APPENDIX D

Mississippi State Department of Health

DETERMINATION OF REVIEWABILITY APPLICATION FORM
(PROCESSING FEE: $500.00)

1. Title of Project _____

2. Facility name, address, county, ZIP code.

3. Legal name and address of applicant, if different from Item 2 above.

4. Principal agent to contact for this project (Include address, county, ZIP code, Email and telephone number).

5. Type of organization (e.g., county-owned, not-for-profit acute care hospital).

6. Provide a brief narrative description of the project, including location of new construction, areas involved in repair or renovation, square feet involved in new construction or renovation, new services being proposed, and/or equipment acquisition proposed.

7. Enclose architect's schematic drawings if new construction or renovation project.

8. If new construction is being developed by entity other than the applicant

   (a) Identify owners/Board of Directors and enclose charters of incorporation or partnership agreement, etc.

   (b) Identify tenants that will occupy the building, if applicable.

   (c) Will the facility share the same parking lot as the hospital.

9. Estimated project cost

a.	Construction Cost – New	
b.	Construction Cost – Renovation	
c.	Capital Improvement Cost (i.e., minor painting and repairs, refurbishing)	
d.	Total Fixed Equipment Cost	
e.	Total Non-Fixed Equipment Cost	
f.	Land Cost	
g.	Site Preparation Cost	
h.	Fees (architectural, consultant, etc.)	
i.	Contingency Reserve	
j.	Capitalized Interest	
k.	Other Costs (specify) _____	
l.	Total Estimated Project Cost	

10. If the project involves purchase/lease of equipment, provide the following:

    a. Independent report of the fair market value of major medical equipment, if not new equipment.

       Original purchase price of equipment
       Purchase and installation date (s) of equipment
       Depreciation schedule of equipment, and
       Fair market value of equipment.

    b. A copy of the proposed vendor contract, including lease amount, if applicable.

    c. Assurance that the entity desiring to acquire or otherwise control the equipment is a registered business entity authorized to do business in Mississippi.

    d. Name of proposed health care facility or facilities to be served, if mobile or shared unit. Include a copy of proposed vendor service contract.

11. Anticipated purchase and installation date(s) for equipment/service.

12. Provide a construction cost estimate signed by an architect licensed to practice in Mississippi or a contractor authorized to do business in Mississippi.

13. Sign the attached Certification page.

CERTIFICATION

STATE OF MISSISSIPPI
COUNTY OF _____

I (we) do solemnly swear or affirm on behalf of _____ _____, after diligent research, inquiry and study, that the information and material, contained in this foregoing application for a Declaratory Ruling is true, accurate, and correct, to the best of my (our) knowledge and belief. I (we) understand that the Mississippi State Department of Health will rely on this information and material in making its determination and if it finds that the application contains distorted facts or misrepresentation, the Department may require Certificate of Need review of the project. I (we) will notify the Department should subsequent increases in the cost of any portion of this project cause the capital expenditure to exceed $1,500,000 for equipment or $2,000,000 for other than equipment, and will apply for a CON.

It is further understood that this determination ruling is valid for a period of twelve months. If the project is not implemented within the twelve month period, I (we) must request a second ruling by the Department. I (we) understand that if the statute or Plan changes during a twelve month period in which the proposed project is not implemented, the Department will make its determination ruling in accordance with the proposed statute/Plan change.

_____ _____
Signature Signature

_____ _____
Title Title

_____
Name of Facility

Sworn to and subscribed before me, this the _____ day of _____, 20 ____.

_____
Notary Public

_____
My Commission