

**MISSISSIPPI STATE DEPARTMENT OF
HEALTH APPLICATION FOR A CERTIFICATE
OF NEED
APPLICATION FOR EXTENSION/RENEWAL OF AN EXPIRED CERTIFICATE OF
NEED**

One (1) original CON application 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: **CON 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 and Certification Page including attachments with the filing fee should be mailed or hand delivered to the following address:

Division of Health Planning and Resource Development
Mississippi State Department of Health - Office of Health Protection
143-B Le Fleur's Square
Jackson, MS 39211

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.

The fee assessed for prior approved projects shall be one-half of the original assessment. The minimum assessment shall be not less than \$2,500.00 and the maximum fee shall not exceed \$37,500. All checks or money orders must be made payable to the Mississippi State Department of Health.

| | | |
|-----------------------------|----|---------------|
| TITLE OF PROJECT: | | |
| Capital Expenditure: | \$ | CON Review #: |

I. APPLICANT/FACILITY INFORMATION

| APPLICANT | | | | |
|------------------------|--|--------|--|-----------|
| Applicant Legal Name: | | | | |
| d/b/a (if applicable): | | | | |
| Address: | | | | |
| City: | | State: | | Zip Code: |

| | | | |
|---|------|----------------------------------|-------------------------------------|
| County: | | Telephone: | |
| Parent Organization (if applicable): | | | |
| E-mail Address: | Fax: | | |
| PRIMARY CONTACT PERSON | | | |
| Name: | | Title or Position: | |
| Firm: | | | |
| Address: | | | |
| City: | | State: | Zip Code: |
| Telephone: | | Fax: | |
| E-mail Address: | | | |
| LEGAL COUNSEL / CONSULTANT (if applicable) | | | |
| Name: | | <input type="checkbox"/> Counsel | <input type="checkbox"/> Consultant |
| Firm: | | | |
| Address: | | | |
| City: | | State: | Zip Code: |
| Telephone: | | Fax: | |
| E-mail Address: | | | |

1. If the name of the existing or proposed facility is different than the Applicant's legal name provide the facility information.

| FACILITY | | | | |
|----------|--|------------|--|-----------|
| Name: | | | | |
| Address: | | | | |
| City: | | State: | | Zip Code: |
| County: | | Telephone: | | |

2. If the existing or proposed facility will be managed or operated by a different entity other than the Applicant, enter the entity information below.

| MANAGEMENT / OPERATING ENTITY | | | | |
|-------------------------------|--|--------|--|-----------|
| Name: | | | | |
| Address: | | | | |
| City: | | State: | | Zip Code: |
| Telephone: | | Fax: | | |

3. Select the type of ownership of the present or proposed facility.

| | | | |
|---|---|--|--|
| TAX EXEMPT | <input type="checkbox"/> Not-for-Profit Corporation | | |
| | <input type="checkbox"/> Public (Hospital or Government) | | |
| TAX PAYING | <input type="checkbox"/> General Partnership | <input type="checkbox"/> Business Corporation | <input type="checkbox"/> Sole Proprietor |
| | <input type="checkbox"/> Limited Liability Partnership or Limited Partnership | <input type="checkbox"/> Limited Liability Company | |
| State of Incorporation or Organization: | | | |

4. Please provide documentation of the organizational and legal structure as indicated in the table below.

5. Facility Type (select one)

Hospital-Based Freestanding Nursing Home Not Applicable

| ORGANIZATIONAL STRUCTURE | |
|---|---|
| Not-for-Profit Corporation | <ul style="list-style-type: none"> ▪ Name of Each Officer and Director ▪ Letter of Good Standing from Secretary of State |
| Public | <ul style="list-style-type: none"> ▪ All Governing Authority Approvals for this Project |
| Sole Proprietor | <ul style="list-style-type: none"> ▪ County Business Authorization Documents, if available |
| General Partnership | <ul style="list-style-type: none"> ▪ Name, Partnership Interest, and Percentage Ownership of Each Partner ▪ Partnership Agreement |
| Limited Liability Partnership or Limited Partnership | <ul style="list-style-type: none"> ▪ Name, Partnership Interest, and Percentage Ownership of Each Partner ▪ Letter of Good Standing from Secretary of State |
| Business Corporation | <ul style="list-style-type: none"> ▪ Name of Each Officer and Director ▪ Letter of Good Standing from Secretary of State |
| Limited Liability Company | <ul style="list-style-type: none"> ▪ Name of Each Member and Managing Member, Officers, and/or Directors ▪ Letter of Good Standing from Secretary of State |

II. PROJECT DESCRIPTION

1. Describe in detail ALL of the characteristics of the project. Be sure to include any changes in the project since original approval. Specifically, discuss:
 - a. Reason for expiration.
 - b. How long has the CON been expired.
 - c. Status of project at time of expiration and current status of project.
 - d. Continued need for project.
 - e. Applicant’s ability to complete the project.
 - f. Timeline for completion of the project.

2. Attach a copy of the original Application.

III. COMPLIANCE WITH STATE HEALTH PLAN, POLICIES, AND PROCEDURES

1. Describe how the project complies with the health care needs addressed in the current *State Health Plan*. **Note: CON applications will be reviewed under the State Health Plan that is in effect at the time the application is received by the Department. Prior approved projects must continue to be in compliance with the Plan in effect at the time the original project was approval.**
2. Describe how the proposed project complies with the *Mississippi Certificate of Need Review Manual*, all adopted policies and procedures of the Mississippi State Department of Health, statute and federal regulations, if applicable.

IV. CERTIFICATION

Complete and submit original Certification Page for this project.

**MISSISSIPPI STATE DEPARTMENT OF HEALTH
CERTIFICATION**

APPLICANT: _____

TITLE OF PROPOSED PROJECT: _____

TOTAL CAPITAL EXPENDITURE: _____

I (we) swear or affirm on behalf of _____ after diligent research, inquiry and study, that the information and material contained in the attached application for a Certificate of Need is true, accurate, and correct, to the best of my (our) knowledge and belief. It is understood that the Mississippi State Department of Health will rely on this information and material in making its decision as to the issuance of a Certificate of Need, and if it finds that the application contains distorted facts or misrepresentation or does not reveal truth or accuracy, the Department may refrain from further review of the application and consider it rejected. It is further understood that if a Certificate of Need is issued based upon evidence contained in this application, such Certificate may be revoked, canceled, or rescinded if the Department of Health determines its findings were based on evidence, not true, not factual, inaccurate, and incorrect.

I (we) certify that no revision or alteration of the proposal submitted will be made without obtaining prior written consent of the Department of Health. **Furthermore, I (we) will furnish the Department of Health a progress report on the proposal every six (6) months until the project is completed.**

Print or Type Name

Signature

Title

Facility Name (if Different)

STATE OF _____

COUNTY OF _____

Sworn to and subscribed before me, this the _____ day of _____, 20____ .

Notary Public

My Commission Expires