemployment statement showing denial or eligibility and amount receiving.
  - Written documentation of **all** forms of income. *(i.e. trust funds, stock dividends, child support, alimony, social security, public assistance, food stamps, etc.)*
    - If you have not had any income for the past three (3) months or there has been a recent change in your financial situation you **must** include a statement or letter explaining your situation. If someone else is supporting you, they must sign the support statement on page 4 of the application.
- **Identification**:
  - Two forms of identification. (i.e. *driver's license, government issued photo ID, social security card, birth certificate or pass-port)*
- **Any other information that demonstrates financial hardship or need for financial assistance.** *(i.e. public assistance award or denial letters, letters of support, bank statements, etc)*

** If, for any reason, you cannot provide us the information requested, please attach a written statement explaining why you cannot provide this information.*

Send completed applications and documentation to:

Axzons HomeCare
Attn: Patient Access **OR** **FAX:**

____
____

Failure to submit all requested information may result in denial of your application. Applications should be returned within **14** days or requests may be denied.

Please note that if financial assistance is granted it will only cover your medical bills from our facility. It will not apply to the bills for other medical providers, hospitals or physicians unless they specifically agree to accept it. **PLEASE CONTACT THE OTHER MEDICAL PROVIDERS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.**

When applying for financial assistance you are giving consent for us to make necessary inquiries to confirm financial obligations or references. If you have any questions, **please contact one of our financial counselors at ____________________________**.

Financial Assistance Application

Date: ___________________

Patient Information

Acct Number(s):____ Total Amount Due: _______________

Patient Name: _________________________________ Date of Birth: ____________ SS#: ________________

Spouse or Guarantor Name: ____

Date of Birth: ________________ SS#: ___________________

Address: ____

City: ______________________ State: _____ Zip: ____________ Years/months at residence: ____________

Home Phone:___________________ Cell Phone:___________________ Other Phone:___________________

Household Information

Member Name	Age	Relationship	Employer	Annual Gross Income
		SELF		$
				$
				$
				$
				$

Total Family Size: ________ Total Dependents: ________ Total Household Income: $______________

Screening Information:

- Do you currently have health insurance? (Y/N)____ If yes, please provide insurance info below:
  - Insurance Name: _______________________________ ➢ Policy # _________________________
  - Group Name/Number: ____
- Have you had health insurance that has been terminated in the past 3 months? (Y/N)____ If yes, complete the following:
  - What type of insurance? (i.e. Medicaid, BCBS, Tricare, etc,) _________________________________
  - Reason for insurance termination? ____
  - Did you apply for cobra insurance coverage? (Y/N) ____ If so, when? ____________
  - Former Employer Name: ________________________________
- Are you active duty or retired military? (Y/N)____ If so, are you eligible for VA Benefits? (Y/N)____
- Have you applied for Medicaid or Disability? (Y/N)____ If yes, complete the following:
  - When? ______________ ➢ Where? ________________________________
  - Caseworker? ____________________________
  - Has your household or income status changed since you last applied? (Y/N)____
- Were you a victim of a crime? (Y/N)____ If yes, complete the following.

- Have you filed a Police Report? (Y/N)____ (Must be filed within 72 hrs of incident)
- Completed Victim of Crime application? (Y/N)____

- If you have any other special circumstances which you would like us to consider when reviewing your application, please explain below:

____
____
____
____
____

Financial Assessment

Account Number(s)____
Patients Name____ Date:_____________

Monthly Expenses		**Assets**	
Rent/Mortgage	$_______________	Checking Account(s)	$________________
Utilities	$_______________	Savings Account(s)	$_______________
Food	$_______________	Other Cash Assets	$_______________
Cell Phone/Pager	$_______________	Credit Cards (Available Credit)	$_______________
Cable	$_______________		
Auto Loan	$_______________	**Monthly Gross Income**	
Auto Insurance	$_______________	Employment Income	$_______________
Loans	$_______________	Spouse Income	$_______________
Child Support	$_______________	Retirement Income	$_______________
Credit Cards (Min Payment)	$_______________	Food Stamps	$_______________
Other	$_______________	Government Benefits	$_______________
	$_______________	Child Support	$_______________
	$_______________	Other	$_______________
Total Expenses	**$_______________**	**Total Income**	**$________________**

TOTAL MONTHLY INCOME **$_______________**

TOTAL MONTHLY EXPENSES **$_______________**

AMOUNT AVAILABLE **$_______________**

Patient/Guarantor Certification

I, ____, CERTIFY the information I have provided is true and accurate to the best of knowledge. I understand that if I do not cooperate with AXZONS in supplying ANY additional requested information; my application may be denied for possible financial assistance. I understand that the information which I submit is subject to verification by the AXZONS, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I understand that this application pertains to AXZONS charges and not physician's charges. I understand that if any information I have given proves to be untrue, AXZONS will re-evaluate my financial status and take whatever action becomes appropriate. I am also aware that I am only applying for the accounts specified above, and that my financial status will have to be reevaluated and may require a new application for any/all future treatment I receive at AXZONS.

_________________________________ ___________
Patient/Guarantor Signature Date

For Office Use Only	
Reviewed by: __________________________ Date______________	Approved by:
Recommendation:	____________________________ Date________________
☐ Charity: ______%	____________________________ Date________________
☐ Indigent	____________________________ Date________________
☐ Denied: Reason____	

Additional Financial Documentation
(Only completed when applicable)

Account Number(s)____

Patients Name____ Date:____________

______ **Support Statement:**

My signature will certify that I, ______________________________, do provide all necessary essentials for living for the patient's behalf, and have done so for a period of ______ years / months.

____ ____________________ ___________________
Signature of Patient's Supporter Relation to Patient Date

______ **Homeless Affidavit**

I, (PRINT NAME) ____ hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

______________________________ ____________
Signature Date

______ **No Changes to Financial Status since Previous Application for Assistance**

I, (PRINT NAME) ____ hereby certify there have been no changes to my (nor my spouse's) financial status since my previous application for financial assistance from St. Mary's which was completed on ________________. Please select of the following options:

- ☐ I am still being supported by another. They do provide all necessary essentials for living for my behalf, and have done so for a period of __________ years/months.
- ☐ I am still Homeless. I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.
- ☐ There are no changes to my (or my spouse's) income or household size since my previous application.

______________________________ ____________
Signature Date

APPENDIX K

Supplemental Documentation re:

Relationship to Health Care Delivery System

Community Linkage Plan

AXZONS COMMUNITY LINKAGE PLAN

Objective: To link the services of community healthcare systems with other related community services by various working agreements, referral arrangements to assure continuity of care focusing on coordinated, integrated systems which promote continuity rather than acute, episodic care.

Axzons Experience: Axzons team has years of experience dealing with the healthcare community partners by virtue of managing the homecare in New York and by being in the medical profession.

Plan to introduce: Axzons will introduce itself in the community with all relevant healthcare community service providers, healthcare institutions and other relevant players to ensure efficient and effective utilization of services and care provided to the needy.

Plan to Co-ordinate: Axzons will co-ordinate the plan to provide homecare services with all relevant healthcare community service providers, healthcare institutions and other relevant players. The outcome of co-ordination will help community partners provide homecare services to the patients in proposed areas as part of continuity of care from hospital to rehabilitation to home. This will help improve the healthcare of the community members, reducing the revisits to the hospitals for the same illnesses, in turn an efficient system helping cost effectiveness for providing care.

Plan to Co-operate: Axzons will co-operate with all relevant healthcare community service providers, healthcare institutions and other relevant players to provide homecare services as part of continuity of care by getting involved with various referral arrangements and working relationships or agreements to ultimately focusing on improving the healthcare of the community members, reducing the revisits to the hospitals for the same illnesses, in turn an efficient system helping cost effectiveness for providing care.

Commitment: Axzons will continuously work with other relevant community partners and stake holders towards developing a coordinated system of healthcare where care is provided continuously to members of the community for the betterment of the community members and providers.

APPENDIX L

1) Continuous Quality Improvement Program;

2) Admittance policy;

3) Consumer Rights Policy;

4) Charity Care and Indigent Care policy;

5) Cultural diversity policy;

6) Equal opportunity employment plans;

7) Provision of information policy;

8) Solicitation and Distribution policy; and

9) Annual & Quarterly Quality Improvement Evaluations

Axzons Continuous Quality Improvement Program

PURPOSE

1. To ensure that quality improvement processes and activities are regularly conducted for ongoing agency and client service improvement and,
2. to ensure adherence to federal and state regulations and Agency policies procedures and Standards of Conduct.

POLICY

Axzons Health System Corporation is committed to delivering quality services and promotes a philosophy of continuous quality improvement throughout. The Agency develops and implements quality improvement processes and activities, which are used to monitor performance and evaluate and improve the delivery of client services.

DEFINITIONS

1. Continuous Quality Improvement
   Continuous Quality Improvement (CQI) is an organizational process in which personnel identify, plan, and implement ongoing improvements in service delivery. CQI provides a vital way to assess and monitor the delivery of services to ensure that they are consistent with an agency's policies & procedures and home care principles & best practices.

PROCEDURES

1. The Manager/Administrator shall be responsible for establishing, maintaining and implementing a continuous quality improvement system/plan.
2. All employees shall:
   i. be involved in CQI;
   ii. receive orientation and training related to CQI; and,
   iii. bear a responsibility for CQI.
3. Clients, families and employees shall be involved in decision-making, regarding quality improvement activities.
4. When issues are identified, employees shall be consulted and corrective action shall be taken to resolve the problem or issue.
5. Regular staff meetings shall be held and information shall be shared to ensure that an acceptable level of quality control is maintained.
6. The effectiveness of any corrective actions taken shall be evaluated by the Manager/ Administrator, using feedback from everyone involved.

Quality Control Measures

7. Activities used in maintaining quality control shall include, but not be limited to, the following:
   a. Human Resource Management
      i. All candidates for employment shall be carefully screened prior to hiring including conducting a criminal background check on them.
      ii. Clients shall receive service and care from employees who have the necessary knowledge, training, experience, skills and qualifications to provide safe, ethical and effective service.
   b. Supervision
      i. All homecare workers shall be supervised on a regular basis, which includes in-home assessments of practical skills when delivering personal care services.
      ii. Assessments shall be performed on a semi-annual basis and more frequently, if necessary.
   c. In-home Visits
      Supervisor shall make regular, in-home visits to all clients, who receive personal care, to:
      i. review the service plan;
      ii. determine effectiveness of service; and,
      iii. determine client satisfaction with the services provided.
   d. Client Satisfaction with Implemented Services
      i. The *Client Satisfaction with Implemented Services* form shall be completed every 3 months to discuss the services being provided by the Agency and clients' satisfaction with these services.
      ii. The information submitted shall be analyzed and corrective actions shall be taken if it is determined that changes are required to the services in place.
      iii. Changes shall be documented and the *Care Plan* adjusted, as indicated.
   e. Client Record/Documentation Audit
      i. Supervisor shall review client records, prepared by the home care workers, to ensure that the client records are complete and that the services provided are consistent with the Agency's policies and procedures.
      ii. Client records shall be reviewed on a quarterly basis
   f. Review of Supervisor Reports
      Administrator/Manager shall review Supervisor reports on a quarterly basis to ensure that employees are following the Agency's policies and procedures and that a high level of care is being maintained.

   g. Client Complaints and Incident Reports

Client Complaints and Incident Reports shall be reviewed on a regular basis to:
i. ensure that quality control measures have been taken;
ii. ensure that correct processes were followed; and,
iii. measure staff judgment and performance against established standards.
All incidents and complaint shall be documented on a log, maintained in the Agency Office.

h. Customer Service Survey
   i. The *Customer Services Survey* shall initially be conducted within 90 days from the implementation of services and annually, thereafter.
   ii. The *Customer Service Survey* form shall be utilized to obtain feedback on clients' satisfaction with the Agency's Customer Service practices.
   iii. The information submitted shall be analyzed and corrective actions shall be taken if it is determined that customer services are in need of improvement

Agency Audits

8. Agency audits shall be conducted by the Compliance Officer, who shall be properly trained, in accordance with audit specifications and acceptable auditing procedures.
9. The Agency Manager shall ensure Auditors are without conflict of interest.
10. Agency operations audits and impromptu audits shall be regularly scheduled and conducted to assess:
    a. compliance with state and federal regulations;
    b. compliance with Agency policies and procedures;
    c. compliance with billing procedures;
    d. adequacy of internal controls, including:
       i. billing processes;
       ii. cash receipts;
       iii. payment postings;
       iv. write-offs; and,
       v. refunds.

False Claims and Fiscal Abuse Monitoring (Refer to Policy: *Compliance with Federal Deficit Reduction & False Claims Acts*)

11. To ensure adherence to all related laws, regulations and Agency policies, the Compliance Officer/Designee is responsible for the ongoing monitoring of billings to Medicaid for fraud, abuse and/or false claims practices which:
    a. are inconsistent with proper business, fiscal or medical practices;
    b. result in the reimbursement of services that are not medically necessary;
    c. result in unnecessary costs to Medicaid and Medicaid and,

  d. fail to meet professionally recognized standards for health care.

