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