Michigan Department of Licensing and Regulatory Affairs (LARA)

Health Facilities Engineering Section - APPLICATION FOR PLAN REVIEW

611 W. Ottawa Street - Ottawa Building – 1st Floor - Lansing, MI 48933 - (517) 241-3408

Facility Name:	Address:		
City:	State:	County:	Zip Code:
Project Description:			

Facility Type		Certificate of Need Information	Plan Review Fee
(Please Check) ☐- Hospital ☐- Nursing Home ☐- Dialysis ☐- Freestanding Surgical Outpatient Facility (FSOF) ☐- Home for the Aged * ☐- Hospice Residence ☐- Other __________	HFES is currently following the 2018 FGI Guidelines ☐ ☐	Does This Project Require a Certificate of Need? ☐ YES ☐ NO If Yes: CON #: __________ Date Approved: __________	Calculate your estimated capital expenditure Construction Costs $ ________ Professional Fees $ ________ Fixed Equipment $ ________ (Does not include Radiological Equipment) EST. CAPITAL EXPENDITURE (Total) $ ________ Please use the Fee Schedule below ↓

Submittal Requirements

REQUIRED PLAN REVIEW FEE $ ____________
(Rounded off to the nearest dollar)

Please verify ALL of these items are included in your submittal. Incomplete submittals will delay plan review.

- Application for Plan Review ______
- Check made payable to the STATE OF MICHIGAN ______
- Operational Narrative ______
- DHS-BCAL Form BCAL-1605 Request for PR (HFA Only) * ______
- One Set of Drawings - Schematic ¨ Preliminary ¨ or Sealed Final ¨

FEE SCHEDULE

Calculate the amount of your plan review fee based on the **ESTIMATED CAPITAL EXPENDITURE. (Fees may be adjusted at the completion of the project based on the final actual cost)**

A) .5% of the first $1,000,000
B) .85% of the amount over $1,000,000
C) Maximum of $60,000

NOTE: Application & Fee, Op. Narrative, Sealed Blueprints & BCAL-1605 (if HFA) must be received before the plan review process can begin.

Contact/Owner's Representative (Please print or type)

Contact Person:		Company/Facility Name:		
Address:		City:	State:	Zip:
Telephone: Fax:	County:	E-Mail Address:		

Architect (Please print or type)

Architect's Name:		Company/Facility Name:		
Address:		City:	State:	Zip:
Telephone: Fax:	County:	E-Mail Address:		

[For Internal Use Only]

Date Check Received:	Check #:	Check Amount:	BHS Facility #:	Staff Assignment:

Please mail the Application for Plan Review, your check made payable to the STATE OF MICHIGAN, one set of drawings, specifications, and an operational narrative to the address listed at the top of this form. Photocopies are acceptable. You can obtain a copy of this form by visiting our web site at: www.michigan.gov/hfes

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