APPENDIX 1

MISSISSIPPI DEPARTMENT OF HEALTH

Notice Of Intent To Apply For A Certificate Of Need

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

1. Facility name, address, county and zip code.

2. Legal name of applicant organization (Include address, county, zip code, if different).

3. Principal agent to contact for this project (Include address, county, zip code and telephone number.)

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

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

6. Project Title _____

7. Narrative description of project, including location of new construction, areas involved in repair or renovation, new services being proposed, and/or equipment acquisitions proposed.

8. Provide a brief justification for the project.

9. Estimate project costs

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. Approximate: a. project starting date _____
b. project completion date _____

11. Type of review requested: a. Quarterly _____
b. Expedited _____
c. Unknown _____

12. Does this project involve correction of code or Licensure deficiencies?

a. If yes, are <u>all</u> deficiencies corrected by this project?

b. List any project components which do not involve correction of code or licensure deficiencies.

Submitted by

_____
SIGNATURE

_____
NAME (type)

_____
TITLE

_____
DATE