MISSISSIPPI STATE DEPARTMENT OF HEALTH

Office of Health Planning and Resource Development

SMALL COMMUNITY HOSPITAL PILOT PROGRAM
APPLICATION FOR EXEMPTION

This application is the exclusive means by which a small community hospital requests an exemption from Certificate of Need review under the Small Community Hospital Pilot Program. Do not use this form to ask a general question about whether an unrelated project or activity is subject to Certificate of Need review; that question should be submitted on the Department's standard Determination of Reviewability form, available separately on the Department's website.

This application requires a processing fee of One Thousand Five Hundred Dollars ($1,500.00), payable to the Mississippi State Department of Health by as prescribed. No application will be processed until the required fee is received.

An applicant requesting the ESRD Exemption should review Section five (5) of this application carefully before submitting, as the ESRD Exemption is subject to a regional allocation limit and a comparative review process described in that section.

1. Applicant Hospital Information

Hospital Name: _____

Hospital License Number: _____

Physical Address of Main Building Campus: _____

City: _____

County: _____

Mississippi Public Health Region (1–4): _____

Authorized Contact Name and Title: _____

Telephone Number: _____

Email Address: _____

2. Small Community Hospital Eligibility

Check the box below that describes the basis on which the applicant’s hospital qualifies as a small community hospital. Only one (1) box should be checked.

☐ Qualifies under subsection (2)(a) the hospital is located in a county that does not contain any portion of a municipality, whose population exceeds fifteen thousand (15,000) according to the 2020 decennial census.

☐ Qualifies under subsection (2)(b) — the hospital is located within the region designated by the Mississippi State Department of Health as the Delta Public Health Region as of January 1, 2026.

Attach documentation sufficient to establish the basis checked above (e.g., a statement identifying the county and municipality population per the 2020 decennial census, or confirmation of location within the Delta Public Health Region).

☐ The applicant's hospital certifies that it is not a licensed Rural Emergency Hospital as designated by the federal Centers for Medicare and Medicaid Services.

3. Exemption Requested

Check the box below that describes the exemption requested. If the applicant's hospital is requesting more than one (1) type of exemption, submit a separate application for each.

☐ General Exemption — an exemption from the requirement to obtain a Certificate of Need for an activity described in Section four 4 below.

☐ Geriatric Psychiatric Unit Exemption — an exemption to operate a geriatric psychiatric unit.

☐ ESRD Exemption — an exemption to operate an end-stage renal disease (outpatient dialysis) facility. If checked, complete Section five 5 below.

4. Description of Proposed Activity

Provide the physical address of each location where the proposed exempted activity will be offered, established, or operated. If the proposed activity will occur at an off-campus location, the applicant must attach supporting documentation sufficient to demonstrate that the location is within a five (5) mile radius of the hospital's main building campus as of January 1, 2026. Acceptable documentation may include a map, GIS exhibit, survey, or other documentation acceptable to the Department.

Approved Service Location(s): _____

_____

_____

Check all that apply:

☐ The proposed activity is located on the hospital's main building campus as of January 1, 2026, and/or within a five (5) mile radius of that campus and does not extend to a clinic or other facility not located on the main campus.

☐ The proposed activity does not involve a service or activity that is subject to a general Certificate of Need moratorium.

☐ The proposed activity will not establish, relocate, or result in a licensed hospital location within thirty-five (35) miles of another licensed hospital, consistent with the statutory limitation.

☐ The proposed activity will not jeopardize a licensed hospital's federal Critical Access Hospital designation.

5. ESRD Exemption — Additional Information

Complete this section only if requesting the ESRD Exemption checked in Section 3 above.

Regional allocation limit. No more than two (2) ESRD Exemptions may be awarded within each of the four (4) Public Health Regions designated by the Department as of January 1, 2026, for a maximum of eight (8) statewide.

Comparative review. The Department evaluates all complete ESRD Exemption applications filed for the same Public Health Region together. The Department will issue its determinations forty-five (45) calendar days from July 1, 2026, considering all complete applications filed for each Public Health Region as of that date together. A complete ESRD Exemption application filed after that initial determination date for a region that still has exemptions available will be evaluated and decided individually as received.

