

**MISSISSIPPI STATE DEPARTMENT OF HEALTH
APPLICATION FOR AN EMERGENCY CERTIFICATE OF NEED**

To expedite consideration, the application may be submitted by e-mail (HPRD@msdh.ms.gov) followed by submission of the original to the address allocated below.

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.

Please include the filing fee calculated at (CON Fee = 0.50 x 1% of proposed capital expenditure). The minimum fee shall not be less than Five Thousand Dollars (\$5,000.00), and the maximum fee shall not exceed Twenty-Five Thousand Dollars (\$25,000.00). All checks or money orders must be made payable to the Mississippi State Department of Health.

I. APPLICANT/FACILITY INFORMATION

APPLICANT		
Applicant Legal Name:		
d/b/a (if applicable):		
Address:		
City:	State:	Zip Code:
County:	Telephone:	
Parent Organization (if applicable):		
CONTACT PERSON		
Name:	Title or Position:	
Telephone:	Fax:	
E-mail Address:		

1. Is the name of the existing or proposed facility different than the Applicant's legal name?
(Instructions for electronically selecting check box: 1) place cursor over appropriate check box; 2) right click on mouse; 3) select Properties; 4) cursor or arrow down to Value; 5) change from false to true)

☐ Yes ☐ No

If YES → Enter the facility information below.

If NO → Continue to Section II.

FACILITY		
Facility Name:		
Facility Address:		
City:	State:	Zip Code:
County:	Phone:	

II. EVENT DESCRIPTION AND INCURRED LOSS OR DAMAGE

1. Description of Causative Event (check all that apply)

- ☐ Fire
- ☐ Natural Disaster (i.e. tornado, hurricane, etc.)
- ☐ Water Damage
- ☐ Failure of Equipment or Systems
- ☐ Other

a. If other, describe below.

2. Date of Event: _____

3. Description of Degree of Loss of Property (facility or equipment)

Describe in as much detail as possible the incurred loss or damage. Documentation of the loss should be included with the application. If unavailable, documentation must be supplemented as soon as it becomes available.

4. Effects of Event on Operations of Health Care Services

Describe in as much detail as possible the result or probable result of such loss or damage, including how such loss or damage would jeopardize the health and/or safety of the patients (temporary or permanent discontinuation of services, closure of facility, etc).

III. PROJECT DESCRIPTION

1. Describe all of the characteristics of the proposed project.

2. Applicant is proposing a change in services provided or facility capacity?

☐ Yes ☐ No

If YES → Answer questions 2a through 2d

If NO → Continue to question 3.

a. Applicant is proposing an addition or expansion of service(s)?

☐ Yes ☐ No

If YES → Explain below.

If NO → Continue to question 2b.

b. Applicant is proposing a change in existing bed complement or number of beds?

☐ Yes ☐ No

If YES → Explain below.

If NO → Continue to question 2c.

c. Applicant is proposing an upgrade in facility and/or equipment?

☐ Yes ☐ No

If YES → Explain below.

If NO → Continue to question 2d.

d. Applicant is proposing other types of changes in services provided or facility capacity?

☐ Yes

☐ No

If YES → Explain below.

If NO → Continue to question 3.

3. Applicant is proposing to relocate equipment and/or facility out of the current service area or county?

☐ Yes

☐ No

If YES → Explain below.

If NO → Continue to question 4.

4. Attach an itemized list of equipment and/or facilities to be repaired or replaced.

5. Complete the following table describing the estimated cost or expenditure contemplated. Attach a cost estimate from vendor or contractor.

	<u>Estimated Cost</u>
1. Equipment Replacement	\$
2. Equipment Repair	
3. Facility Replacement	
4. Facility Repair	
5. Other (specify)	
Total	\$

6. Anticipated date repairs or replacement will commence: _____

7. Anticipated date of completion of repairs or replacement: _____

8. Complete and sign the Certification page.

**MISSISSIPPI STATE DEPARTMENT OF HEALTH
CERTIFICATION**

APPLICANT: _____

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 an Emergency 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 an Emergency Certificate of Need, and if it finds that the application contains distorted facts or misrepresentation or does not reveal truth or accuracy, the State Department of Health may refrain from further review of the application and consider it rejected. **It is further understood that the applicant has fully disclosed in the application to the State Department of Health any change in capacity.** It is further understood that if an emergency Certificate of Need is issued based upon evidence contained in this application, such Certificate may be revoked, canceled or rescinded if the State 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 State Department of Health. Furthermore, I (we) will furnish the State Department of Health a progress report on the proposal every six (6) months until the project is completed.

Signature

Signature

Title

Title

STATE OF _____
COUNTY OF _____

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

Notary Public

My Commission Expires