Georgia
Certificate of Need
Request for Determination

FOR DIVISION OF HEALTH PLANNING USE ONLY	
LETTER NUMBER **DET**	*DATE STAMP*
Signed Original and 1 Copy ____________	Fee Verified ____________

GENERAL INFORMATION:

This Determination Request form is the required document that the Department reviews in the analysis and evaluation of determination requests in accordance with CON Administrative Rule 111-2-2-.10(2). A determination request is a request that provides a specific proposed action and asks the Department for an official ruling of how a specific regulation or law impacts that action.

1. Requesting Parties must submit a signed original and one (1) copy of the signed form and the appropriate fee.
2. The filing fee of $250 shall be made payable to the “Department of Community Health” and shall be remitted by Certified Check or Money Order.
3. Failure to submit the required fee and number of copies and the original will result in non-acceptance of the form.
4. The Department will make every attempt to review the information submitted and issue a determination within 60 days of acceptance.
5. **This form MUST NOT be used to request a determination that equipment below threshold does not require CON review or for a LNR request for a single-specialty or joint venture ambulatory surgical center.**

PLEASE COMPLETE THE FOLLOWING TABLE TO VERIFY PROPER SUBMISSION OF YOUR REQUEST	
REQUESTING PARTY NAME:	
1. Have you submitted an original signed in blue ink and provided 1 copy of this signed Determination Request form?	☐ **Yes** ☐ **No**
2. Have you submitted a Certified Check or Money Order made payable to “Department of Community Health” in the amount of $250.00?	☐ **Yes** ☐ **No**

Submit the ***original and one (1) copy*** of this form and all additional documentation to:

Division of Health Planning
Determination Requests
Department of Community Health
2 Peachtree Street, NW, 5th Floor
Atlanta, Georgia 30303

Revised April 14, 2009

Instructions

1. Please read all instructions and review this Determination Request form in its entirety before attempting to complete and submit it.

2. This Determination Request form **must** be typewritten or completed and printed in this MS Word format. Handwritten responses must not be submitted and will not be accepted.

3. Only one specific proposed action may be addressed in each request. If a Requesting Party has multiple proposed actions for which it seeks a determination, separate forms must be submitted for each such action.

4. Throughout this Determination Request form, the following symbols are utilized for emphasis:

   🗁 Emphasizes instances where supporting documentation is requested and required to be attached; and

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

5. Any exhibits or appendices to this form should be submitted on one-sided, 8 ½ by 11-inch paper only. Such exhibits or appendices should not be tabbed or otherwise separated from this main application. If the Requesting Party wishes to label its exhibits or appendices when submitting multiple attachments, it should do so by numbering or lettering the exhibit or appendix on the first page of such attachment itself.

6. A signed original Determination Request and one (1) copy are required in addition to the appropriate fee of $250 for a Determination Request to be accepted by the Department. The fee shall be made payable by certified check or money order only to "Department of Community Health."

7. The signed original Determination Request form and the single copy must be submitted on loose leaf, one-sided 8 ½ by 11-inch paper only. These documents must **not** be hole-punched or bound by staple. The documents may be clipped or rubber banded to divide the original from the copy.

8. The original and the single copy must be submitted in a single envelope to the address indicated on the cover page of this form.

9. Faxed copies of documents and information are not official and must be followed-up with the original documents for inclusion in the file.

Section 1 – Requesting Party Identification

1. Please complete the following information identifying the party requesting this determination. The Contact Person should be an individual directly affiliated with the Requesting Party and not a consultant or attorney.

REQUESTING PARTY #1		
Legal Entity or Person:		
Address 1:		
Address 2:		
City:	State:	Zip:
County:		
CONTACT PERSON		
Name:	Title:	
Address 1:		
Address 2:		
City:	State:	Zip:
Phone:	Fax:	
E-mail:		

2. If there is an additional party requesting this determination (there are co-requesting parties), please complete the following information identifying the second party. The Contact Person should be an individual directly affiliated with the Requesting Party and not a consultant or attorney.

REQUESTING PARTY #2 *(if applicable)*		
Legal Entity or Person:		
Address 1:		
Address 2:		
City:	State:	Zip:
County:		
CONTACT PERSON		
Name:	Title:	
Address 1:		
Address 2:		
City:	State:	Zip:
Phone:	Fax:	
E-mail:		

3. Does the Requesting Party(ies) have Legal Counsel to whom legal questions regarding this request may be addressed?

☐ **YES** ☐ **NO**

If **YES** ➔ Identify the legal counsel below.

