



## HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

### **ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM**

Application Number: \_\_\_\_\_ Date of Receipt: \_\_\_\_\_  
To be assigned by Agency

### **APPLICANT PROFILE**

Project Title: \_\_\_\_\_

Project Address: \_\_\_\_\_

Applicant Facility/Organization: \_\_\_\_\_

Name of CEO or equivalent: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Contact Person for this Application: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

### **CERTIFICATION BY APPLICANT**

I hereby attest that I reviewed the application and have knowledge of the content and the information contained herein. I declare that the project described and each statement amount and supporting documentation included is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (please type or print)

\_\_\_\_\_  
Title (please type or print)

**1. TYPE OF ORGANIZATION:** (Please check all applicable)

- Public \_\_\_\_\_
- Private \_\_\_\_\_
- Non-profit \_\_\_\_\_
- For-profit \_\_\_\_\_
- Individual \_\_\_\_\_
- Corporation \_\_\_\_\_
- Partnership \_\_\_\_\_
- Limited Liability Corporation (LLC) \_\_\_\_\_
- Limited Liability Partnership (LLP) \_\_\_\_\_
- Other: \_\_\_\_\_

**2. PROJECT LOCATION INFORMATION**

A. Primary Service Area(s) of Project: (please check all applicable)

- Statewide: \_\_\_\_\_
- O`ahu-wide: \_\_\_\_\_
- Honolulu: \_\_\_\_\_
- Windward O`ahu: \_\_\_\_\_
- West O`ahu: \_\_\_\_\_
- Maui County: \_\_\_\_\_
- Kaua`i County: \_\_\_\_\_
- Hawai`i County: \_\_\_\_\_

**3. DOCUMENTATION** (Please attach the following to your application form):

- A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent)
- B. A listing of all other permits or approvals from other government bodies (federal, state, county) that will be required before this proposal can be implemented (such as building permit, land use permit, etc.)
- C. Your governing body: list by names, titles and address/phone numbers
- D. If you have filed a Certificate of Need Application this current calendar year, you may skip the four items listed below. All others, please provide the following:
  - Articles of Incorporation
  - By-Laws
  - Partnership Agreements
  - Tax Key Number (project's location)

4. **TYPE OF PROJECT.** This section helps our reviewers understand what type of project you are proposing. Please place an “x” in the appropriate box.

	Used Medical Equipment (over \$400,000)	New/Upgraded Medical Equip. (over \$1 million)	Other Capital Project (over \$4 million)	Change in Service	Change in Beds
Inpatient Facility					
Outpatient Facility					
Private Practice					

5. **BED CHANGES.** Please complete this chart only if your project deals with a change in your bed count and/or licensed types. Again, this chart is intended to help our reviewers understand at a glance what your project would like to accomplish. Under the heading “Type of Bed,” please use only the categories listed in the certificate of need rules.

Type of Bed	Current Bed Total	Proposed Beds for your Project	Total Combined Beds if your Project is Approved
<b>TOTAL</b>			

**6. PROJECT COSTS AND SOURCES OF FUNDS**

**A. List All Project Costs:**

**AMOUNT:**

- |    |  |       |
|----|--|-------|
| 1. | Land Acquisition   | _____ |
| 2. | Construction Contract  | _____ |
| 3. | Fixed Equipment  | _____ |
| 4. | Movable Equipment  | _____ |
| 5. | Financing Costs  | _____ |
| 6. | Fair Market Value of assets acquired by<br>lease, rent, donation, etc. | _____ |
| 7. | Other: _____   | _____ |

**TOTAL PROJECT COST:** \_\_\_\_\_

**B. Source of Funds**

- |    |                      |       |
|----|----------------------|-------|
| 1. | Cash                 | _____ |
| 2. | State Appropriations | _____ |
| 3. | Other Grants         | _____ |
| 4. | Fund Drive           | _____ |
| 5. | Debt                 | _____ |
| 6. | Other: _____         | _____ |

**TOTAL SOURCE OF FUNDS:** \_\_\_\_\_

7. **CHANGE OF SERVICE:** If you are proposing a change in service, then please briefly list what services will be added/modified. Be sure to include the establishment of a new service or the addition of a new location of an existing service. Please reference the Certificate of Need Rules Section 11-186-5 for the categories of services. If you are unable to determine which category best describes your project, please consult with agency staff.

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8. **IMPLEMENTATION SCHEDULE:** Please present a projected time schedule for the completion of this project from start to finish. Include all of the following items that are applicable to your project:

- a) Date of site control for the proposed project,
- b) Dates by which other government approvals/permits will be applied for and received,
- c) Dates by which financing is assured for the project,
- d) Date construction will commence,
- e) Length of construction period,
- f) Date of completion of the project,
- g) Date of commencement of operation

Please remember that the Agency does monitor the implementation of Certificates approved. Non-implementation of a project as described in your application may result in a fine and/or withdrawal of the certificate of need.

9. **EXECUTIVE SUMMARY:** Please present a brief summary of your project. In addition, provide a description of how your project meets each of the certificate of need criteria listed below. If a new location is proposed, please attach an easy to read map that shows your project site.

- a) Relationship to the State of Hawai`i Health Services and Facilities Plan.
- b) Need and Accessibility
- c) Quality of Service/Care
- d) Cost and Finances (include revenue/cost projections for the first and third year of operation)
- e) Relationship to the existing health care system
- f) Availability of Resources.

**10. Eligibility to file for Administrative Review.** This project is eligible to file for Administrative review because: (Check all applicable)

- It involves bed changes, which will have a capital expense of \$1,000,000 or less, and which will have an increased annual operating expense of less than \$500,000.
- It involves service changes which will have a capital expense of \$1,000,000 or less, and which will have an increased annual operating expense of less than \$500,000.
- It is an acquisition of a health care facility or service, which will result in lower annual operating expenses for that facility, or service.
- It is a change of ownership, where the change is from one entity to another substantially related entity.
- It is an additional location of an existing service or facility.
- The applicant believes it will not have a significant impact on the health care system.