12. At the end of each fiscal year, the Agency's shall conduct an internal audit to review:
    a. accounts receivable,
    b. delinquent accounts;
    c. admissions;
    d. payments;
    e. reimbursements; and,
    f. staff expenses.
13. The Audit Report shall include:
    a. what was audited;
    b. the names & positions of the individual(s) who conducted the audit;
    c. date of audit;
    d. notation of any issues;
    e. investigation of any issues;
    f. recommendations for corrective actions and follow-ups.
14. The Audit Report shall be submitted to the Agency Manager for:
    a. further investigation of any issues, if indicted;
    b. consideration of submitted recommendations; and,
    c. provision of additional or different plans of action.
15. The Agency Manager shall sign all Audit Reports to acknowledge he/she has reviewed the report.
16. Investigations
    a. The Compliance Officer shall coordinate the investigation with the appropriate Supervisor.
    b. Any violations discovered shall be reported to the Agency Manager and/or the Agency's Board of Directors.
    c. If indicated, reports of violations, including self-reporting, shall be made to the appropriate authority including:
       i. the Office of the Inspector General;
       ii. Centers for Medicaid and Medicare Services;
       iii. Medicare Approved Contractors and/or,
       iv. State Department of Inspection and Appeals.

17. Corrective Actions
    a. If an Internal investigation discovers that a violation has occurred then corrective actions shall be initiated, to:
       i. make prompt restitution of any overpayment amounts; and,

    ii. implement changes to prevent a similar reoccurrence of the violation;
  b. Depending on the severity and frequency of the violation(s), consequences applied to the individual(s) involved may include:
    iii. re-training,
    iv. discipline, up to and including termination of employment or contract;
    v. prosecution by law.

18. Record Maintenance
  a. Records shall be maintained for:
    i. all internal audits conducted;
    ii. investigation conducted on offenses detected;
    iii. corrective actions taken; and,
    iv. follow-up reports on effectiveness of corrective actions.
  b. All Internal Agency Audit Reports and related records shall be maintained in the Agency Office and shall be made available for mandatory audits by outside authorities.
19. Manager/Administrator shall be responsible for ensuring that all external regulatory standards and all relevant local/state/federal legislation/guidelines are complied with.

GUIDELINES

1. The following model (PDCA) may be used for continuous quality improvement. The *plan–do–check–act* cycle (see below) is a four-step model for carrying out improvement/change and shall be repeated again and again for continuous quality improvement:
  a. Plan: Recognize an activity, event, procedure etc. that requires improvement and plan the solution/process, which will achieve the desired outcome
  b. Do: Test the solution/process.
  c. Check: Measure and review the results.
  d. Act: Take action by implementing the improved solution. If the solution does not work, repeat the process again with a different solution/process.

Plan-Do-Check-Act Cycle

2. Evidence of quality improvements shall include, but not be limited to, the following:
   a. service delivery has improved;
   b. documentation has improved;
   c. clients are more informed and satisfied;
   d. screening and hiring practices have improved;
   e. liability and risk is reduced;
   f. safety and well being of staff, clients and family have improved; and,
   g. staff training has improved.

CROSS-POLICY REFERENCES
1. Compliance
2. Compliance with Federal Deficit Reduction & False Claims Acts
3. Billings and Receivables
4. Pre-employment Background Checks
5. Performance Appraisals
6. Client Satisfaction Review

FORMS
1. Incident Report
2. Client Satisfaction with Implemented Services
3. Customer Service Survey

REFERENCES
1. Federal Deficit Reduction Act of 2005, Section 6032
2. False Claims Act

Axzons Admittance and

Readmittance of Clients Policy

PURPOSE

1. To ensure that the Agency only admits clients whose care needs can be met safely at home, as determined primarily through an in-home assessment.
2. To outline the conditions and process for admitting individuals, as clients of the Agency.
3. To outline conditions and criteria for re-admitting clients who have been discharged pr transferred from the Agency.

POLICY for ADMITTING CLIENTS

Axzons Homecare Ltd. utilizes the following standards for accepting individuals as clients:

1. The Agency shall accept referrals from almost any source including, but not limited to individuals, families, neighbors, hospitals, community organizations, home health agencies, physicians, third party payors, Veterans Organizations and Social Services
2. **The Agency's medical staff should have privileges allowing a reasonable acceptance of referrals of Medicaid patients, PeachCare patients, and all other patients who are unable to pay all or a portion of their healthcare costs.**
3. Referral sources shall provide the following information when making a referral to this Agency:
   a. potential client's name, address and telephone number;
   b. physician's name and address;
   c. medical diagnosis;
   d. type of level of service needed;
   e. referral source's name, title and phone number; and,
   f. name and telephone number of primary caregiver and emergency contact, if other that the primary caregiver.
4. The Agency shall conduct an assessment before accepting individuals as clients.
5. The Agency shall not discriminate on the basis of religion, race, color, creed, sex, age, handicap, sexual orientation, communicable disease or place of national origin, in its admittance of individuals as clients.
6. The Agency shall be qualified and/or licensed to provide the services required in a safe, efficient and responsible manner.
7. The Agency shall have a sufficient number of qualified personnel and resources to meet a potential client's requested/needed services.
8. The services requested/needed fall within the Agency's scope of services.
9. The Agency may contract services out to qualified individuals and/or other agencies.

10. Clients shall reside within the geographical area served by the Agency.
11. The potential client's home environment shall be adequate for safe and effective care.
12. The potential client shall be willing and able to function at home with required services in place.

13. The potential client's family/caregiver(s)/pertinent other(s) shall be willing to accept in-home services and be willing, able and available to participate in the care.
14. Potential clients with medical problems shall be under the care of a physician or shall be willing to seek care from a physician for medical supervision purposes.
15. Individuals, diagnosed with active pulmonary tuberculosis shall be evaluated for admittance only if the following conditions are met prior to the assessment:
    a. The infected individual has been on an anti-tuberculin regime for at least 2 weeks.
    b. The infected individual shows clinical improvement.
    c. The infected individual has had 3 consecutive samples that are AFB negative.
16. The potential client shall have the financial means to pay for services, either through state/federal assistance programs, private insurance or personal assets.
17. The Agency shall reserve the right to refuse service to anyone who does not meet the admittance criteria.
18. The potential client/representative shall be given the opportunity to either accept or refuse services.
19. The potential client/representative shall sign the required forms indicating acceptance of services.
20. Refusal of any or all identified service needs shall be documented on the assessment form and recorded in a service refusal log.

PROCEDURES for ADMITTING CLIENTS

1. In-home evaluations shall be conducted in a timely fashion following a request for service.
2. Supervisor shall evaluate a potential client's/representative's request for services prior to accepting an individual as a client.
3. The evaluation shall be comprehensive enough to determine the ability of the Agency to meet the requests and needs based on the Agency's overall service capability.
4. The identified needs/problems shall be reviewed with the potential client/ representative to determine the services required and the ability of the Agency to meet the potential client's requests/needs.
5. If the Agency can provide the services, the potential client/representative shall be provided with all the necessary information/material in order to make an informed decision.
6. Supervisor shall document that the above information has been given to the potential client/representative.
7. The potential client/representative, after review, shall be given the opportunity to either accept or refuse services.

8. If a potential client is accepted for service, a *Service Plan* shall be developed jointly with the potential client/representative and a written *Service Agreement* shall be signed by the potential client/representative and the Supervisor.
9. A copy of the *Service Plan* and the *Service Agreement* shall be given to the client and the originals shall be placed in the client's record.

POLICY for RE-ADMITTING CLIENTS

It is the policy of Axzons Health System Corporation to determine if individuals may be re-admitted as Agency clients and if service to them may be reinstated by conducting one or more of the following:

1. the completion of another General Needs Assessment;
2. a review of the Progress Summary Notes; or,
3. an update of the Service Plan/Care Plan which shall:
   a. show new or revised goals and interventions; and,
   b. specify a timeline for follow-up and evaluation.

PROCEDURES FOR RE-ADMITTING CLIENTS

1. Supervisor shall review the reasons client was discharged or transferred initially and determine what changes have occurred, which may justify re-admittance.
2. Supervisor shall conduct another General Needs Assessment and determine if the Agency can meet current needs.
3. Supervisor shall develop Service Plan/Care Plan with input from the client/client's representative/family.
4. Supervisor shall apply the policies and procedures, which are addressed in the *Agency's Service Delivery Process* section, in respect to managing the case and completing the required forms.

SCOPE

This policy applies to all members of the Agency workforce including, but not limited to, employees, medical staff, volunteers, students, physician office staff, and other persons performing work for or at Agency.

CROSS POLICY REFERENCES

1. Provision of Information
2. Service Plan
3. Service Agreement

FORMS
1. Service Plan
2. Service Agreement

Axzons Consumer Rights Policy

PURPOSE

1. To ensure clients are aware of their rights;
2. To ensure compliance with applicable laws; and,
3. To ensure that staff are educated about and respectful of client's rights when delivering services.

APPLICATION

This policy applies to Clients/ Consumers of Axzons Homecare Ltd. and defines their rights.

DEFINITIONS

Client

For purposes of this policy a client is a consumer or other individual or entity who uses services delivered by Axzons Homecare Ltd.

POLICY

Pursuant to Ga. Comp. R. & Regs.111-2-2-.32(3)(2)(l)(1) Axzons Homecare Ltd. has established written policies regarding the rights of the patient and developed procedures implementing such These rights, policies and procedures afford each patient the right to:

(1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record;
(2) be given a statement of the services available by the agency and related charges;
(3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient.
(i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change.
(ii) All information required by this paragraph shall be provided to the patient both orally and in writing;
(4) **be informed that the agency prohibits the exclusion of services to any patient on the basis of age, disability, gender, race, or ability to pay.**
(5) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services;
(6) participate in the planning of his or her care and be advised in advance of any changes to

the plan of care;

(7) refuse care and treatment after being fully informed of and understanding the consequences of such actions;
(8) be informed of the procedures for submitting patient complaints;
(9) voice complaints and recommend changes in policies and services to agency staff, the Georgia State Department of Community Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal;
(10) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints in accordance with the provisions.
The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Community Health's Office of Health Systems Management;
(11) be treated with consideration, respect and full recognition of his/her dignity and individuality; and
(12) privacy, including confidential treatment of patient records, and to refuse release of records to any individual outside the agency except in the case of the patient's transfer to a health care facility, or as required by law or third-party payment contract.
(b) The governing authority shall make all personnel providing patient care services on behalf of the agency aware of the rights of patients and the responsibility of personnel to protect and promote the exercise of such rights.
(c) If a patient lacks capacity to exercise these rights, the rights shall be exercised by an individual, guardian or entity legally authorized to represent the patient.

PROCEDURES

1. Supervisor/Alternate and client/client's representative shall review the Rights & Responsibilities of Client & Agency with the client/client's representative during the initial assessment and obtain the required signatures.
2. A copy of the signed *Rights & Responsibilities of Client & Agency* form shall be given to the client prior to the commencement of services. The original shall be placed in the client's file.
3. Supervisor shall make a notation in the client's record that:
   a. the *Rights & Responsibilities of Client & Agency* form was reviewed with the client/client's representative;
   b. the required signatures were obtained;
   c. a copy of the *Rights & Responsibilities of Client & Agency* form was left in the client's home; and,

4. Should the client not understand his/her "*Rights*" the Supervisor/alternate shall document the lack of understanding in the client's record and give the reason why it was not understood. If the client's representative or someone else is in the home is able to comprehend the details, the Supervisor/Alternate shall document this information.

Client Rights

The Agency's form (*Rights & Responsibilities of Client & Agency*) shall include the following client rights. i.e. The client's rights to:

1. be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record;
2. be given a statement of the services available by the Agency and related charges;
3. **be informed that the agency accepts all patients including financially indigent, medically indigent, Medicaid, PeachCare and Medicare Patients.**
4. **be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors (private pay, Commercial insurance as well as Medicaid, PeachCare and Medicare) and the extent to which payment may be required from the patient.**
   (i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change.
   (ii) All information required by this paragraph shall be provided to the patient both orally and in writing;
5. be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services;
6. participate in the planning of his or her care and be advised in advance of any changes to the plan of care;
7. refuse care and treatment after being fully informed of and understanding the consequences of such actions;
8. be informed of the procedures for submitting patient complaints;
9. voice complaints and recommend changes in policies and services to agency staff, the Georgia State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal;
10. submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints.

11. Be notified if the patient is not satisfied by the response the patient may complain to the Department of Community Health's Office of Health Systems Management;
12. The address for the complaints to DCH to be provided to patients is

13.

Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303
800-657-6442

14. be treated with consideration, respect and full recognition of his/her dignity and individuality; and
15. privacy, including confidential treatment of patient records, and to refuse release of records to any individual outside the agency except in the case of the patient's transfer to a health care facility, or as required by law or third-party payment contract.
16. **Prohibit exclusion of service and be dealt with without regard to race, color, age, sex, sexual orientation, creed, religion, disability and familial/cultural factors, or ability to pay.**
17. receive complete information about his/her health and recommended treatments, as developed jointly with this Agency;
18. provided with information on alternative services that may be available;
19. participate in a referral to another service provider or a health care institution;
20. refuse to participate in experimental research;
21. receive reasonable notice of any changes in their service, within an agreed upon amount of time, prior to the changes place
22. be informed of the cost of services and procedures and to be informed of all changes in services, procedures and fees, as they occur;
23. refuse services or treatment and be informed of the consequences of that refusal;
24. be free from mental, verbal, sexual and physical abuse, neglect, involuntary seclusion and exploitation;
25. receive privacy and confidentiality with regard to their health, social, and financial circumstances and what takes place in their homes, in accordance with laws and Agency policies;
26. receive confidential treatment of their personal and medical records;
27. approve or refuse the release of their personal or medical records to any individual/entity other than the Agency except when client records are transferred to another service provider or a health facility or as otherwise authorized by law;
28. make suggestions or complaints or present grievances to the Agency, government agencies or other entities or individuals without fear of the threat of retaliation.
29. receive a prompt response, through an established complaint or grievance procedure, to any complaints, suggestions or grievances they may have;

30. access procedures for making complaints to the:
    a. authority responsible for health quality;
    b. Adult Protective Services Program of the local Department of Social Services, if the client is an adult:
    c. The Child Protective Services Program of the local Department of Social Services, if the client is a child.
31. cared for by qualified, competent and trained personnel;
32. be taught the procedures used to provide care required, to enhance the client's ability to provide as much self-care as possible;
33. designate an individual of the client's choice , to receive instruction on care procedures, which are provided to the client, in order that the designated individual can assist the client as much as possible;
34. have full access to the information regarding their health condition and their care records maintained by this Agency, to the extent required by law;
35. be spoken to or communicated with in a manner or language they can understand;
36. speak freely without fear;
37. have their homes and property treated with respect;
38. be free from involuntary confinement, and from physical or chemical restraints;
39. be free from any actions that would be interpreted as being abusive. e.g. intimidation, physical/sexual/verbal/mental/emotional/material or financial abuse, etc.;
40. report all instances of potential abuse, neglect, exploitation, involving any employee of the Agency, to the *Elder Abuse Hotline*;
41. express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of the Agency;
42. be informed of procedures for initiating complaints about the delivery of service or resolving conflict, without fear of reprisal or retaliation;
43. be informed of the laws, regulations and policies of the Agency including:
    a. *Code of Ethics;*
    b. *Unstable Health Conditions;*
    c. *Withdrawal/Termination of Services*; AND,
    d. others, as required/requested.
44. be provided with the name, certification and staff position of all persons supplying, staffing or supervising the care and services you receive;
45. be informed of where ownership lies for any equipment/supplies provided in the provision of services;
46. receive written information on the care plan, including the names of Care Aide(s), & Supervisor assigned and the Agency's phone number;

47. provide input on which Care Aide they want and request a change of Care Aide, if desired;
48. be briefed on any procedure/treatment before it is carried out in order that they can give informed consent;
49. receive regular nursing supervision of the |Care Aide, if medically-related personal care is needed;
50. be given written documentation on the Agency's Advance Directives Policy;
51. to die with dignity;
52. be informed, within a reasonable amount of time, of the Agency's plans to terminate the care or service and/or their intention to transfer their care to another agency; and,
53. have their family or legal representative exercise the client's rights when the legal representative is legally authorized to do so

CROSS-POLICY REFERENCES

1. Client & Agency Responsibilities
2. Advance Directives
3. Standards of Conduct & Work Ethics
4. Complaints/Compliments
5. Unstable Health Conditions
6. Withdrawal/Termination of Services
7. Service Plan
8. Service Agreement
9. Privacy & Confidentiality

REGULATORY REFERENCE

This policy has a regulatory reference to Ga. Comp. R. & Regs.111-2-2-.32(3)(2)(l)(1)

RESPONSIBLE PARTY

1. Supervisor Client's services is responsible for adhering to this policy's directives.
2. Manager Client's Services

FORMS

1. Rights & Responsibilities of Client & Agency of Client & Agency

Axzons Indigent and Charity Care Policy

Axzons HomeCare Policies and Procedures	Axzons HomeCare
Section 4: Patient Access Services	
Policy Title: Indigent and Charity Care	Policy Number: Effective Date: Revision Date: Approved By: Director Page Number: Page 1 of 10

PURPOSE:

The purpose of this policy is to establish guidelines for Charity Care for patients of Axzons Health System Corporation ("**AXZONS**") who incur significant financial burden as a result of the amount they are expected to owe "out-of-pocket" for acute care health care services.

In addition, this policy provides administrative and accounting guidelines for the identification, classification and reporting of patients as Charity Care as distinguished from Bad Debts.

POLICY STATEMENT:

Charity Care is provided to a patient with a demonstrated inability to pay. Charity adjustments may only be granted to patients receiving non-elective care. A patient is eligible for Charity Care consideration based upon meeting certain income eligibility criteria as established by the Federal Poverty Income Guideline Sliding Scale. Charity Care represents health care services that are/were provided but never expected to result in payments. As a result, Charity Care does not qualify for recognition as receivable or net patient revenue in the financial statements.

Charity Care may include unpaid coinsurance and deductibles. Bad Debt is payment not received for service rendered for which payment was anticipated and services were provided in good faith. Bad Debt patients do not meet the criteria for Charity Care, that is, they are considered able to pay but unwilling to satisfy their outstanding obligations.

Charity Care data reporting for services provided is based on charges incurred during the patients visit/encounter.

AXZONS proactively makes reasonable efforts to determine whether a patient is eligible for financial assistance before engaging in any collection activities. AXZONS has established respectful and effective procedures for addressing the needs of those persons who are unable to pay for all or most of their care. In order to preserve the dignity of these persons and to facilitate the process of securing necessary information, AXZONS performs financial screening upon scheduling for diagnostic imaging procedures. Patients who represent

increased financial risk as a result of the amount they are expected to owe "out-of-pocket" are referred to a Financial Counselor for assistance in applying for alternative payment programs (e.g., Medical Assistance) determining Charity Care eligibility, establishing payment plans or other financing arrangements.

Patients with insurance should not have their patient liability unpaid balance, coinsurance, deductible or non-covered service written-off to Charity Care unless financial hardship can be proven.

The need for Charity Care is a sensitive and personal issue for recipients and needs to be addressed with reverence for those who are in need. Confidentiality of information and individual dignity shall be maintained for all that seek charitable services.

AXZONS provides medically necessary care to all regardless of ability to pay. Partial and/or full Charity Care is based on the individual's ability to pay.

PROCEDURE:

1. **Eligibility Criteria:** Excluded from coverage are any third parties who may be liable for payment for services.
    - 1.1. **Charity Care Application: (See Exhibit B)**
        - 1.1.1. Any individual who indicates the financial inability to pay a bill for a medically necessary service shall be evaluated for Charity Care assistance.
        - 1.1.2. The Statement of Financial Condition (Exhibit B) is used to document each patient's overall financial situation. This application should be available in the primary language(s) of the service area.
        - 1.1.3. Credit reports may be used, when appropriate, to verify an individual's financial circumstances.
        - 1.1.4. A patient's employment status and earning capacity is taken into consideration when evaluating a Charity Care request.
        - 1.1.5. The data used in making a determination concerning eligibility for Charity Care should be verified.
        - 1.1.6. Once a determination has been made a notification form is provided to each applicant advising them of the decision.
    - 1.2. **Full Charity Care: 100% Discount**
        - 1.2.1. A patient whose household income (as calculated on the Statement of Financial Condition) is equal to or less than 200% of the most recent Federal Poverty Guidelines (FPG) qualifies for a Full Charity Care discount.
        - 1.2.2. For the purposes of State reporting, a patient whose household income is equal to or less than 125% of the most recent FPG is categorized as Indigent Care.
    - 1.3. **Partial Charity Care:**
        - 1.3.1. A patient whose household income is greater than 200% and less than 400% of the most recent FPG qualifies for a Partial Charity Care discount and are determined each year by the Accounting department.
        - 1.3.2. Flexible, interest-free payment plans are available (e.g., extended payment terms), as appropriate.

1.4. **Catastrophic Charity Care:**

1.4.1. In order to qualify for Catastrophic Charity Care Circumstances, the patient's Allowable Medical Expenses must exceed 40% of household income as described below:

1.4.2. AXZONS multiplies the household income as defined in Section L by 40%

1.4.3. AXZONS determines the patient's Allowable Medical Expenses.

1.4.4. AXZONS compares 40% of the household income as defined in Section L to the total amount of the patient's Allowable Medical expenses. If the total of the Allowable Medical Expenses is greater than 40% of the household income and/or assets, then the patient meets the Catastrophic Charity Care qualification. AXZONS subtracts 40% of the household income and/or assets from the Allowable Medical Expenses to determine the amount by which the Allowable Medical Expenses exceed the available income and/or assets; this amount is then eligible for a Charity Care write-off.

1.5. **Special Circumstances:**

1.5.1. Deceased patients without an estate or third party coverage are eligible for Charity Care.

1.6. **Governmental Assistance:**

1.6.1. In determining whether each individual qualifies for Charity Care, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medicaid, Healthy Families Program, Victims of Crime, State Children Services, etc.

1.6.2. Persons eligible for programs such as Medicaid but whose eligibility status is not established for the period during which the medical services were rendered, should be granted Charity Care for those services. AXZONS will make the granting of charity contingent upon applying for governmental assistance. Patients are required to complete a Medicaid application.

1.7. **AXZONS Collection Efforts:**

1.7.1. Accounts with applications pending for Charity Care or other assistance programs are held until the outcome of the application. A "pending charity approval" is defined as an application that has been fully completed by the patient, submitted and is in the process of being determined for eligibility.

1.7.2. It is acceptable (but not preferable) to take an account through the full collection cycle and later reclassify it as Charity Care, as long as a consistent process is followed and a legitimate basis exists that the patient is unable to pay. For example, self-pay accounts written-off and sent to Bad Debt, reclassifying the account to Charity Care may be considered on the basis of all of the following factors:

1.7.3. No third party coverage or inadequate coverage exists

1.7.4. No payments are recorded on the account

1.7.5. The patient/guarantor was billed a minimum of 4 times

1.7.6. Verifiable income and/or assets are provided by the patient and include all household adults.

1.8. **Collection Agency:**

1.8.1. In some cases, a patient eligible for Charity Care may not have been identified prior to initiating external collection action. Accordingly, each collection agency engaged should be made aware of the policy on Charity Care. This allows the agency to report amounts that they have determined to be uncollectible due to the inability to pay in accordance with the Charity Care eligibility guidelines.

1.8.2. Collection agencies shall not, in dealing with the uninsured patients at or below the 400% Federal Poverty Level, use or threaten to use wage garnishments or liens on primary residences as a means of collecting on unpaid AXZONS bills. AXZONS must specifically authorize institutional litigation. This does not preclude agencies from pursuing reimbursement from third-party liability settlements.

1.8.3. If a collection agency identifies special circumstances demonstrating a particular patient as being unable (versus unwilling) to pay their bill, their liability may be considered Charity Care, even if they were originally classified as a Bad Debt. The patient should be reclassified to Charity Care.

1.9. **Eligibility Period:**

1.9.1. The eligibility period is the year in which financial statements provided from patients meet charity care guidelines and care was received. If financial income or insurance status changes for the year the services incurred, the patient may become ineligible for charity as the guidelines may not be met.

1.10. **Time Requirements for Determination:**

1.10.1. While it is desirable to determine the amount of Charity Care for which a patient is eligible as close to the time of service as possible, there is no rigid limit on the time when the determination is made. In some cases, eligibility is readily apparent and a determination can be made before, on, or soon after the date of service. In other cases, it can take investigation to determine eligibility, particularly when the patient has limited ability or willingness to provide needed information. Every effort should be made to determine a patient's eligibility for Charity Care at the earliest reasonable date.

1.11. **Definition of Income:**

1.11.1. Annual earnings and cash benefits from all sources before taxes, less payments made for alimony and child support. Proof of earnings may be determined by annualizing pay at current earning rates. Bank Accounts and open available lines of credit are considered income.

2. **Accounting for Charity Care:**

2.1.1. Charity Care write-offs are accounted for in separate Deduction from Revenue general ledger accounts. One account should be used to track Charity Care given under the Full and Partial Charity Care provision; the other account should be used to track Charity Care given under the catastrophic coverage component. This allows tracking and monitoring of the amount and type of Charity Care being granted. The transaction codes used for accounting for Charity Care and their mapping to the General Ledger must be reviewed annually to ensure accuracy.

3. **Roles and Responsibilities:**

3.1.1. A collaborative review between the Vice President and the Chief Financial Officer shall be made of this policy annually. Approval and reporting to the local Board occurs to ensure oversight and accountability.

3.1.2. It shall be the responsibility of Patient Financial Services for the day-to-day administration of this policy.

4. **Recordkeeping:**

4.1.1. Records relating to potential Charity Care patients must be readily obtainable. Consideration should be given to maintaining a central file of the Statement of Financial Condition and other Charity Care summary forms if they are otherwise not readily accessible.

4.1.2. In addition, notes relating to the Charity Care application and approval or denial should be entered on the patient's account.

