

For DHHS Use Only

DHHS Application Number
Date Submitted
Facility Number
Sub-Area/Planning Area

**LETTER OF INTENT
CERTIFICATE OF NEED**

Michigan Department of Health & Human Services

CERTIFICATE OF NEED
333 S. Grand Avenue, 4th Floor
Lansing, Michigan 48933

Phone: (517) 241-3344 – Fax: (517) 241-2962

<p>AUTHORITY: PA 368 of 1978, as amended COMPLETION: Is Voluntary, but is required to obtain a Certificate of Need. If NOT completed, a Certificate of Need will NOT be issued.</p>	<p>The Department of Health & Human Services is an equal opportunity employer, services and programs provider.</p>
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SECTION 1 - Facility Information

Current/Proposed Facility Name			Area Code and Telephone Number	Extension
Facility Street Address			County	
City	State	ZIP Code	Applicant's Federal ID	

SECTION 2 - Applicant Organization

SECTION 3 - Agent Information

Legal Name of Applicant Organization (Include assumed name applicable to this project)			Authorized Agent Name		
Area Code, Telephone No. & Ext.			FAX No. (Area Code and No.)		
Street Address			Street Address		
City	State	ZIP Code	City	State	ZIP Code
Email (administrator):			Email:		
Authorized Agent Organization			Authorized Agent Organization		

SECTION 4 - Facility Type

<input type="checkbox"/> Hospital	<input type="checkbox"/> Psychiatric Hospital
<input type="checkbox"/> Long Term (Acute) Care Hospital	<input type="checkbox"/> Inpatient Psychiatric Unit
<input type="checkbox"/> Hospital Long Term Care Unit	<input type="checkbox"/> Health Maintenance Organization
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> OTHER: Not a Licensed Health Facility (Specify)
<input type="checkbox"/> Freestanding Surgical Outpatient Facility	

SECTION 5 - Project Title/Summary

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SECTION 6 - Services Change

List the service(s) affected by this project, and place a check in the column to indicate how the service(s) will change.	Type of Service Change			
	New	Expand	Replace	Relocate
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 7 - Type of Licensed Beds/Positions

* Must be completed →	Number of Beds/Treatment Positions		
	* Current	Proposed	Change + or -
Medical/Surgical Beds - <i>Including Licensed Rehab Beds</i>			
Medical/Surgical Beds - <i>With NICU Designation</i>			
Medical/Surgical Beds – with Swing Bed Designation			
Nursing Home Beds - <i>Including HLTCU</i>			
Nursing Home Special Pool Beds – TBI/SCI			
Nursing Home Special Pool Beds – Behavioral			
Nursing Home Special Pool Beds – Hospice			
Nursing Home Special Pool Beds – Ventilator-Dependent			
Nursing Home Special Pool Beds – Alzheimer’s			
Nursing Home Special Pool Beds – Religious			
Nursing Home Special Pool Beds – Skilled (Rural)			
Psychiatric Beds – <i>Adult</i>			
Psychiatric Beds - <i>Child/Adolescent</i>			

SECTION 8 – Project Costs (Use Whole Dollars Only)