Priority rule. If more than two (2) small community hospitals within the same Public Health Region have filed a complete ESRD Exemption application within the applicable comparative review window, the Department will award the available exemption(s) in that region to the hospital(s) located in areas most remote from existing dialysis units.

Fallback option. A small community hospital that applies for the ESRD Exemption but is not awarded one (1) because the available exemptions for its Public Health Region have already been awarded to other applicant hospitals may use its General Exemption allotment for a different eligible service instead. The processing fee paid with this application will be applied, without additional charge, toward that hospital's application for the General Exemption.

Allotment interaction. An ESRD Exemption, if awarded, counts toward, and does not add to, the applicant hospital's exemption allotment under Section three (3) above.

Address of Proposed ESRD Facility Location:

_____

_____

Describe the location of existing dialysis units relative to the applicant's hospital, including approximate distances, to assist the Department's evaluation of remoteness if the applicable Public Health Region is oversubscribed:

☐ If this application is not awarded an ESRD Exemption due to the regional allocation limit, the applicant's hospital elects to have its General Exemption allotment applied to the following alternate eligible service (optional — leave blank to be contacted by the Department before an election is made):

Alternate Service (if elected): _____

_____

6. Acknowledgment — State Exemption Process Only

By signing this application, the applicant hospital acknowledges that an exemption issued under the Small Community Hospital Pilot Program addresses only the requirement to obtain a Certificate of Need under Mississippi law. It does not constitute approval, certification, licensure, or authorization of any kind under federal law, and it does not waive or supersede any requirement for facility licensure, professional licensure, accreditation, inspection, Medicare certification, Medicaid enrollment, zoning compliance, life safety compliance, or any other applicable federal, state, or local law, rule, or regulation.

The applicant hospital further acknowledges that, to the extent it intends to bill Medicare and/or Medicaid for the exempted service, it remains solely responsible for satisfying all applicable federal requirements — including, where applicable, the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation or Conditions for Coverage for the service type — and that issuance of an exemption under this Program does not satisfy, substitute for, or otherwise affect any such separate federal obligation.

7. Certification

The undersigned certifies that the information provided in this application is true, accurate, and complete to the best of their knowledge, and that the applicant hospital understands that material misrepresentation, inaccuracy, or omission in this application may result in denial, modification, suspension, or revocation of any exemption issued in reliance upon it.

_____ _____

Signature of Chief Executive Officer or Administrator *Date*

Printed Name: _____

Title: _____

NOTE: *This application implements the Small Community Hospital Pilot Program established by Section 1 of House Bill No. 1622, 2026 Regular Session, as amended by Section 8 of Senate Bill No. 2474, 2026 Regular Session, codified at Miss. Code Ann. § — — — (2026) (official classification pending). This application and the procedures described herein are administered in accordance with the Mississippi Certificate of Need Review Manual.*

FOR DEPARTMENT USE ONLY

Date Received: _____

Application Tracking Number: _____

Fee Received ($1,500.00): _____

Date Public Notice Posted: _____

Eligibility Documentation Reviewed:

☐ Hospital licensure verification

☐ Geographic/county population or Delta Public Health Region eligibility verification

☐ Rural Emergency Hospital exclusion confirmed (not applicable)

☐ Service description and site/location verification

☐ Moratorium and thirty-five (35)-mile/CAH safeguard review

☐ For ESRD Exemption applications: Public Health Region and remoteness information reviewed

☐ Legal review

Hospital Exemption Allocation Count (cumulative, including this application if approved):

_____

_____

MSDH Review Staff: _____

_____

Date of Department Decision: _____

☐ Approved

☐ Denied

☐ Approved — ESRD Exemption not awarded; allotment redirected to General Exemption per Section five (5) above

If approved, the Department's CON Exemption shall be issued in accordance with the Mississippi Certificate of Need Review Manual.