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| SEAL31.TIF | **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.***

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| **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 |

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| **CONTACT INFORMATION** |
| CERTIFICATE OF NEEDINDIANA STATE DEPARTMENT OF HEALTHDIVISION OF LONG TERM CARE2 North Meridian Street, Section 4BIndianapolis, IN 46204Telephone: (317) 233-7613Fax: (317) 233-7322E-mail: providers@isdh.IN.gov |

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| **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.** |

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| **APPLICANT CONTACT PERSON** |
| Name      | Title      |
| Relation to Licensee / Owner       |
| E-mail       | Telephone(     )      |

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| **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.)*      |

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| **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      |

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| **GENERAL PROJECT DESCRIPTION** |
| \* Attach additional documentation as necessary. |

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