5. **Public Notice and Posting:**

5.1. Public notice of the availability of assistance through this policy is made through each of the following means:

5.2. Posting notices in a visible manner in locations where there is a high volume of patient traffic, such as billing offices, admitting offices, and AXZONS outpatient service settings.

5.3. Including language on patient liability statements sent to patients indicating:

5.3.1. AXZONS contact name and phone number that patients may call in order to gain information on AXZONS's Charity Care, reduced payment, and other financial assistance policies.

5.4. Posting notice of the availability of assistance and contact names and phone numbers on AXZONS's web site and notices.

5.5. Upon request, a full text copy of the Charity Care policy should be made available.

5.6. Posting annually on the website or otherwise make available to the public on a reasonable basis:

5.6.1. The costs of charity care provided.

5.7. Internally this policy shall be made available to all AXZONS Employees by being posted on AXZONS's Intranet under Administrative Policies.

5.8. Posted notices (as listed above) shall be in the primary language(s) of the service area and in a manner consistent with all applicable federal and state laws and regulations.

EXHIBIT: B

Financial Assistance Application Form

To be considered for financial assistance you **must provide** the following*:

- **A completed and signed Financial Assistance Application.**
- **Proof of Income:** (Please provide each of the following or an explanation of why not provided)
  - Federal Income Tax return(s) for your household for the most recent calendar year.
  - Bank Statements for all bank accounts for the last 2 months
  - Two (2) most recent pay stubs or a statement from your employer regarding your income.
    - ***If self employed***, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.
    - Unemployment statement showing denial or eligibility and amount receiving.
  - Written documentation of **all** forms of income. *(i.e. trust funds, stock dividends, child support, alimony, social security, public assistance, food stamps, etc.)*
    - If you have not had any income for the past three (3) months or there has been a recent change in your financial situation you **must** include a statement or letter explaining your situation. If someone else is supporting you, they must sign the support statement on page 4 of the application.
- **Identification**:
  - Two forms of identification. (i.e. *driver's license, government issued photo ID, social security card, birth certificate or pass-port)*
- **Any other information that demonstrates financial hardship or need for financial assistance.** *(i.e. public assistance award or denial letters, letters of support, bank statements, etc)*

* *If, for any reason, you cannot provide us the information requested, please attach a written statement explaining why you cannot provide this information.*

Send completed applications and documentation to:

Axzons HomeCare
Attn: Patient Access **OR** **FAX:**

____
____

Failure to submit all requested information may result in denial of your application. Applications should be returned within **14** days or requests may be denied.

Please note that if financial assistance is granted it will only cover your medical bills from our facility. It will not apply to the bills for other medical providers, hospitals or physicians unless they specifically agree to accept it. **PLEASE CONTACT THE OTHER MEDICAL PROVIDERS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.**

When applying for financial assistance you are giving consent for us to make necessary inquiries to confirm financial obligations or references. If you have any questions, **please contact one of our financial counselors at _____________________________**.

Financial Assistance Application

Date: __________________

Patient Information

Acct Number(s):____ Total Amount Due: _______________

Patient Name: ________________________________ Date of Birth: ____________ SS#: ________________

Spouse or Guarantor Name: ____

Date of Birth: ________________ SS#: ___________________

Address: ____

City: ______________________ State: _____ Zip: ____________ Years/months at residence: ____________

Home Phone:___________________ Cell Phone:___________________ Other Phone:___________________

Household Information

Member Name	Age	Relationship	Employer	Annual Gross Income
		SELF		$
				$
				$
				$
				$

Total Family Size: ________ Total Dependents: ________ Total Household Income: $______________

Screening Information:

❖ Do you currently have health insurance? (Y/N)____ If yes, please provide insurance info below:
  ➢ Insurance Name: _______________________________ ➢ Policy # _________________________
  ➢ Group Name/Number: ____

❖ Have you had health insurance that has been terminated in the past 3 months? (Y/N)____ If yes, complete the following:
  ➢ What type of insurance? (i.e. Medicaid, BCBS, Tricare, etc,) _________________________________
  ➢ Reason for insurance termination? ____
  ➢ Did you apply for cobra insurance coverage? (Y/N) ____ If so, when? ____________
  ➢ Former Employer Name: ________________________________

❖ Are you active duty or retired military? (Y/N)____ If so, are you eligible for VA Benefits? (Y/N)____

❖ Have you applied for Medicaid or Disability? (Y/N)____ If yes, complete the following:
  ➢ When? ______________ ➢ Where? ________________________________
  ➢ Caseworker? ____________________________
  ➢ Has your household or income status changed since you last applied? (Y/N)____

❖ Were you a victim of a crime? (Y/N)____ If yes, complete the following.

- Have you filed a Police Report? (Y/N)____ (Must be filed within 72 hrs of incident)
- Completed Victim of Crime application? (Y/N)____

- If you have any other special circumstances which you would like us to consider when reviewing your application, please explain below:

____
____
____
____
____

Financial Assessment

Account Number(s)____
Patients Name____ Date:_____________

Monthly Expenses		**Assets**	
Rent/Mortgage	$_______________	Checking Account(s)	$________________
Utilities	$_______________	Savings Account(s)	$_______________
Food	$_______________	Other Cash Assets	$_______________
Cell Phone/Pager	$_______________	Credit Cards (Available Credit)	$_______________
Cable	$_______________		
Auto Loan	$_______________	**Monthly Gross Income**	
Auto Insurance	$_______________	Employment Income	$_______________
Loans	$_______________	Spouse Income	$_______________
Child Support	$_______________	Retirement Income	$_______________
Credit Cards (Min Payment)	$_______________	Food Stamps	$_______________
Other	$_______________	Government Benefits	$_______________
	$_______________	Child Support	$_______________
	$_______________	Other	$_______________
Total Expenses	**$_______________**	**Total Income**	**$________________**

TOTAL MONTHLY INCOME **$_______________**

TOTAL MONTHLY EXPENSES **$_______________**

AMOUNT AVAILABLE **$_______________**

Patient/Guarantor Certification

I, ____, CERTIFY the information I have provided is true and accurate to the best of knowledge. I understand that if I do not cooperate with AXZONS in supplying ANY additional requested information; my application may be denied for possible financial assistance. I understand that the information which I submit is subject to verification by the AXZONS, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I understand that this application pertains to AXZONS charges and not physician's charges. I understand that if any information I have given proves to be untrue, AXZONS will re-evaluate my financial status and take whatever action becomes appropriate. I am also aware that I am only applying for the accounts specified above, and that my financial status will have to be reevaluated and may require a new application for any/all future treatment I receive at AXZONS.

_________________________________ ____________

Patient/Guarantor Signature Date

*****For Office Use Only****	
Reviewed by: __________________________ Date______________	Approved by:
Recommendation:	___________________________ Date________________
☐ Charity: ______%	___________________________ Date________________
☐ Indigent	___________________________ Date________________
☐ Denied: Reason____	

Additional Financial Documentation
(Only completed when applicable)

Account Number(s)____

Patients Name____ Date:____________

______ **Support Statement:**

My signature will certify that I, ______________________________, do provide all necessary essentials for living for the patient's behalf, and have done so for a period of ______ years / months.

____ ____________________ ___________________
Signature of Patient's Supporter Relation to Patient Date

______ **Homeless Affidavit**

I, (PRINT NAME) ____ hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

______________________________ ____________
Signature Date

______ **No Changes to Financial Status since Previous Application for Assistance**

I, (PRINT NAME) ____ hereby certify there have been no changes to my (nor my spouse's) financial status since my previous application for financial assistance from St. Mary's which was completed on ________________. Please select of the following options:

- ☐ I am still being supported by another. They do provide all necessary essentials for living for my behalf, and have done so for a period of __________ years/months.
- ☐ I am still Homeless. I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.
- ☐ There are no changes to my (or my spouse's) income or household size since my previous application.

______________________________ ____________
Signature Date

Axzons Cultural Diversity Policy

<table>
<tr><td>Axzons Health System Corporation
Policies and Procedures</td><td rowspan="2">Axzons HomeCare</td></tr>
<tr><td>Section 4: Human Resources</td></tr>
<tr><td rowspan="5">Policy Title: Cultural Diversity</td><td>Policy Number: 4.120</td></tr>
<tr><td>Effective Date: 07/15/2017</td></tr>
<tr><td>Revision Date: 06/14/2022</td></tr>
<tr><td>Approved By: Director</td></tr>
<tr><td>Page Number: Page 1 of 2</td></tr>
</table>

PURPOSE

To provide guidelines for working with a diverse population with regards to race, culture, religion and special needs; and, to ensure that all persons have equal opportunity by establishing affirmative action plans.

POLICY

Axzons Health System Corporation is committed to promoting the concept and acceptance of cultural diversity by:

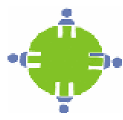
1. recognizing and endorsing equal opportunity;
2. understanding and educating employees/clients/families about the value of diversity;
3. being aware of the challenges that cultural diversity can generate; and,
4. establishing policies to counteract discrimination towards cultural diversity.

DEFNINTIONS

1. Cultural Diversity
   Cultural Diversity refers to the many types of human social structures, belief systems, and strategies for adapting to situations in different parts of the world.

PROCEDURES

1. The traditions and customs of all employees/clients/families shall be recognized and valued.
2. An open and tolerant attitude towards different religions, cultures, ethnic groups, races and personal views shall be practiced.
3. Actions shall be applied and polices developed to counter racism and intolerance.
4. Any dissension and conflict on cultural, ethnic or linguistic grounds shall be resolved, using appropriate measures.
5. Practices, which are consistent with the needs of socially and culturally diverse personnel, shall be applied.
6. Employee cultural and religious obligations shall be recognized.
7. Clients' special racial, religious, ethnic and cultural needs will be determined and documented during their initial assessment.
8. Positive client relations shall be promoted by providing clients with employees who have similar racial, ethnic, cultural, religious and/or linguistic backgrounds, whenever possible.
9. The Manager/Administrator and Supervisor shall be responsible for monitoring the cultural diversity policy and for ensuring that employees adhere to it.



GUIDELINES

1. The Agency shall strive to create work environments that are free from intolerance, prejudice and racism.
2. All reasonable actions shall be taken to ensure employees are aware of their responsibility to become more knowledgeable of and sensitive to other cultures and to ensure that their activities recognize and support diversity.
3. Whenever possible, appropriate professional development and learning opportunities shall be provided to staff to enable them to acquire the knowledge and skills to interact with, and operate effectively in, a diverse society.
4. All employees shall receive training on cultural diversity.
5. A record of training shall be kept for all employees and shall include:
   a. dates when training was given;
   b. summary on what training was given;
   c. names and credentials of person(s) providing the training; and,
   d. names and positions of people attending the training sessions.

   Records are to be maintained for 3 years from the date of training.

FORMS

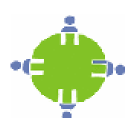
Standards of Conduct

CROSS-POLICY REFERENCES

1. Equal Opportunity

REFERENCES

1. U.S. Equal Employment Opportunity Commission (EEOC)



Axzons Equal Opportunity Employment Plan

PURPOSE

To ensure that all persons have equal opportunity and to establish guidelines for affirmative action plans, in accordance with federal, state and local regulations.

POLICY

Axzons Health System Corporation is an Equal Opportunity Employer and prohibits discrimination of any kind because of color, creed, national origin, sex, religion, handicap, marital status, communicable diseases, disability, veteran status, sexual orientation, gender reassignment, age (unless age is a factor necessary for the normal operation or achievement objectives), pregnancy (unless the performance of duties puts the client and/or employee at risk) and/or other characteristics protected by law.

DEFINITIONS

1. Equal Opportunity
   Equal Opportunity is the right of all persons to be accorded full and equal consideration on the basis of merit or other relevant, meaningful criteria, regardless of protected group status.
2. Affirmative Action
   Affirmative actions are good faith efforts to ensure equal employment opportunity and correct the effects of past discrimination against affected groups. Where appropriate, affirmative action includes goals to correct underutilization and development of results-oriented programs to address problem areas.

PROCEDURES

1. Diversity, fairness and justice in the workplace shall be promoted.
2. Discrimination, prejudice and victimization in the workplace shall not be tolerated.
3. State and federal, non-discrimination rules and regulations shall be complied with.
4. Equal opportunity and respect shall be provided to all individuals in matters of service and employment.
5. Any conditions, procedures and/or behavior, which can lead to discrimination, shall be eliminated.
6. All Agency policies, procedures and guidelines shall be established/maintained to reflect and reinforce its commitment to equality.
7. The Manager/Administrator shall assume responsibility for affirmative actions plans and may seek outside consultation from the Equal Employment Opportunity Office when necessary.
8. When selecting new employees, members of the selection committee shall:

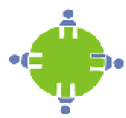
   a. agree on selection criteria to be used for the job position;
   b. provide information about the job position in the same manner to all applicants;
   c. ask all applicants the same questions; and,
   d. choose the successful candidate, based on the selection criteria.
9. All employees shall be recruited and promoted on the basis of ability and other objective relevant criteria.
10. Contractors, supplying services on behalf the Agency, shall be expected to conform to the same non discrimination policies.