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

<table>
<tr><th colspan="4">LEGAL COUNSEL</th></tr>
<tr><td colspan="4">Name:</td></tr>
<tr><td colspan="4">Firm:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td>City:</td><td colspan="2">State:</td><td>Zip:</td></tr>
<tr><td colspan="2">Phone:</td><td colspan="2">Fax:</td></tr>
<tr><td colspan="4">E-mail:</td></tr>
</table>

4. Did a Consultant prepare and/or provide information in this Determination Request? ☐ **YES** ☐ **NO**

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

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

<table>
<tr><th colspan="4">CONSULTANT</th></tr>
<tr><td colspan="4">Name:</td></tr>
<tr><td colspan="4">Firm:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td>City:</td><td colspan="2">State:</td><td>Zip:</td></tr>
<tr><td colspan="2">Phone:</td><td colspan="2">Fax:</td></tr>
<tr><td colspan="4">E-mail:</td></tr>
</table>

5. Does the Requesting Party(ies) wish to designate and authorize an individual other than the Requesting Party Contact(s) listed in response to Question 1 to act as the representative of the Requesting Party(ies) for purposes of this request?

☐ **YES** ☐ **NO**

If **YES** ➔ Please complete the information in the following table on the next page. By doing so, the Requesting Party(ies) authorizes the representative to submit this determination request; to provide the Department of Community Health with all information necessary for a determination on this request; to enter into agreements with the Department of Community Health in connection with this request; and to receive and respond, if applicable, to notices in matters relating to this request.

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

AUTHORIZED REPRESENTATIVE		
Name:		
Firm:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
Email:		

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

6. Does the Requesting Party(ies) have any lobbyist employed, retained, or affiliated with the Requesting Party(ies) directly or through its contact person(s) or authorized representative?

☐ **YES** ☐ **NO**

If **YES** ➔ Please complete the information in the table below for each lobbyist employed, retained, or affiliated with the Requesting Party(ies). 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 Requesting Party(ies)**	**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 – General Information Regarding Proposed Action

7. Complete the following table to provide general information regarding the proposed action for which a determination is being sought. If you select an item in the "Nature of Request" row indicating that an Exhibit must be completed, complete the required Exhibit, which is included at the end of this form. Discard all Exhibits that are not required before submittal.

Title of Proposed Action	*(example: Replacement of Pharmacy Information System)*
Location of Proposed Action ☐ *Check if not applicable or if multiple locations*	*Address 1:* *Address 2:* *City:* *State:* *Zip:* *County:*
Dates of Proposed Action	*Starting Date:* *Completion Date:*
Nature of Request *(Only one type of request may be submitted per form)*	☐ Repair/Replacement of Physical Plant Equipment ☐ Expenditures to Eliminate Safety Hazards/Comply with Accreditation Standards ☐ Addition or Replacement of Computer or Information Systems ☐ Capital Expenditures Below Threshold ☐ Senate Bill 433 (2008) CON Exemption: Specify: ***Not to be used for LNR-ASC requests** ☐ Other: The following require the completion of an additional Exhibit which is indicated below: ☐ Potential Non-Reviewable Cost Overrun *(Complete Exhibit 1)* ☐ 10% Increase in Bed Capacity *(Complete Exhibit 2)* ☐ Replacement of CON-approved Diagnostic or Therapeutic Equipment *(Complete Exhibit 3)* ☐ Transfer of Home Health Counties *(Complete Exhibit 4)* ☐ Therapeutic Cardiac Catheterization Statutory Exemption (Accepted only May 1 through May 15) *(Complete Exhibit 5)*

Section 3 – Proposal Description

8. Please provide a detailed description of the proposed action including a statement as to what determination is being sought. You may provide this description in the space provided below, or in lieu of using the space provided, attach separate 8.5” x 11” sheet(s) providing the information requested.

Section 4 – Certification

By signing below,

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

b) I understand that a representative of the Certificate of Need Program may make a direct request of me for additional information in order to issue a Determination; and

c) I further understand that if issued a Determination, the Requesting Party is bound to any representations that have been made within this Determination Request and any and all supplemental information and Exhibits.

