MISSISSIPPI STATE DEPARTMENT OF HEALTH

Certificate of Need (CON)

Progress Report/ Six-Month Extension Request/Final Report

One (1) original Six Month Extension (SME) 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: **SME application submission.** Please provide a Table of Contents referencing the Exhibits along with dividers or tabs to distinguish the appropriate Exhibit documentation. Please provide updated details of the project and attach the previous approved SME Report with Application (if applicable).

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.

Note: ALL Six- Month Extensions must be received thirty (30 Days Prior to Expiration Date)

Report/Request Type: [ ] Six-Month Progress Report **($1,000.00 Filing Fee)**

[ ] Six-Month Extension Request **($2,500.00 Filing Fee)**

[ ] Final Report **($1,000.00 Filing Fee**)

1. CON Information

a. CON Review #: ____________________ CON#: ______________________________________

b. Facility Name: ____

c. Project Title: ____

d. Effective Date: __________________ Expiration Date: ______________________________

e. Current Extension Period Expiration Date:

f. CON Holder Name: ____

Address: ____

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g. CON Contact Person: ______________________________

Address: ______________________________

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Telephone: ______________________________

Email Address: ______________________________

h. Attach a photocopy of the original Certificate of Need.

i. **Capital Expenditure Authorized:** $ ______________________________

j. **Capital Expenditure Made to Date:** $ ______________________________

2. Documentation of Commencement of Construction or Other Preparation Substantially Undertaken

A. Describe any changes in the individual business or corporate officers and directors since the original approval.

B. Describe any agreements in existence, being planned, or that have occurred since original approval. Attach a copy of current partnership agreement or articles of incorporation, if different from that provided in the original application.

C. Provide documentation for activities accomplished during the pre-construction phase of the project including, but not limited to, the following:

1. Acquisition of land/ property (title, evidence of payment, etc.).
2. Completion of topographic or boundary surveys
3. Site preparation (contractor selection, contract, evidence of payment, etc.)
4. Completion of site development plan(s)
5. Architectural plans/drawings (architect selection, contract, evidence of payment, statement of partial completion of plans/drawings, letter evidencing submission of plans to Health Facilities Licensure and Certification, Division of Fire Safety, letter of findings, comments or remediation; resolutions submitted; approval of commencement of construction.)
6. If the approved expenditure has not been obligated, provide evidence that **permanent financing has been obtained**. If financing has not been obtained, provide evidence of fund commitment from lending institution or agency.

D. Provide documentation of construction activities:

1. Date construction contract offered for bid: ____________________
2. Date contract awarded: ____________________
3. Date any site preparation is estimated to be complete: ____________________

4. Percentage of work completed: ____________________
5. Estimated date of completion: ____________________

E. If actual construction has not commenced, provide date it will commence and the reasons for the delay.

F. Provide documentation of activities to established services through the acquisition of capital equipment:

1. Equipment purchase/ lease agreement.
2. Date contract signed between buyer and vendor: ____________________
3. Name of mobile equipment vendor: ____________________
4. Registration/serial number of mobile equipment vendor: ____________________
5. Date equipment is to be delivered: ____________________
6. Date equipment to be placed in service: ____________________
7. Have there been any changes in funding sources? [ ] Yes [ ] No

   If yes, explain: ____

8. Number of procedures performed by month: ____________________
9. Provide evidence that the Division of Radiological Health has approved the plans for provision of radiation therapy services, if applicable.

G. If the CON is for a project involving no construction, (e.g., establishment of services), please provide documentation including, but not limited to, the following:

1. Hiring or entering contracts with necessary staff/medical professionals to provide service
2. Estimated date that any new staff required will be hired: ____________________
3. Estimated date any new service will be available to public: ____________________
4. Submission of a fire/life safety code inspection request.
5. Submission of an application for facility inspection/licensure of service.

H. Complete and 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 Progress Report/Six-Month Extension Request 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 decision as to the granting of an extension of the Certificate of Need, and if it finds that the report/request contains distorted facts or misrepresentation, the Department may refrain from further review of the report/request and consider it rejected. It is further understood that if the Certificate of Need is extended based upon the evidence contained in this request, such certificate may be revoked, canceled, or rescinded if the Mississippi State Department of Health determines its findings were based on evidence, not true, factual, accurate, and correct.

I (we) certify that no revision or alteration of the proposal submitted will be made without obtaining prior written consent of the Mississippi State Department of Health and that I (we) will furnish to the Mississippi State Department of Health a progress report and/or a request for a six-month extension on the proposal every six (6) months until the project is completed.

____________________________________ ____________________________________
Signature Signature

____________________________________ ____________________________________
Title Title

____
Name of Facility

Sworn to and subscribed before me, this the _______day of _____________________, 20 __.

____
Notary Public

____
My Commission Expires