Reset Form

CERTIFICATE OF NEED APPLICATION

State Form 56795 (7-19)
Indiana State Department of Health - Division of Long Term Care

For office use only
File number

Please Print or Type.

INTENDED PROJECT – *CHECK ALL THAT APPLY TO THE PROJECT.*

☐ Proposed New Facility Construction	☐ Increased Count of Comprehensive Care Beds	☐ Transfer Comprehensive Care Bed(s) to / from another Location

CONTACT INFORMATION

CERTIFICATE OF NEED
INDIANA STATE DEPARTMENT OF HEALTH
DIVISION OF LONG TERM CARE
2 North Meridian Street, Section 4B
Indianapolis, IN 46204
Telephone: (317) 233-7613
Fax: (317) 233-7322
E-mail: providers@isdh.IN.gov

ELIGIBILITY

Certificate of Need applications will be accepted July 1 through July 31 each year. Applications submitted after July 31, will be reviewed the following year. All Certificate of Need applications must be accompanied with a certified check, cashier's check, or money order in the amount of $ 5,000 made payable to "*Indiana State Department of Health".* Failure to submit the application fee at the time of filing will result in the application not being accepted for processing. The application fee is non-refundable.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

With certain exceptions, a Certificate of Need is required to:

- Build, develop, or establish a new health care facility (Non–replacement facility);
- Move an existing health care facility to another county;
- Relocate beds from one facility to another;
- Change the comprehensive bed capacity of a health care facility;
- Change the type or scope of any health care service offered by a health care facility;

Exceptions that do not require a Certificate of Need can be found at IC 16-29-7-1 and IC 16-29-7-16.
If you believe you meet one of the exceptions, please contact ISDH at Providers@isdh.IN.gov for review of your request.

APPLICANT CONTACT PERSON

Name	Title
Relation to Licensee / Owner	
E-mail	Telephone ( )

FACILITY INFORMATION

Name of Facility		
Street Address *(number and street)*		P.O. Box
City	County	ZIP Code+4
Telephone Number ( )	E-mail address	
Current ISDH license / facility number	☐ Comprehensive (Certified) beds ☐ Residential beds	
Need calculations for county *(Attach supporting documentation.)*		
Demonstration for statistical need *(Attach supporting documentation.)*		

LICENSEE / OWNERSHIP INFORMATION

Current Licensee / Owner of the Facility		Employer identification number (EIN)
Street Address *(number and street)*		P.O. Box
City	State	ZIP Code+4
Telephone Number ( )	E-mail address	

GENERAL PROJECT DESCRIPTION

* Attach additional documentation as necessary.

CERTIFICATION

I certify that:

- The applicable county is eligible to receive beds via transfer in accordance with the rates published by ISDH as determined by IC 16-29-7-12(c).
- I understand the applicant has the burden of including with this application sufficient information for each of the criteria for review under IC 16-29-7-12(d).
- The information in and accompanying this application is accurate.
- I will provide accurate and complete information necessary to the review of an application for a Certificate of Need.
- I understand any additional information necessary to the review of an application for a Certificate of Need is public information and will be made available by the ISDH.
- I am duly authorized to provide and release the information deemed necessary by ISDH to the review of this application.
- I am duly authorized to sign this document and otherwise act on behalf of the the licensee/owner of the facility(ies) named in this application.

Signature of Applicant	Date *(month, day, year)*
Printed name	Title
Relation to Licensee / Owner	