GUIDELINES
1. Employees shall be given equality training.
2. All employees shall be provided with appropriate and accessible learning opportunities in line with their and the Agency's needs.
3. A record of training shall be kept for all employees and shall include:
   a. dates when training was given;
   b. summary on what training was given;
   c. names and credentials of person(s) providing the training; and,
   d. names and positions of people attending the training sessions.

   Records are to be maintained for 3 years from the date of training.

FORMS
Standards of Conduct

REFERENCES
1. U.S. Equal Employment Opportunity Commission (EEOC)
2. Civil Rights Act of 1964 (Title VI)
3. Section 504 Rehabilitation Act of 1973 (Section 504)
4. Age Discrimination Act of 1975
5. Americans with Disabilities Act of 1992 (42 USC;12101)



Axzons Provision of Information Policy

Axzons Homecare Ltd. Policies and Procedures	Axzons HomeCare
Section 3: Service Delivery & Client Care	
Policy Title: Provision of Information	**Policy Number: 3.10.10** **Effective Date: 11/21/2022** **Revision Date: 12/01/2022** **Approved By: Director** **Page Number: Page 1 of 2**

PURPOSE

To ensure that potential and/or existing clients/clients' representatives are able to make informed decisions on the suitability of the Agency to meet their specific care needs.

POLICY

Axzons Homecare Ltd.ensures that current and potential clients/ clients' representatives have access to comprehensive information, which will enable them to make informed decisions on whether or not the Agency can meet their specific requests and needs.

PROCEDURES

An up-to-date information package shall be provided prior to the initiation of services. The information shall be presented in a clear and easily understood manner and include:

1. a list of the home care services that the Direct Care Worker will be providing;
2. types of services offered and their limitations;
3. **Types of Insurances accepted for financially indigent, medically indigent, Medicaid, PeachCare, Medicare besides Private pay, other commercial insurances.**
4. process for developing the Service Plan;
5. terms and conditions as set out in the Service Agreement;
6. address and contact details for the office;
7. hours of operation and statutory holidays observed by the Agency;
8. details of license and insurance coverage;
9. the name of the Direct Care Worker(s) who will deliver the services;
10. the days and times that services will be delivered;
11. the hourly or weekly fees and total costs for services to be provided,
12. the name of a Departmental Representative(s) they can contact for information about:
    i. licensing criteria for home care agencies or registries; and,
    ii. the Agency's responsibilities and adherence to the rules and regulations established for home care agencies.
13. The telephone number of the Ombudsman Program located with the local Area Agency on Aging (AAA).
14. The hiring and competency requirements for direct care workers to be acceptable for employment or referral by this Agency.
15. A disclosure, prepared in Departmental format, which specifies:
    a. whether the individuals, who provide the services to the client/consumer, are Agency employees or are independent /third party contractors affiliated with the Agency; and,
    b. which taxes, insurances and other obligations the Agency and/or clients/consumers

are responsible to handle.

Axzons Solicitation and Distribution Policy

<table>
<tr><td>Axzons Health System Corporation
Policies and Procedures</td><td rowspan="2">Axzons HomeCare</td></tr>
<tr><td>Section 4: Human Resources</td></tr>
<tr><td rowspan="5">Policy Title: Solicitation and Distribution</td><td>Policy Number: 4.141</td></tr>
<tr><td>Effective Date: 07/15/2017</td></tr>
<tr><td>Revision Date: 06/14/2022</td></tr>
<tr><td>Approved By: Director</td></tr>
<tr><td>Page Number: Page 1 of 1</td></tr>
</table>

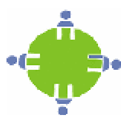
PURPOSE

To advise employees about the Agency's policy for soliciting, canvassing, peddling and/or distribution of literature on the job site during working hours.

POLICY

Axzons Health System Corporation prohibits solicitation and distribution on its premises or through mail by non-employees. Solicitation and distribution by employees is permitted only as outlined in this policy.

1. A limited number of fund drives by employees on behalf of charitable organizations or for employees' gifts may be authorized.
2. Prior approval is required from the Agency Manager before any solicitation or distribution activities are undertaken.
3. Solicitation or distribution of literature for any group or organization, including charitable organizations, may be permitted providing the sale of merchandise is limited to Agency functions and activities.
4. Solicitation and distribution activities must not:
   a. interfere with the efficiency of business operations;
   b. pose a threat to security; and/or,
   c. be annoying to others.
5. Solicitation or distribution by an employee of another employee is prohibited during work time. Work time does not include authorized meal and other breaks.
6. The lobbying for political candidates or causes is prohibited on the job-site.
7. The solicitation or distribution of any written or printed materials to clients in their homes or in any area wherein service is being delivered is prohibited.
8. Authorization must be obtained from the Agency Manager prior to attaching any solicitation or advertising materials to the Agency Bulletin Board. .
9. Use of the Agency's mail systems, photocopiers, telephone lists, bulletin boards and the like to promote outside business interests is prohibited.
10. Individuals, who are not employed by the Agency, are prohibited from:
    a. soliciting funds or signatures;
    b. conducting membership drives;
    c. posting, distributing literature or gifts;
    d. offering to sell or to purchase merchandise or services, except as authorized by the Agency; and/or,
    e. engaging in any other solicitation, distribution, or similar activity on Company premises.



Axzons Annual & Quarterly Quality Improvement Evaluations

PURPOSE

To provide systematic processes for annual and quarterly Agency evaluations to assure the appropriateness and quality of its services to:

1. ensure policies are being followed;
2. policies are revised, as indicated;
3. problems are identified, and,
4. problem resolutions are implemented..

DEFINITIONS

1. **Evaluation**

   An evaluation shall mean the review and assessment of an agency's/company's operations and services.

POLICY

Axzons Health System Corporation requires that its policies and administrative practices be reviewed regularly to determine the extent to which they promote client care that is appropriate, adequate, effective, and efficient.

Annual Review

The Agency Administrator and/or appropriate, personnel shall conduct at least an annual evaluation of Agency operations. The evaluation shall consist of a documentation review, including, but not limited to, the following:

1. Mission Statement;
2. Program Evaluation;
3. Policies and Procedures;
4. Administrative Files;
5. Payroll Files;
6. Quality and Risk Management - policies and processes;
7. Confirmation of compliance with:
   a. local/state/federal rules and regulations;
   b. licensing;
   c. insurance;
   d. Workers' Compensation;
   e. health and safety; and,
   f. labor requirements.
8. Personnel Files;

9. Worker Stats
   a. personnel qualifications;
   b. number of workers currently employed including:
      i. full time;
      ii. part time;
      iii. casual; and,
      iv. on call.
   c. adequacy of staff to meet client needs;
   d. staff turnover rate;
   e. type, amount and adequacy of supervision;
10. Client Evaluations:
   1. number of clients served;
   a. number of service hours or visits provided;
   b. client outcomes;
   c. admission and discharge policies;
   d. numbers and reasons for non-acceptance of clients;
   e. reasons for discharge; and,
   f. arrangements for services with other agencies or individuals;
11. Client Files including:
   a. service records;
   b. service agreements,
   c. progress notes
   d. assessments
   e. plan of care;
12. Emergency Care;
13. Scope Of Services offered; and,
14. Infection Control Practices.

Quarterly Review

1. The Agency Administrator and/or Supervisor/Registered Nurse shall conduct a quarterly review of active and closed client records to:
   a. assure that the quality of service is satisfactory and appropriate; and,
   b. ensure that Agency policies are followed in providing services.
2. The review shall consist of a sample of all home care services provided by the Agency.

PROCEDURES

1. A summary of the findings shall be prepared in a report, which will provide:
   a. the names and qualifications of the persons carrying out the evaluation;
   b. the criteria and methods used to accomplish it; and,
   c. any action(s) taken by the Agency as a result of its findings.
2. The Evaluation Report will be forwarded to the Agency's Governing Body and a copy kept on file in the Agency office.
3. The Manager/Administrator shall be responsible for ensuring that recommendations are acted on, as determined appropriate.

APPENDIX M

Letters of Support

Not Applicable

APPENDIX N

1. Community Linkage Plan
2. Human Resources Plan
3. Continuous Quality Improvement Policy
4. Indigent and Charity Care Policy
5. Consumer Rights Policy
6. Table: Financial Average Charges Per Agency Visit
7. JCAHO Accreditation Award

Axzons Community Linkage Plan

AXZONS COMMUNITY LINKAGE PLAN

Objective: To link the services of community healthcare systems with other related community services by various working agreements, referral arrangements to assure continuity of care focusing on coordinated, integrated systems which promote continuity rather than acute, episodic care.

Axzons Experience: Axzons team has years of experience dealing with the healthcare community partners by virtue of managing the homecare in New York and by being in the medical profession.

Plan to introduce: Axzons will introduce itself in the community with all relevant healthcare community service providers, healthcare institutions and other relevant players to ensure efficient and effective utilization of services and care provided to the needy.

Plan to Co-ordinate: Axzons will co-ordinate the plan to provide homecare services with all relevant healthcare community service providers, healthcare institutions and other relevant players. The outcome of co-ordination will help community partners provide homecare services to the patients in proposed areas as part of continuity of care from hospital to rehabilitation to home. This will help improve the healthcare of the community members, reducing the revisits to the hospitals for the same illnesses, in turn an efficient system helping cost effectiveness for providing care.

Plan to Co-operate: Axzons will co-operate with all relevant healthcare community service providers, healthcare institutions and other relevant players to provide homecare services as part of continuity of care by getting involved with various referral arrangements and working relationships or agreements to ultimately focusing on improving the healthcare of the community members, reducing the revisits to the hospitals for the same illnesses, in turn an efficient system helping cost effectiveness for providing care.

Commitment: Axzons will continuously work with other relevant community partners and stake holders towards developing a coordinated system of healthcare where care is provided continuously to members of the community for the betterment of the community members and providers.

Axzons Human Resources Plan

AXZONS HR PLAN

Objective: To recruit, hire and retain the appropriate numbers of qualified personnel to meet the requirements of the services proposed to be provided and that such personnel are available in the proposed geographic service area.

Plan to Recruit: Axzons will create appropriate job descriptions and place them on leading job portals, churches, handshake for universities, social media, on its website. Axzons will host private job fairs in collaboration with local healthcare community partners who will also benefit from the same.

Plan to Hire: Axzons will conduct appropriate interviews to find the best talent with the appropriate knowledge and skills for the position recruiting.

Plan to Retain: Provide position appropriate salaries and benefits depending upon their annual performances. Provide appropriate insurance to retain best talent. Provide trainings and educational resources to improve upon the talent.

Commitment: Axzons will continually improve upon technology it uses and revies benefit plans and update salary based upon the position and state standard to continuously retain the best talent possible in the proposed geographic service area.

Axzons Continuous Quality Improvement Program

PURPOSE

1. To ensure that quality improvement processes and activities are regularly conducted for ongoing agency and client service improvement and,
2. to ensure adherence to federal and state regulations and Agency policies procedures and Standards of Conduct.

POLICY

Axzons Homecare Ltd.is committed to delivering quality services and promotes a philosophy of continuous quality improvement throughout. The Agency develops and implements quality improvement processes and activities, which are used to monitor performance and evaluate and improve the delivery of client services.

DEFINITIONS

1. Continuous Quality Improvement
   Continuous Quality Improvement (CQI) is an organizational process in which personnel identify, plan, and implement ongoing improvements in service delivery. CQI provides a vital way to assess and monitor the delivery of services to ensure that they are consistent with an agency's policies & procedures and home care principles & best practices.

PROCEDURES

1. The Manager/Administrator shall be responsible for establishing, maintaining and implementing a continuous quality improvement system/plan.
2. All employees shall:
   i. be involved in CQI;
   ii. receive orientation and training related to CQI; and,
   iii. bear a responsibility for CQI.
3. Clients, families and employees shall be involved in decision-making, regarding quality improvement activities.
4. When issues are identified, employees shall be consulted and corrective action shall be taken to resolve the problem or issue.
5. Regular staff meetings shall be held and information shall be shared to ensure that an acceptable level of quality control is maintained.
6. The effectiveness of any corrective actions taken shall be evaluated by the Manager/ Administrator, using feedback from everyone involved.