REQUESTING PARTY #1 CERTIFICATION	
Signature of Authorized Signatory (BLUE INK ONLY):	
Name:	
Title:	*Date:*

REQUESTING PARTY #2 CERTIFICATION *(if applicable)*	
Signature of Authorized Signatory (BLUE INK ONLY):	
Name:	
Title:	*Date:*

EXHIBIT 1:
Potential Non-Reviewable Cost Overrun

Only complete this Exhibit if you have indicated in Question 7, Page 4 that this Determination Request involves a Potential Non-Reviewable Cost Overrun. If your proposed action does not relate to a potential non-reviewable cost overrun, DISCARD AND DO NOT SUBMIT THIS EXHIBIT.

1. Identify the CON project that is the subject of this request for determination regarding a potential non-reviewable cost overrun by completing the information in the table below:

PROJECT IDENTIFICATION	
Project Number	**GA**
Date of CON Issuance	

2. Complete the table on the next page, Exhibit 1: Page 2, to identify the original estimated project costs. This should correspond to those cost estimates presented in the original CON application that was approved. Enter the requested information from this table below:

ORIGINAL PROJECT ESTIMATES	
(1) Line 22, Exhibit 1:Page 2	
(2) Multiply Line 1 above by 110%	
(3) Total Square Footage (Add Square Footage from Lines 1, 2 & 3 from Exhibit 1: Page 2)	
(4) Multiply Line 3 above by 105%	

3. Complete the table on Exhibit 1: Page 3 to identify the new estimated project costs. Enter the requested information from this table below:

NEW PROJECT ESTIMATES	
(1) Line 22, Exhibit 1:Page 3	
(2) Total Square Footage (Add Square Footage from Lines 1, 2 & 3 from Exhibit 1: Page 3)	

4. Is the projected cost overrun related to any of the following issues? Check all that apply. Be sure to explain any of the issues identified in Section 3, Question 8 of this request on page 5 or in your attached proposal description.

- ☐ Unanticipated engineering or construction problem
- ☐ Increased costs of major fixed equipment
- ☐ Federal, State, or local fire requirements adopted after the issuance of CON
- ☐ Subsequent project bidding prior to contractual obligations
- ☐ Increases in materials and costs due to a delay in excess of one year of project construction and/or renovation activity resulting from an appeal proceeding

5. Will the cost overrun have no or minimal impact on costs and/or charges per patient day or procedure?

☐ **YES** ☐ **NO**

6. Has the scope of the project increased by this cost overrun, e.g. is there a change in number or type of beds? ☐ **YES** ☐ **NO**

ORIGINAL 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				← *Add Lines 1 through 4*
Equipment				
(6) Fixed Equipment (not in construction contract)				
(7) Moveable Equipment				
(8) Subtotal Equipment				← *Add Lines 6 through 7*
Other				
(9) Contingency				
(10) Legal and Administrative Fees				
(11) Interim Financing				
(12) Underwriting Costs				
(13) Building and Fire Code Compliance				
(14) Other:				
(15) Subtotal Other				← *Add Lines 9 through 14*
(16) TOTAL COST APPLICABLE TO FILING FEE				← *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				
(19) Subtotal Predevelopment				← *Add Lines 18a and 18b*
(20) Escrow for Debt Service				
(21) TOTAL COST EXCLUDED FROM FILING FEE				← *Add Lines 17, 19, and 20*
(22) GRAND TOTAL ESTIMATED PROJECT COST				← *Add Lines 16 and 21*

NEW 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				← *Add Lines 1 through 4*
Equipment				
(6) Fixed Equipment (not in construction contract)				
(7) Moveable Equipment				
(8) Subtotal Equipment				← *Add Lines 6 through 7*
Other				
(9) Contingency				
(10) Legal and Administrative Fees				
(11) Interim Financing				
(12) Underwriting Costs				
(13) Building and Fire Code Compliance				
(14) Other:				
(15) Subtotal Other				← *Add Lines 9 through 14*
(16) TOTAL COST APPLICABLE TO FILING FEE				← *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				
(19) Subtotal Predevelopment				← *Add Lines 18a and 18b*
(20) Escrow for Debt Service				
(21) TOTAL COST EXCLUDED FROM FILING FEE				← *Add Lines 17, 19, and 20*
(22) GRAND TOTAL ESTIMATED PROJECT COST				← *Add Lines 16 and 21*