

**MISSISSIPPI STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH PLANNING AND RESOURCE DEVELOPMENT**

Determination of Reviewability (DR) Application Form
(Processing Fee: \$2,500.00)

One (1) original DR application with the Certification Page must be mailed, or hand delivered to the Mississippi State Department of Health, and a complete copy of the application and attachments should be emailed to HPRD@msdh.ms.gov. Be sure to include the following words in the subject line of the e-mail: **DR application submission**. Please provide a Table of Contents referencing the Exhibits along with dividers or tabs to distinguish the appropriate Exhibit documentation.

The original application including attachments and filing fee should be mailed or hand delivered to the following address:

Mississippi State Department of Health
Division of Health Planning and Resource Development (Osbourne - Suite 150)
570 East Woodrow Wilson
Jackson, MS 39215-1700

Note: (CONFIDENTIAL Information)

If the CON Application contains information deemed CONFIDENTIAL, please submit a statement (*the statement must provide an explanation as to why the applicant considers the information specified to be deemed CONFIDENTIAL*); clarifying why the allocated information is deemed CONFIDENTIAL.

CONFIDENTIAL information must be submitted under a separate cover, isolated from the CON application.

I. Project Information (All Projects)

1. Title of Project: _____

2. Type of Facility: _____ Hospital _____ Nursing Home _____ Freestanding ASC
_____ Other (If Other Please Specify):

3. (If a single specialty ambulatory surgery center): Please state specialty: _____

II. Facility/Applicant Information (All Projects)

1. Facility name, address, city, county, zip code.
2. Legal name and address of the applicant, if different from information allocated above.
3. Principal agent to contact for this project (Include address, city, county, zip code, email and telephone number).
4. Type of organization (e.g., county-owned, not-for-profit acute care hospital).
5. Provide evidence that the entity proposing to provide the service is authorized to do business in the State of Mississippi.

III. Project Description (All Projects)

1. Provide a brief narrative description of the project or proposed facility, including types of services currently offered, type of surgery that will be performed (if applicable), 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.
2. If the proposed project involves relocation, please state the distance between the current/existing facility and the proposed facility.
3. Is the facility currently operational and serving patients?
4. What days of the week and time will the facility be operating?

5. Please submit the following:
- Architect’s schematic drawings.
 - Site approval from the Division of Fire Safety and Construction, Bureau of Health Facilities Licensure and Certification.
 - Building/Facility Lease Agreement (*if applicable*)
 - Building/Facility Purchase Agreement (*if applicable*)
 - Construction cost estimate (*signed from a MS licensed architect or a contractor authorized to do business in Mississippi., if applicable*)

6. If new construction is being developed by an 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.

7. 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 | |

8. If the project involves purchase/lease of equipment, provide the following:
 - a. A copy of the proposed vendor contract, including lease amount, if applicable.
 - b. Assurance that the entity desiring to acquire or otherwise control the equipment is a registered business entity authorized to do business in Mississippi.
 - c. Name of proposed health care facility or facilities to be served, if mobile or shared unit. Include a copy of proposed vendor service contract.
 - d. In addition, if the proposed project does not involve new equipment, provide independent report on the fair market value of the major medical equipment, such as:
 - Original purchase price of equipment
 - Purchase and installation date (s) of equipment
 - Depreciation schedule of equipment
 - Fair market value of equipment.

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

IV. SINGLE SPECIALTY AMBULATORY SURGERY FACILITY ONLY

1. If the proposed project involves the establishment, change or re-structure of a single specialty ambulatory surgery facility, identify physicians in the group and state which physician(s) will perform surgery. Certify that: a) each physician will maintain medical staff privilege at a full-service hospital, or b) at least one member of the physician group has staff privileges at a full-service hospital and will be available at the facility or on call with a thirty (30) minute travel time of the full -service hospital during hours of operation of the facility.

2. Please certify that the surgical procedures performed in this facility will comply with federal and state regulations regarding anesthesia.

3. Certify that the proposed facility will have a formal transfer agreement with a full-service hospital to provide services which are required beyond the scope of the single specialty facility's programs. The facility must also have a formal process for providing follow-up services to the patients (e.g., home health care, outpatient services) through proper coordination mechanisms.

4. Certify that the surgical services to be provided by the practice will be limited to those procedures that are either office procedures performed under local or regional anesthesia, or procedures that are more complex than office procedures but less complex than major procedures requiring prolonged postoperative monitoring and hospital care to ensure safe recovery and desirable results; that the procedures will be limited to those which the patient will arrive at the facility and expect to be discharged on the same day; that all procedures will

only be performed by the physicians or dentists listed in the application and each are and will continue to be licensed to practice in the State of Mississippi.

5. Please provide a list of physicians indicating the days and hours of service that will be provided.
6. Certify that any changes in the physicians or dentists listed in the application (through addition or withdrawal) will be communicated by written notice to the department within thirty (30) days of the change.
7. If the project involves a single specialty ambulatory surgery facility: The facility must be physically separated from non-surgical activities, as required by the "Interpretative Guidelines and Survey Procedures for Ambulatory Surgical Services". Please certify your compliance with this criterion.

V. End Stage Renal Disease (ESRD) Facilities and Home Training Stations ONLY

1. If the project involves hemodialysis/End Stage Renal Disease (ESRD) or Home Training Stations, please provide the following:
 - Most Current Approved Documentation (with the number of hemodialysis/ESRD or home training stations)
 - Number of current stations
 - Number of proposed additional stations
 - Facility Star Rating

VI. Sign the attached Certification Page (ALL PROJECTS)

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 \$1,500,000.00 for equipment, \$5,000,000.00 for clinical health services and/or \$10,000,000.00 for non-clinical health services, 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 (12)-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