1. New Construction - Clinical (<input type="text"/> sq. ft.)	\$ <input type="text"/>
2. New Construction – Non Clinical (<input type="text"/> sq. ft.)	\$ <input type="text"/>
3. Renovation and Remodeling - Clinical (<input type="text"/> sq. ft.)	\$ <input type="text"/>
4. Renovation and Remodeling – Non Clinical (<input type="text"/> sq. ft.)	\$ <input type="text"/>
5. Architect/Engineering Fees	\$ <input type="text"/>
6. Contingencies	\$ <input type="text"/>
7. Feasibility Study/Surveys	\$ <input type="text"/>
8. Site Preparation	\$ <input type="text"/>
9. Fixed Medical Equipment	\$ <input type="text"/>
10. Fixed Non-Medical Equipment	\$ <input type="text"/>
11. Covered Clinical Equip (PET, MRI, etc.) – Lease term (if applicable) <input type="text"/>	\$ <input type="text"/>
12. Movable Equipment (Medical and Non-Medical)	\$ <input type="text"/>
13. Fees (consulting, legal, banking, etc.)	\$ <input type="text"/>
14. Space Lease Cost – Term:	\$ <input type="text"/>
15. Land Purchase	\$ <input type="text"/>
16. Building Purchase	\$ <input type="text"/>
17. Interest During Construction	\$ <input type="text"/>
18. Other (<i>explain</i>): <input type="text"/>	\$ <input type="text"/>
19. Other (<i>explain</i>): <input type="text"/>	\$ <input type="text"/>
20. Other (<i>explain</i>): <input type="text"/>	\$ <input type="text"/>
21. TOTAL PROJECT COSTS	\$ <input type="text"/>

SECTION 9 – Sources of Funds (Use Whole Dollars Only)

1. Unrestricted Cash	\$ <input type="text"/>
2. Designated Funds	\$ <input type="text"/>
3. Restricted Funds	\$ <input type="text"/>
4. Mortgages/Loans (FHA, HUD, etc.)	\$ <input type="text"/>
5. Bond Issue	\$ <input type="text"/>
6. Other Funds (i.e., grants, etc.)	\$ <input type="text"/>
7. Capital/Operating Lease	\$ <input type="text"/>
8. Gifts, Bequests, Donations, and Pledges	\$ <input type="text"/>
9. Interest Income During Construction	\$ <input type="text"/>
10. Other (<i>explain</i>): <input type="text"/>	\$ <input type="text"/>
11. Other (<i>explain</i>): <input type="text"/>	\$ <input type="text"/>
12. Other (<i>explain</i>): <input type="text"/>	\$ <input type="text"/>
13. TOTAL SOURCES OF FUNDS	\$ <input type="text"/>

SECTION 10 - Facility/Replacement

Does the project involve the replacement/relocation of licensed beds from one licensed site to another geographic location? **NO** **YES (Distance):**

SECTION 11 - Project Type (check all applicable categories)

<input type="checkbox"/> Acquire an Existing Health Facility	<input type="checkbox"/> Relocate Covered Clinical Service
<input type="checkbox"/> Begin Operation of Health Facility	<input type="checkbox"/> Acquire Covered Clinical Service
<input type="checkbox"/> Replace Existing Health Facility	<input type="checkbox"/> Covered Capital Expenditure
<input type="checkbox"/> Add Beds	<input type="checkbox"/> New Construction
<input type="checkbox"/> Replace Beds at Current Licensed Site	<input type="checkbox"/> Renovation
<input type="checkbox"/> Initiate Covered Clinical Service	<input type="checkbox"/> Add Host Site
<input type="checkbox"/> Replace/Upgrade Covered Clinical Service	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Expand Covered Clinical Service	

SECTION 12 – Project Description

Provide a concise narrative description of the proposed project, including its physical elements.

- At a minimum, include specific information about:
 - (1) the covered clinical service(s) involved in the project;
 - (2) location(s) and, where applicable, a breakdown by floors, departments, or services;
 - (3) the total square footage of new construction or renovation and how the size of affected departments will increase or decrease; and
 - (4) the total square footage to be leased or purchased.

Attach additional sheets as necessary.

SECTION 13 - Filed Ownership papers

Attach a copy of the applicant’s **filed** ownership papers, i.e., Articles of Incorporation, proof of ownership, proof of Limited Liability Company, proof of sole proprietorship, etc.

SECTION 14 - Certifications

- I certify that, to the best of my knowledge and belief, the information submitted is true and correct.
- I further certify that I am authorized to submit this Letter of Intent on behalf of the applicant.

The information on this form was prepared for this applicant by:

Name (Print or Type)	Signature	Date
Title (Print or Type)		