

**MISSISSIPPI STATE DEPARTMENT OF HEALTH**

**NOTICE OF INTENT TO APPLY FOR A CERTIFICATE OF NEED**

(Must be received 30 days prior to submission of a CON application)

<b>TITLE OF PROJECT:</b>			
<b>Type of Review:</b>	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Expedited	<input type="checkbox"/> Unknown

**I. APPLICANT/FACILITY INFORMATION**

<b>APPLICANT</b>			
Applicant Legal Name:			
d/b/a (if applicable):			
Address:			
City:	State:	Zip Code:	
County:	Telephone:		
Parent Organization (if applicable):			
E-mail Address:		Fax:	
<b>PRIMARY CONTACT PERSON</b>			
Name:	Title or Position:		
Firm:			
Address:			
City:	State:	Zip Code:	
Telephone:	Fax:		
E-mail Address:			
<b>LEGAL COUNSEL /CONSULTANT(if applicable)</b>			
Name:	<input type="checkbox"/> Counsel <input type="checkbox"/> Consultant		
Firm:			
Address:			
City:	State:	Zip Code:	
Telephone:	Fax:		
E-mail Address:			

<b>FACILITY (if different from Applicant)</b>			
Name:			
Address:			
City:	State:	Zip Code:	
County:	Telephone:		

1. Select the type of ownership of present or proposed facility.

<b>TAX EXEMPT</b>	<input type="checkbox"/> Not-for-Profit Corporation		
	<input type="checkbox"/> Public (Hospital or Government)		
<b>TAX PAYING</b>	<input type="checkbox"/> General Partnership	<input type="checkbox"/> Business Corporation	<input type="checkbox"/> Sole Proprietor
	<input type="checkbox"/> Limited Liability Partnership or Limited Partnership	<input type="checkbox"/> Limited Liability Company	
State of Incorporation or Organization:			

2. Identify any proposed bed changes (increases/decreases) by licensure category.

## **II. PROJECT DESCRIPTION**

1. Provide a narrative description of the project, including location of new construction, areas involved in repair or renovation, new services being proposed, and/or equipment acquisition proposed.
2. Provide a brief justification for the project.
3. Does the project involve correction of code or Licensure deficiencies?
  - a. If yes, are all deficiencies corrected by this project?
  - b. List any project components which do not involve correction of code or licensure deficiencies.
4. Estimated project costs:

Construction Cost – New	\$
Construction Cost – Renovation	
Capital Improvement Cost (i.e. minor painting and repairs, refurbishing)	
Total Fixed Equipment Cost	
Total Non-Fixed Equipment Cost	
Land Cost	
Site Preparation Cost	
Fees (architectural, consultant, etc.)	
Contingency Reserve	
Capitalized Interest	
Other Costs (specify)	
<b>Total Estimated Project Cost</b>	

5. Approximate: (a) project starting date \_\_\_\_\_  
(b) project completion date \_\_\_\_\_

**Submitted by:**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
Name (type)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date