Quality Control Measures

7. Activities used in maintaining quality control shall include, but not be limited to, the following:
   a. Human Resource Management
      i. All candidates for employment shall be carefully screened prior to hiring including conducting a criminal background check on them.
      ii. Clients shall receive service and care from employees who have the necessary knowledge, training, experience, skills and qualifications to provide safe, ethical and effective service.
   b. Supervision
      i. All homecare workers shall be supervised on a regular basis, which includes in-home assessments of practical skills when delivering personal care services.
      ii. Assessments shall be performed on a semi-annual basis and more frequently, if necessary.
   c. In-home Visits
      Supervisor shall make regular, in-home visits to all clients, who receive personal care, to:
      i. review the service plan;
      ii. determine effectiveness of service; and,
      iii. determine client satisfaction with the services provided.
   d. Client Satisfaction with Implemented Services
      i. The *Client Satisfaction with Implemented Services* form shall be completed every 3 months to discuss the services being provided by the Agency and clients' satisfaction with these services.
      ii. The information submitted shall be analyzed and corrective actions shall be taken if it is determined that changes are required to the services in place.
      iii. Changes shall be documented and the *Care Plan* adjusted, as indicated.
   e. Client Record/Documentation Audit
      i. Supervisor shall review client records, prepared by the home care workers, to ensure that the client records are complete and that the services provided are consistent with the Agency's policies and procedures.
      ii. Client records shall be reviewed on a quarterly basis
   f. Review of Supervisor Reports
      Administrator/Manager shall review Supervisor reports on a quarterly basis to ensure that employees are following the Agency's policies and procedures and that a high level of care is being maintained.

   g. Client Complaints and Incident Reports

Client Complaints and Incident Reports shall be reviewed on a regular basis to:
i. ensure that quality control measures have been taken;
ii. ensure that correct processes were followed; and,
iii. measure staff judgment and performance against established standards.
All incidents and complaint shall be documented on a log, maintained in the Agency Office.

h. Customer Service Survey
   i. The *Customer Services Survey* shall initially be conducted within 90 days from the implementation of services and annually, thereafter.
   ii. The *Customer Service Survey* form shall be utilized to obtain feedback on clients' satisfaction with the Agency's Customer Service practices.
   iii. The information submitted shall be analyzed and corrective actions shall be taken if it is determined that customer services are in need of improvement

Agency Audits

8. Agency audits shall be conducted by the Compliance Officer, who shall be properly trained, in accordance with audit specifications and acceptable auditing procedures.
9. The Agency Manager shall ensure Auditors are without conflict of interest.
10. Agency operations audits and impromptu audits shall be regularly scheduled and conducted to assess:
    a. compliance with state and federal regulations;
    b. compliance with Agency policies and procedures;
    c. compliance with billing procedures;
    d. adequacy of internal controls, including:
       i. billing processes;
       ii. cash receipts;
       iii. payment postings;
       iv. write-offs; and,
       v. refunds.

False Claims and Fiscal Abuse Monitoring (Refer to Policy: *Compliance with Federal Deficit Reduction & False Claims Acts*)

11. To ensure adherence to all related laws, regulations and Agency policies, the Compliance Officer/Designee is responsible for the ongoing monitoring of billings to Medicaid for fraud, abuse and/or false claims practices which:
    a. are inconsistent with proper business, fiscal or medical practices;
    b. result in the reimbursement of services that are not medically necessary;
    c. result in unnecessary costs to Medicaid and Medicaid and,

   d. fail to meet professionally recognized standards for health care.

12. At the end of each fiscal year, the Agency's shall conduct an internal audit to review:
    a. accounts receivable,
    b. delinquent accounts;
    c. admissions;
    d. payments;
    e. reimbursements; and,
    f. staff expenses.
13. The Audit Report shall include:
    a. what was audited;
    b. the names & positions of the individual(s) who conducted the audit;
    c. date of audit;
    d. notation of any issues;
    e. investigation of any issues;
    f. recommendations for corrective actions and follow-ups.
14. The Audit Report shall be submitted to the Agency Manager for:
    a. further investigation of any issues, if indicted;
    b. consideration of submitted recommendations; and,
    c. provision of additional or different plans of action.
15. The Agency Manager shall sign all Audit Reports to acknowledge he/she has reviewed the report.
16. <u>Investigations</u>
    a. The Compliance Officer shall coordinate the investigation with the appropriate Supervisor.
    b. Any violations discovered shall be reported to the Agency Manager and/or the Agency's Board of Directors.
    c. If indicated, reports of violations, including self-reporting, shall be made to the appropriate authority including:
       i. the Office of the Inspector General;
       ii. Centers for Medicaid and Medicare Services;
       iii. Medicare Approved Contractors and/or,
       iv. State Department of Inspection and Appeals.

17. <u>Corrective Actions</u>
    a. If an Internal investigation discovers that a violation has occurred then corrective actions shall be initiated, to:
       i. make prompt restitution of any overpayment amounts; and,

   ii. implement changes to prevent a similar reoccurrence of the violation;
 b. Depending on the severity and frequency of the violation(s), consequences applied to the individual(s) involved may include:
   iii. re-training,
   iv. discipline, up to and including termination of employment or contract;
   v. prosecution by law.

18. <u>Record Maintenance</u>
 a. Records shall be maintained for:
   i. all internal audits conducted;
   ii. investigation conducted on offenses detected;
   iii. corrective actions taken; and,
   iv. follow-up reports on effectiveness of corrective actions.
 b. All Internal Agency Audit Reports and related records shall be maintained in the Agency Office and shall be made available for mandatory audits by outside authorities.
19. Manager/Administrator shall be responsible for ensuring that all external regulatory standards and all relevant local/state/federal legislation/guidelines are complied with.

GUIDELINES

1. The following model (PDCA) may be used for continuous quality improvement. The *plan–do–check–act* cycle (see below) is a four-step model for carrying out improvement/change and shall be repeated again and again for continuous quality improvement:
   a. Plan: Recognize an activity, event, procedure etc. that requires improvement and plan the solution/process, which will achieve the desired outcome
   b. Do: Test the solution/process.
   c. Check: Measure and review the results.
   d. Act: Take action by implementing the improved solution. If the solution does not work, repeat the process again with a different solution/process.

Plan-Do-Check-Act Cycle

2. Evidence of quality improvements shall include, but not be limited to, the following:
   a. service delivery has improved;
   b. documentation has improved;
   c. clients are more informed and satisfied;
   d. screening and hiring practices have improved;
   e. liability and risk is reduced;
   f. safety and well being of staff, clients and family have improved; and,
   g. staff training has improved.

CROSS-POLICY REFERENCES
1. Compliance
2. Compliance with Federal Deficit Reduction & False Claims Acts
3. Billings and Receivables
4. Pre-employment Background Checks
5. Performance Appraisals
6. Client Satisfaction Review

FORMS
1. Incident Report
2. Client Satisfaction with Implemented Services
3. Customer Service Survey

REFERENCES
1. Federal Deficit Reduction Act of 2005, Section 6032
2. False Claims Act

Axzons Indigent and Charity Care Policy

Axzons HomeCare Policies and Procedures	Axzons HomeCare
Section 4: Patient Access Services	
Policy Title: Indigent and Charity Care	Policy Number:
	Effective Date:
	Revision Date:
	Approved By: Director
	Page Number: Page 1 of 10

PURPOSE:

The purpose of this policy is to establish guidelines for Charity Care for patients of Axzons Health System Corporation ("**AXZONS**") who incur significant financial burden as a result of the amount they are expected to owe "out-of-pocket" for acute care health care services.

In addition, this policy provides administrative and accounting guidelines for the identification, classification and reporting of patients as Charity Care as distinguished from Bad Debts.

POLICY STATEMENT:

Charity Care is provided to a patient with a demonstrated inability to pay. Charity adjustments may only be granted to patients receiving non-elective care. A patient is eligible for Charity Care consideration based upon meeting certain income eligibility criteria as established by the Federal Poverty Income Guideline Sliding Scale. Charity Care represents health care services that are/were provided but never expected to result in payments. As a result, Charity Care does not qualify for recognition as receivable or net patient revenue in the financial statements.

Charity Care may include unpaid coinsurance and deductibles. Bad Debt is payment not received for service rendered for which payment was anticipated and services were provided in good faith. Bad Debt patients do not meet the criteria for Charity Care, that is, they are considered able to pay but unwilling to satisfy their outstanding obligations.

Charity Care data reporting for services provided is based on charges incurred during the patients visit/encounter.

AXZONS proactively makes reasonable efforts to determine whether a patient is eligible for financial assistance before engaging in any collection activities. AXZONS has established respectful and effective procedures for addressing the needs of those persons who are unable to pay for all or most of their care. In order to preserve the dignity of these persons and to facilitate the process of securing necessary information, AXZONS performs financial screening upon scheduling for diagnostic imaging procedures. Patients who represent

increased financial risk as a result of the amount they are expected to owe "out-of-pocket" are referred to a Financial Counselor for assistance in applying for alternative payment programs (e.g., Medical Assistance) determining Charity Care eligibility, establishing payment plans or other financing arrangements.

Patients with insurance should not have their patient liability unpaid balance, coinsurance, deductible or non-covered service written-off to Charity Care unless financial hardship can be proven.

The need for Charity Care is a sensitive and personal issue for recipients and needs to be addressed with reverence for those who are in need. Confidentiality of information and individual dignity shall be maintained for all that seek charitable services.

AXZONS provides medically necessary care to all regardless of ability to pay. Partial and/or full Charity Care is based on the individual's ability to pay.

PROCEDURE:

1. **Eligibility Criteria:** Excluded from coverage are any third parties who may be liable for payment for services.
   1.1. **Charity Care Application: (See Exhibit B)**
      1.1.1. Any individual who indicates the financial inability to pay a bill for a medically necessary service shall be evaluated for Charity Care assistance.
      1.1.2. The Statement of Financial Condition (Exhibit B) is used to document each patient's overall financial situation. This application should be available in the primary language(s) of the service area.
      1.1.3. Credit reports may be used, when appropriate, to verify an individual's financial circumstances.
      1.1.4. A patient's employment status and earning capacity is taken into consideration when evaluating a Charity Care request.
      1.1.5. The data used in making a determination concerning eligibility for Charity Care should be verified.
      1.1.6. Once a determination has been made a notification form is provided to each applicant advising them of the decision.
   1.2. **Full Charity Care: 100% Discount**
      1.2.1. A patient whose household income (as calculated on the Statement of Financial Condition) is equal to or less than 200% of the most recent Federal Poverty Guidelines (FPG) qualifies for a Full Charity Care discount.
      1.2.2. For the purposes of State reporting, a patient whose household income is equal to or less than 125% of the most recent FPG is categorized as Indigent Care.
   1.3. **Partial Charity Care:**
      1.3.1. A patient whose household income is greater than 200% and less than 400% of the most recent FPG qualifies for a Partial Charity Care discount and are determined each year by the Accounting department.
      1.3.2. Flexible, interest-free payment plans are available (e.g., extended payment terms), as appropriate.

1.4. **Catastrophic Charity Care:**

1.4.1. In order to qualify for Catastrophic Charity Care Circumstances, the patient's Allowable Medical Expenses must exceed 40% of household income as described below:

1.4.2. AXZONS multiplies the household income as defined in Section L by 40%

1.4.3. AXZONS determines the patient's Allowable Medical Expenses.

1.4.4. AXZONS compares 40% of the household income as defined in Section L to the total amount of the patient's Allowable Medical expenses. If the total of the Allowable Medical Expenses is greater than 40% of the household income and/or assets, then the patient meets the Catastrophic Charity Care qualification. AXZONS subtracts 40% of the household income and/or assets from the Allowable Medical Expenses to determine the amount by which the Allowable Medical Expenses exceed the available income and/or assets; this amount is then eligible for a Charity Care write-off.

1.5. **Special Circumstances:**

1.5.1. Deceased patients without an estate or third party coverage are eligible for Charity Care.

1.6. **Governmental Assistance:**

1.6.1. In determining whether each individual qualifies for Charity Care, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medicaid, Healthy Families Program, Victims of Crime, State Children Services, etc.

1.6.2. Persons eligible for programs such as Medicaid but whose eligibility status is not established for the period during which the medical services were rendered, should be granted Charity Care for those services. AXZONS will make the granting of charity contingent upon applying for governmental assistance. Patients are required to complete a Medicaid application.

1.7. **AXZONS Collection Efforts:**

1.7.1. Accounts with applications pending for Charity Care or other assistance programs are held until the outcome of the application. A "pending charity approval" is defined as an application that has been fully completed by the patient, submitted and is in the process of being determined for eligibility.

1.7.2. It is acceptable (but not preferable) to take an account through the full collection cycle and later reclassify it as Charity Care, as long as a consistent process is followed and a legitimate basis exists that the patient is unable to pay. For example, self-pay accounts written-off and sent to Bad Debt, reclassifying the account to Charity Care may be considered on the basis of all of the following factors:

1.7.3. No third party coverage or inadequate coverage exists

1.7.4. No payments are recorded on the account

1.7.5. The patient/guarantor was billed a minimum of 4 times

1.7.6. Verifiable income and/or assets are provided by the patient and include all household adults.

1.8. **Collection Agency:**

1.8.1. In some cases, a patient eligible for Charity Care may not have been identified prior to initiating external collection action. Accordingly, each collection agency engaged should be made aware of the policy on Charity Care. This allows the agency to report amounts that they have determined to be uncollectible due to the inability to pay in accordance with the Charity Care eligibility guidelines.

1.8.2. Collection agencies shall not, in dealing with the uninsured patients at or below the 400% Federal Poverty Level, use or threaten to use wage garnishments or liens on primary residences as a means of collecting on unpaid AXZONS bills. AXZONS must specifically authorize institutional litigation. This does not preclude agencies from pursuing reimbursement from third-party liability settlements.

1.8.3. If a collection agency identifies special circumstances demonstrating a particular patient as being unable (versus unwilling) to pay their bill, their liability may be considered Charity Care, even if they were originally classified as a Bad Debt. The patient should be reclassified to Charity Care.

1.9. **Eligibility Period:**

1.9.1. The eligibility period is the year in which financial statements provided from patients meet charity care guidelines and care was received. If financial income or insurance status changes for the year the services incurred, the patient may become ineligible for charity as the guidelines may not be met.

