**MISSISSIPPI STATE DEPARTMENT OF HEALTH**

**DIVISION OF HEALTH PLANNING AND RESOURCE DEVELOPMENT**

**NOTICE OF INTENT (NOI) TO APPLY FOR A CERTIFICATE OF NEED (CON)**

 (NOI must be received fifteen (15) days prior to submission of a CON application)

NOI applications must be mailed, or hand delivered, and a complete copy should be emailed to HPRD@msdh.ms.gov. The original application including attachments 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

|  |  |
| --- | --- |
| **TITLE OF PROPOSED PROJECT:** |   |
| **LOCATION:** |  |
| **CAPITAL EXPENDITURE:** | $ |

1. **APPLICANT/FACILITY INFORMATION**

|  |
| --- |
| **APPLICANT** |
| Applicant Legal Name: |  |
| d/b/a (if applicable): |  |
| Address: |  |
| City: |  | State: |  | Zip Code: |  |
| County: |  | Telephone: |  |
| Parent Organization (if applicable): |  |
| E-mail Address: | Fax: |
| **PRIMARY CONTACT PERSON** |
| Name: |  | Title or Position: |  |
| Firm: |  |
| Address: |  |
| City: |  | State: |  | Zip Code: |  |
| Telephone: |  | Fax: |  |
| E-mail Address: |  |
| **LEGAL COUNSEL /CONSULTANT (if applicable)** |
| Name: |  | ( ) Counsel ( ) Consultant |
| Firm: |  |
| Address: |  |
| City: |  | State: |  | Zip Code: |  |
| Telephone: |  | Fax: |  |
| E-mail Address: |  |

|  |
| --- |
| **FACILITY (if different from Applicant)** |
| Name: |  |
| Address: |  |
| City: |  | State: |  | Zip Code: |  |
| County: |  | Telephone: |  |

1. Select the type of ownership of the present or proposed facility**.**

|  |  |
| --- | --- |
| **TAX EXEMPT** |  |
|  |
| **TAX PAYING** |  |  |  |
|  |  |
| State of Incorporation or Organization: |  |

2. Identify any proposed bed changes (increases/decreases) by licensure category (*if applicable*).

**II. PROJECT DESCRIPTION**

1. Provide a narrative description of the project, including location of new construction, areas involved in repair or renovation, new services being proposed, and/or equipment acquisition proposed.
2. Provide a brief justification for the project.
3. Does the project involve correction of code or Licensure deficiencies?
	1. If yes, are all deficiencies corrected by this project?
	2. List any project components which do not involve correction of code or licensure deficiencies.

4. Estimated project costs:

|  |  |
| --- | --- |
| Construction Cost – New | $ |
| Construction Cost – Renovation |  |
| Capital Improvement Cost (i.e. minor painting and repairs, refurbishing) |  |
| Total Fixed Equipment Cost |  |
| Total Non-Fixed Equipment Cost |  |
| Land Cost |  |
| Site Preparation Cost |  |
| Fees (architectural, consultant, etc. |  |
| Contingency Reserve |  |
| Capitalized Interest |  |
| Other Costs (specify) |  |
| **Total Estimated Project Cost** |  |

5. Approximate: (a) project starting date \_\_\_\_\_\_\_\_\_\_

 (b) project completion date \_\_\_\_\_\_\_\_\_\_

**Submitted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name (type)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Title

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date