APPENDIX E

Mississippi Department of Health

SINGLE SPECIALTY AMBULATORY SURGERY FACILITY
APPLICATION FOR DETERMINATION OF NON-REVIEWABILITY
(PROCESSING FEE: $500.00)

1. Type of Specialty: _____

2. Facility name, address, county, ZIP Code.

3. Legal name and address of applicant, if different from Item 2 above.

4. Contact person. (Include address, county, ZIP Code, telephone number, Email and FAX number).

5. Provide a brief narrative description of your facility, and the types of services it currently offer. Also identify the type of surgery that will be performed.

6. Identify physicians in the group and state which physician(s) will perform surgery. Certify that: a) each physician will maintain medical staff privilege at a full service hospital, or b) at least one member of the physician group has staff privileges at a full service hospital and will be available at the facility or on call with a 30-minute travel time of the full service hospital during hours of operation of the facility.

7. Please certify that the surgical procedures performed in this facility will be in compliance with federal and state regulations regarding anesthesia.

8. Certify that the proposed facility will have a formal transfer agreement with a full service hospital to provide services which are required beyond the scope of the single specialty facility's programs. The facility must also have a formal process for providing follow-up services to the patients (e.g., home health care, outpatient services) through proper coordination mechanisms.

9. Please state the total cost involved in constructing and equipping the facility for the service. (Estimated Project Cost)

Estimated project cost

a.	Construction Cost – New	
b.	Construction Cost – Renovation	
c.	Capital Improvement Cost (i.e., minor painting and repairs, refurbishing)	
d.	Total Fixed Equipment Cost	
e.	Total Non-Fixed Equipment Cost	
f.	Land Cost	
g.	Site Preparation Cost	
h.	Fees (architectural, consultant, etc.)	
i.	Contingency Reserve	
j.	Capitalized Interest	
k.	Other Costs (specify) _____	
l.	Total Estimated Project Cost	

10. Certify that the surgical services to be provided by the practice will be limited to those procedures that are either office procedures performed under local or regional anesthesia, or procedures that are more complex than office procedures but less complex than major procedures requiring prolonged postoperative monitoring and hospital care to ensure safe recovery and desirable results; that the procedures will be limited to those which the patient will arrive at the facility and expect to be discharged on the same day; that all procedures will only be performed by the physicians or dentists listed in the application and each are and will continue to be licensed to practice in the State of Mississippi.

11. Certify that any changes in the physicians or dentists listed in the application (through addition or withdrawal) will be communicated by written notice to the department within 30 days of the change.

12. The facility must be physically separated from non-surgical activities, as required by the "Interpretative Guidelines and Survey Procedures for Ambulatory Surgical Services". Please certify your compliance with this criterion

13. Please sign the attached certification page.

CERTIFICATION

STATE OF MISSISSIPPI

COUNTY OF _____

I (we) do solemnly swear or affirm on behalf of _____ _____, after diligent research, inquiry and study, that the information and material, contained in this foregoing application for a Declaratory Ruling is true, accurate, and correct, to the best of my (our) knowledge and belief. I (we) understand that the Mississippi Department of Health will rely on this information and material in making its determination. If it finds that the application contains distorted facts or misrepresentation, the Department may require Certificate of Need review of the project. I (we) will notify the Department should at any time ownership of the single specialty facility transfer to a hospital or other health care facility, or should the facility seek to operate a dual specialty surgery facility.

It is further understood that this ruling is valid for a period of twelve months. If the project is not implemented within the twelve month period, I (we) must request a second ruling by the Department. I (we) understand that this determination is made in accordance with the Official Attorney General's Opinion dated March 22, 1994. Should that ruling change prior to initiation of the project, I (we) understand that any subsequent ruling will be made in accordance with the revised Opinion.

_____ _____

Signature Signature

_____ _____

Title Title

_____

Name of Facility

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

_____

Notary Public

_____

My Commission Expire