1.10. **Time Requirements for Determination:**

1.10.1. While it is desirable to determine the amount of Charity Care for which a patient is eligible as close to the time of service as possible, there is no rigid limit on the time when the determination is made. In some cases, eligibility is readily apparent and a determination can be made before, on, or soon after the date of service. In other cases, it can take investigation to determine eligibility, particularly when the patient has limited ability or willingness to provide needed information. Every effort should be made to determine a patient's eligibility for Charity Care at the earliest reasonable date.

1.11. **Definition of Income:**

1.11.1. Annual earnings and cash benefits from all sources before taxes, less payments made for alimony and child support. Proof of earnings may be determined by annualizing pay at current earning rates. Bank Accounts and open available lines of credit are considered income.

2. **Accounting for Charity Care:**

2.1.1. Charity Care write-offs are accounted for in separate Deduction from Revenue general ledger accounts. One account should be used to track Charity Care given under the Full and Partial Charity Care provision; the other account should be used to track Charity Care given under the catastrophic coverage component. This allows tracking and monitoring of the amount and type of Charity Care being granted. The transaction codes used for accounting for Charity Care and their mapping to the General Ledger must be reviewed annually to ensure accuracy.

3. **Roles and Responsibilities:**

3.1.1. A collaborative review between the Vice President and the Chief Financial Officer shall be made of this policy annually. Approval and reporting to the local Board occurs to ensure oversight and accountability.

3.1.2. It shall be the responsibility of Patient Financial Services for the day-to-day administration of this policy.

4. **Recordkeeping:**

4.1.1. Records relating to potential Charity Care patients must be readily obtainable. Consideration should be given to maintaining a central file of the Statement of Financial Condition and other Charity Care summary forms if they are otherwise not readily accessible.

4.1.2. In addition, notes relating to the Charity Care application and approval or denial should be entered on the patient's account.

5. **Public Notice and Posting:**

5.1. Public notice of the availability of assistance through this policy is made through each of the following means:

5.2. Posting notices in a visible manner in locations where there is a high volume of patient traffic, such as billing offices, admitting offices, and AXZONS outpatient service settings.

5.3. Including language on patient liability statements sent to patients indicating:

5.3.1. AXZONS contact name and phone number that patients may call in order to gain information on AXZONS's Charity Care, reduced payment, and other financial assistance policies.

5.4. Posting notice of the availability of assistance and contact names and phone numbers on AXZONS's web site and notices.

5.5. Upon request, a full text copy of the Charity Care policy should be made available.

5.6. Posting annually on the website or otherwise make available to the public on a reasonable basis:

5.6.1. The costs of charity care provided.

5.7. Internally this policy shall be made available to all AXZONS Employees by being posted on AXZONS's Intranet under Administrative Policies.

5.8. Posted notices (as listed above) shall be in the primary language(s) of the service area and in a manner consistent with all applicable federal and state laws and regulations.

EXHIBIT: B

Financial Assistance Application Form

To be considered for financial assistance you **must provide** the following*:

- **A completed and signed Financial Assistance Application.**
- **Proof of Income:** (Please provide each of the following or an explanation of why not provided)
  - Federal Income Tax return(s) for your household for the most recent calendar year.
  - Bank Statements for all bank accounts for the last 2 months
  - Two (2) most recent pay stubs or a statement from your employer regarding your income.
    - ***If self employed***, please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.
    - Unemployment statement showing denial or eligibility and amount receiving.
  - Written documentation of **all** forms of income. *(i.e. trust funds, stock dividends, child support, alimony, social security, public assistance, food stamps, etc.)*
    - If you have not had any income for the past three (3) months or there has been a recent change in your financial situation you **must** include a statement or letter explaining your situation. If someone else is supporting you, they must sign the support statement on page 4 of the application.
- **Identification**:
  - Two forms of identification. (i.e. *driver's license, government issued photo ID, social security card, birth certificate or pass-port)*
- **Any other information that demonstrates financial hardship or need for financial assistance.** *(i.e. public assistance award or denial letters, letters of support, bank statements, etc)*

* *If, for any reason, you cannot provide us the information requested, please attach a written statement explaining why you cannot provide this information.*

Send completed applications and documentation to:

Axzons HomeCare
Attn: Patient Access **OR** **FAX:**

____
____

Failure to submit all requested information may result in denial of your application. Applications should be returned within **14** days or requests may be denied.

Please note that if financial assistance is granted it will only cover your medical bills from our facility. It will not apply to the bills for other medical providers, hospitals or physicians unless they specifically agree to accept it. **PLEASE CONTACT THE OTHER MEDICAL PROVIDERS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.**

When applying for financial assistance you are giving consent for us to make necessary inquiries to confirm financial obligations or references. If you have any questions, **please contact one of our financial counselors at ___________________________**.

Financial Assistance Application

Date: ___________________

Patient Information

Acct Number(s):_____________________________________ Total Amount Due: ______________

Patient Name: ______________________________ Date of Birth: ___________ SS#: _______________

Spouse or Guarantor Name: ____

Date of Birth: _______________ SS#: __________________

Address: ____

City: _____________________ State: _____ Zip: ___________ Years/months at residence: ___________

Home Phone:__________________ Cell Phone:__________________ Other Phone:__________________

Household Information

Member Name	Age	Relationship	Employer	Annual Gross Income
		SELF		$
				$
				$
				$
				$

Total Family Size: ________ Total Dependents: ________ Total Household Income: $______________

Screening Information:

- Do you currently have health insurance? (Y/N)____ If yes, please provide insurance info below:
  - Insurance Name: ______________________________ ➢ Policy # ________________________
  - Group Name/Number: ____
- Have you had health insurance that has been terminated in the past 3 months? (Y/N)____ If yes, complete the following:
  - What type of insurance? (i.e. Medicaid, BCBS, Tricare, etc,) ________________________________
  - Reason for insurance termination? ____
  - Did you apply for cobra insurance coverage? (Y/N) ____ If so, when? ____________
  - Former Employer Name: _______________________________
- Are you active duty or retired military? (Y/N)____ If so, are you eligible for VA Benefits? (Y/N)____
- Have you applied for Medicaid or Disability? (Y/N)____ If yes, complete the following:
  - When? ______________ ➢ Where? _______________________________
  - Caseworker? ___________________________
  - Has your household or income status changed since you last applied? (Y/N)____
- Were you a victim of a crime? (Y/N)____ If yes, complete the following.

- Have you filed a Police Report? (Y/N)____ (Must be filed within 72 hrs of incident)
- Completed Victim of Crime application? (Y/N)____

- If you have any other special circumstances which you would like us to consider when reviewing your application, please explain below:

____
____
____
____
____

Financial Assessment

Account Number(s)____

Patients Name____ Date:_____________

Monthly Expenses		**Assets**	
Rent/Mortgage	$_______________	Checking Account(s)	$________________
Utilities	$_______________	Savings Account(s)	$_______________
Food	$_______________	Other Cash Assets	$_______________
Cell Phone/Pager	$_______________	Credit Cards (Available Credit)	$_______________
Cable	$_______________		
Auto Loan	$_______________	**Monthly Gross Income**	
Auto Insurance	$_______________	Employment Income	$_______________
Loans	$_______________	Spouse Income	$_______________
Child Support	$_______________	Retirement Income	$_______________
Credit Cards (Min Payment)	$_______________	Food Stamps	$_______________
Other	$_______________	Government Benefits	$_______________
	$_______________	Child Support	$_______________
	$_______________	Other	$_______________
Total Expenses	**$_______________**	**Total Income**	**$________________**

TOTAL MONTHLY INCOME $_______________

TOTAL MONTHLY EXPENSES $_______________

AMOUNT AVAILABLE $_______________

Patient/Guarantor Certification

I, ____, CERTIFY the information I have provided is true and accurate to the best of knowledge. I understand that if I do not cooperate with AXZONS in supplying ANY additional requested information; my application may be denied for possible financial assistance. I understand that the information which I submit is subject to verification by the AXZONS, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I understand that this application pertains to AXZONS charges and not physician's charges. I understand that if any information I have given proves to be untrue, AXZONS will re-evaluate my financial status and take whatever action becomes appropriate. I am also aware that I am only applying for the accounts specified above, and that my financial status will have to be reevaluated and may require a new application for any/all future treatment I receive at AXZONS.

_________________________________ ____________

Patient/Guarantor Signature Date

For Office Use Only	
Reviewed by: __________________________ Date______________	Approved by:
Recommendation:	____________________________ Date________________
☐ Charity: ______%	____________________________ Date________________
☐ Indigent	____________________________ Date________________
☐ Denied: Reason____	

Additional Financial Documentation
(Only completed when applicable)

Account Number(s)____

Patients Name____ Date:____________

______ **Support Statement:**

My signature will certify that I, ______________________________, do provide all necessary essentials for living for the patient's behalf, and have done so for a period of ______ years / months.

____ ____________________ ___________________
Signature of Patient's Supporter Relation to Patient Date

______ **Homeless Affidavit**

I, (PRINT NAME) ____ hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

______________________________ ____________
Signature Date

______ **No Changes to Financial Status since Previous Application for Assistance**

I, (PRINT NAME) ____ hereby certify there have been no changes to my (nor my spouse's) financial status since my previous application for financial assistance from St. Mary's which was completed on _________________. Please select of the following options:

- ☐ I am still being supported by another. They do provide all necessary essentials for living for my behalf, and have done so for a period of __________ years/months.
- ☐ I am still Homeless. I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.
- ☐ There are no changes to my (or my spouse's) income or household size since my previous application.

______________________________ ____________
Signature Date

Axzons Consumer Rights Policy

PURPOSE

1. To ensure clients are aware of their rights;
2. To ensure compliance with applicable laws; and,
3. To ensure that staff are educated about and respectful of client's rights when delivering services.

APPLICATION

This policy applies to Clients/ Consumers of Axzons Homecare Ltd. and defines their rights.

DEFINITIONS

Client

For purposes of this policy a client is a consumer or other individual or entity who uses services delivered by Axzons Homecare Ltd.

POLICY

Pursuant to Ga. Comp. R. & Regs.111-2-2-.32(3)(2)(l)(1) Axzons Homecare Ltd. has established written policies regarding the rights of the patient and developed procedures implementing such These rights, policies and procedures afford each patient the right to:

(1) be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record;
(2) be given a statement of the services available by the agency and related charges;
(3) be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors and the extent to which payment may be required from the patient.
(i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change.
(ii) All information required by this paragraph shall be provided to the patient both orally and in writing;
(4) **be informed that the agency prohibits the exclusion of services to any patient on the basis of age, disability, gender, race, or ability to pay.**
(5) be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services;
(6) participate in the planning of his or her care and be advised in advance of any changes to

the plan of care;

(7) refuse care and treatment after being fully informed of and understanding the consequences of such actions;
(8) be informed of the procedures for submitting patient complaints;
(9) voice complaints and recommend changes in policies and services to agency staff, the Georgia State Department of Community Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal;
(10) submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints, and to have the agency investigate such complaints in accordance with the provisions.
The agency is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response the patient may complain to the Department of Community Health's Office of Health Systems Management;
(11) be treated with consideration, respect and full recognition of his/her dignity and individuality; and
(12) privacy, including confidential treatment of patient records, and to refuse release of records to any individual outside the agency except in the case of the patient's transfer to a health care facility, or as required by law or third-party payment contract.
(b) The governing authority shall make all personnel providing patient care services on behalf of the agency aware of the rights of patients and the responsibility of personnel to protect and promote the exercise of such rights.
(c) If a patient lacks capacity to exercise these rights, the rights shall be exercised by an individual, guardian or entity legally authorized to represent the patient.

PROCEDURES

1. Supervisor/Alternate and client/client's representative shall review the Rights & Responsibilities of Client & Agency with the client/client's representative during the initial assessment and obtain the required signatures.
2. A copy of the signed *Rights & Responsibilities of Client & Agency* form shall be given to the client prior to the commencement of services. The original shall be placed in the client's file.
3. Supervisor shall make a notation in the client's record that:
   a. the *Rights & Responsibilities of Client & Agency* form was reviewed with the client/client's representative;
   b. the required signatures were obtained;
   c. a copy of the *Rights & Responsibilities of Client & Agency* form was left in the client's home; and,

4. Should the client not understand his/her "*Rights*" the Supervisor/alternate shall document the lack of understanding in the client's record and give the reason why it was not understood. If the client's representative or someone else is in the home is able to comprehend the details, the Supervisor/Alternate shall document this information.

Client Rights

The Agency's form (*Rights & Responsibilities of Client & Agency*) shall include the following client rights. i.e. The client's rights to:

1. be informed of these rights, and the right to exercise such rights, in writing prior to the initiation of care, as evidenced by written documentation in the clinical record;
2. be given a statement of the services available by the Agency and related charges;
3. **be informed that the agency accepts all patients including financially indigent, medically indigent, Medicaid, PeachCare and Medicare Patients.**
4. **be advised before care is initiated of the extent to which payment for agency services may be expected from any third party payors (private pay, Commercial insurance as well as Medicaid, PeachCare and Medicare) and the extent to which payment may be required from the patient.**
   (i) The agency shall advise the patient of any changes in information provided under this paragraph or paragraph (2) of this subdivision as soon as possible, but no later than 30 calendar days from the date the agency becomes aware of the change.
   (ii) All information required by this paragraph shall be provided to the patient both orally and in writing;
5. be informed of all services the agency is to provide, when and how services will be provided, and the name and functions of any person and affiliated agency providing care and services;
6. participate in the planning of his or her care and be advised in advance of any changes to the plan of care;
7. refuse care and treatment after being fully informed of and understanding the consequences of such actions;
8. be informed of the procedures for submitting patient complaints;
9. voice complaints and recommend changes in policies and services to agency staff, the Georgia State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or his/her designee shall be free from interference, coercion, discrimination or reprisal;
10. submit patient complaints about the care and services provided or not provided and complaints concerning lack of respect for property by anyone furnishing service on behalf of the agency, to be informed of the procedure for filing such complaints.

11. Be notified if the patient is not satisfied by the response the patient may complain to the Department of Community Health's Office of Health Systems Management;
12. The address for the complaints to DCH to be provided to patients is

13.

Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303
800-657-6442

14. be treated with consideration, respect and full recognition of his/her dignity and individuality; and
15. privacy, including confidential treatment of patient records, and to refuse release of records to any individual outside the agency except in the case of the patient's transfer to a health care facility, or as required by law or third-party payment contract.
16. **Prohibit exclusion of service and be dealt with without regard to race, color, age, sex, sexual orientation, creed, religion, disability and familial/cultural factors, or ability to pay.**
17. receive complete information about his/her health and recommended treatments, as developed jointly with this Agency;
18. provided with information on alternative services that may be available;
19. participate in a referral to another service provider or a health care institution;
20. refuse to participate in experimental research;
21. receive reasonable notice of any changes in their service, within an agreed upon amount of time, prior to the changes place
22. be informed of the cost of services and procedures and to be informed of all changes in services, procedures and fees, as they occur;
23. refuse services or treatment and be informed of the consequences of that refusal;
24. be free from mental, verbal, sexual and physical abuse, neglect, involuntary seclusion and exploitation;
25. receive privacy and confidentiality with regard to their health, social, and financial circumstances and what takes place in their homes, in accordance with laws and Agency policies;
26. receive confidential treatment of their personal and medical records;
27. approve or refuse the release of their personal or medical records to any individual/entity other than the Agency except when client records are transferred to another service provider or a health facility or as otherwise authorized by law;
28. make suggestions or complaints or present grievances to the Agency, government agencies or other entities or individuals without fear of the threat of retaliation.
29. receive a prompt response, through an established complaint or grievance procedure, to any complaints, suggestions or grievances they may have;

30. access procedures for making complaints to the:
    a. authority responsible for health quality;
    b. Adult Protective Services Program of the local Department of Social Services, if the client is an adult:
    c. The Child Protective Services Program of the local Department of Social Services, if the client is a child.
31. cared for by qualified, competent and trained personnel;
32. be taught the procedures used to provide care required, to enhance the client's ability to provide as much self-care as possible;
33. designate an individual of the client's choice , to receive instruction on care procedures, which are provided to the client, in order that the designated individual can assist the client as much as possible;
34. have full access to the information regarding their health condition and their care records maintained by this Agency, to the extent required by law;
35. be spoken to or communicated with in a manner or language they can understand;
36. speak freely without fear;
37. have their homes and property treated with respect;
38. be free from involuntary confinement, and from physical or chemical restraints;
39. be free from any actions that would be interpreted as being abusive. e.g. intimidation, physical/sexual/verbal/mental/emotional/material or financial abuse, etc.;
40. report all instances of potential abuse, neglect, exploitation, involving any employee of the Agency, to the *Elder Abuse Hotline*;
41. express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of the Agency;
42. be informed of procedures for initiating complaints about the delivery of service or resolving conflict, without fear of reprisal or retaliation;
43. be informed of the laws, regulations and policies of the Agency including:
    a. *Code of Ethics;*
    b. *Unstable Health Conditions;*
    c. *Withdrawal/Termination of Services*; AND,
    d. others, as required/requested.
44. be provided with the name, certification and staff position of all persons supplying, staffing or supervising the care and services you receive;
45. be informed of where ownership lies for any equipment/supplies provided in the provision of services;
46. receive written information on the care plan, including the names of Care Aide(s), & Supervisor assigned and the Agency's phone number;

47. provide input on which Care Aide they want and request a change of Care Aide, if desired;
48. be briefed on any procedure/treatment before it is carried out in order that they can give informed consent;
49. receive regular nursing supervision of the |Care Aide, if medically-related personal care is needed;
50. be given written documentation on the Agency's Advance Directives Policy;
51. to die with dignity;
52. be informed, within a reasonable amount of time, of the Agency's plans to terminate the care or service and/or their intention to transfer their care to another agency; and,
53. have their family or legal representative exercise the client's rights when the legal representative is legally authorized to do so

CROSS-POLICY REFERENCES
1. Client & Agency Responsibilities
2. Advance Directives
3. Standards of Conduct & Work Ethics
4. Complaints/Compliments
5. Unstable Health Conditions
6. Withdrawal/Termination of Services
7. Service Plan
8. Service Agreement
9. Privacy & Confidentiality

REGULATORY REFERENCE
This policy has a regulatory reference to Ga. Comp. R. & Regs.111-2-2-.32(3)(2)(l)(1)

RESPONSIBLE PARTY
1. Supervisor Client's services is responsible for adhering to this policy's directives.
2. Manager Client's Services

FORMS
1. Rights & Responsibilities of Client & Agency of Client & Agency

Table: Financial Average Charges Per Agency Visit

Financial Average Charges Per Agency Visit 2021

State Service Delivery Regions

See selection criteria at end of report; totals for each area are in area header

Base Location	Facility Name	Skilled Nursing Visits	Physical Therapy Visits	Home Health Aide Visits	Occupational Therapy Visits	Medical Social Services Visits	Speech Pathology Visits	Total Visits	Gross Patient Charges	Average Charge per Visit
2021	**39 Agencies**	**519,348**	**446,694**	**30,537**	**158,426**	**11,002**	**28,217**	**1,194,224**	**65,575,529**	**306.12**
Area 1	**7 Agencies**	**144,088**	**70,764**	**5,695**	**31,455**	**2,561**	**5,870**	**260,433**	**99,810,494**	**383.25**
Catoosa	Home Care Solutions	18,143	6,121	100	3,503	0	438	28,305	5,382,432	190.16
Catoosa	North Georgia Home Health Agency - An Amedisys Company	20,284	11,536	2,091	3,937	70	1,441	39,359	31,596,400	802.77
Floyd	Coosa Valley Home Health, an Amedisys Company	13,987	9,316	68	5,039	794	1,116	30,320	19,393,987	639.64
Floyd	Floyd HomeCare	63,840	26,003	1,515	12,907	1,189	2,322	107,776	16,182,371	150.15
Gordon	Gordon Home Care	7,234	6,649	1,400	1,462	0	365	17,110	3,260,430	190.56
Pickens	Amedisys Northwest Home Health	7,305	7,098	14	2,467	188	143	17,215	19,550,925	1,135.69
Whitfield	Hamilton Home Health	13,295	4,041	507	2,140	320	45	20,348	4,443,949	218.40
Area 3	**26 Agencies**	**300,740**	**321,010**	**19,906**	**105,901**	**7,100**	**18,202**	**772,859**	**38,016,346**	**307.97**
Cherokee	Community Home Health, an Amedisys Company	10,996	11,321	81	5,313	290	646	28,647	6,982,390	243.74
Clayton	SunCrest Home Health of Georgia	12,730	9,756	366	2,663	88	508	26,111	4,745,470	181.74
Cobb	Encompass Health Home Health	4,598	7,278	309	2,555	60	697	15,497	2,987,352	192.77
Cobb	Five Points Healthcare of GA, LLC	1,858	1,495	192	875	134	80	4,634	1,161,294	250.60
Cobb	Kindred at Home - Marietta	47,097	62,729	2,659	15,008	1,222	2,993	131,708	27,158,449	206.20
Cobb	Suncrest Home Health	4,290	3,684	31	1,301	101	60	9,467	1,945,405	205.49

Base Location	Facility Name	Skilled Nursing Visits	Physical Therapy Visits	Home Health Aide Visits	Occupational Therapy Visits	Medical Social Services Visits	Speech Pathology Visits	Total Visits	Gross Patient Charges	Average Charge per Visit
Cobb	WellStar Home Health - Cobb	22,785	19,378	2,162	4,463	1,160	1,219	51,167	11,207,757	219.04
DeKalb	BridgeWay Home Health	700	1,323	38	536	9	19	2,625	1,791,418	682.44
DeKalb	Central Home Health Care, an Amedisys Company	11,078	12,920	93	4,857	22	254	29,224	30,053,687	1,028.39
DeKalb	Suncrest Home Health	674	373	0	183	10	0	1,240	188,270	151.83
Douglas	Central Home Health Health, Douglasville, an Amedisys Company	9,568	9,590	320	2,942	207	503	23,130	42,769,274	1,849.08
Fayette	Kindred at Home - Peachtree City	47,247	46,236	2,385	13,485	1,230	4,349	114,932	20,920,516	182.03
Fulton	Central Home Health Care, Atlanta, an Amedisys Company	10,807	10,559	0	4,833	1	0	26,200	13,728,863	524.00
Fulton	Georgia Home Health	6,803	8,388	0	2,543	90	239	18,063	3,556,672	196.90
Fulton	Guardian Home Care, LLC									
Fulton	Interim Healthcare of Atlanta Inc.	25,388	19,984	4,537	9,983	461	1,023	61,376	14,116,834	230.01
Fulton	Kindred at Home - Atlanta	14,957	17,462	1,619	6,020	196	694	40,948	8,096,302	197.72
Fulton	Medside Home Health Agency									
Fulton	Visiting Nurse Health Systems, Metro Atlanta	25,489	29,394	1,855	10,620	839	800	68,997	15,807,122	229.10
Gwinnett	Encompass Health Home Health	4,119	6,072	261	2,754	27	885	14,118	2,723,213	192.89
Gwinnett	Five Points Healthcare of GA, LLC - Gwinnett	3,557	3,896	395	1,110	288	157	9,403	2,435,921	259.06
Gwinnett	MeSun Health Services, Inc.	651	1,174	62	894	8	0	2,789	310,327	111.27
Gwinnett	Pediatric Services of America - Norcross	1,241	0	0	0	0	0	1,241	188,862	152.19
Gwinnett	Pruitthealth Home Health - Atlanta	16,857	14,984	1,189	6,423	462	1,231	41,146	8,388,743	203.88

Base Location	Facility Name	Skilled Nursing Visits	Physical Therapy Visits	Home Health Aide Visits	Occupational Therapy Visits	Medical Social Services Visits	Speech Pathology Visits	Total Visits	Gross Patient Charges	Average Charge per Visit
Gwinnett	Staff Builders Home Health	9,907	14,068	129	3,444	28	1,678	29,254	12,673,993	433.24
Rockdale	Bridgeway Home Health	7,343	8,946	1,223	3,096	167	167	20,942	4,078,212	194.74
Area 8	**6 Agencies**	**74,520**	**54,920**	**4,936**	**21,070**	**1,341**	**4,145**	**160,932**	**27,748,689**	**172.42**
Crisp	CareSouth - An Affiliate of Crisp Regional Hospital	6,414	5,605	128	142	4	214	12,507	2,190,838	175.17
Muscogee	Encompass Health Home Health	36,919	31,770	1,938	14,786	792	3,189	89,394	16,152,620	180.69
Muscogee	Georgia Home Health	9,647	4,872	182	2,740	154	315	17,910	2,916,515	162.84
Muscogee	Kindred at Home - Columbus	10,889	9,905	655	2,041	156	340	23,986	4,442,736	185.22
Muscogee	Muscogee Home Health Agency									
Muscogee	Ultra Care of Georgia	10,651	2,768	2,033	1,361	235	87	17,135	2,045,980	119.40

Source: Home Health Agency Survey
Prepared By: Department of Community Health

Notes: Total Visits may include other visits not listed here. Agencies can include other types of health-related visits.

The report totals and subtotals include only those records specified in selection criteria, if any, shown below. If no criteria are shown, all records are included.

([Year] >= '2021'AND [Year] <='2021' AND [SSDR] in(1, 3, 8))

Axzons JCAHO Accreditation Award

April 25, 2023

Sandeep Kalra
Administrator
Axzons Health System Corporation
70 East Sunrise Highway, Suite 500
Valley Stream, NY 11581

Joint Commission ID #: 686602
Program: Home Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 4/21/2023

Dear Mr. Kalra:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Home Care

This accreditation cycle is effective beginning March 16, 2023 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.
Please note, if your survey was conducted off-site (virtually): Your organization may be required to undergo an on-site survey once The Joint Commission has determined that conditions are appropriate to conduct on-site survey activity.

Should you wish to promote your accreditation decision, please view the information listed under the'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Deborah A. Ryan, MS, RN
Executive Vice President
Division of Accreditation and Certification Operations