MISSISSIPPI STATE DEPARTMENT OF HEALTH
APPLICATION FOR A CERTIFICATE OF NEED

APPLICATION FOR EXTENSION/RENEWAL OF AN EXPIRED CERTIFICATE OF NEED

TITLE OF PROJECT:		
Capital Expenditure:	$	CON Review #:

I. 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:					

1. If the name of the existing or proposed facility is different than the Applicant's legal name provide the facility information.

FACILITY					
Name:					
Address:					
City:		State:		Zip Code:	
County:		Telephone:			

2. If the existing or proposed facility will be managed or operated by a different entity other than the Applicant, enter the entity information below.

MANAGEMENT / OPERATING ENTITY					
Name:					
Address:					
City:		State:		Zip Code:	
Telephone:		Fax:			

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

TAX EXEMPT	☐ Not-for-Profit Corporation		
	☐ Public (Hospital or Government)		
TAX PAYING	☐ General Partnership	☐ Business Corporation	☐ Sole Proprietor
	☐ Limited Liability Partnership or Limited Partnership	☐ Limited Liability Company	
State of Incorporation or Organization:			

4. **Please provide documentation of the organizational and legal structure as indicated in the table below.**

5. **Facility Type (select one)**

☐ Hospital-Based ☐ Freestanding ☐ Nursing Home ☐ Not Applicable

ORGANIZATIONAL STRUCTURE	
Not-for-Profit Corporation	▪ Name of Each Officer and Director ▪ Letter of Good Standing from Secretary of State
Public	▪ All Governing Authority Approvals for this Project
Sole Proprietor	▪ County Business Authorization Documents, if available
General Partnership	▪ Name, Partnership Interest, and Percentage Ownership of Each Partner ▪ Partnership Agreement
Limited Liability Partnership or Limited Partnership	▪ Name, Partnership Interest, and Percentage Ownership of Each Partner ▪ Letter of Good Standing from Secretary of State
Business Corporation	▪ Name of Each Officer and Director ▪ Letter of Good Standing from Secretary of State
Limited Liability Company	▪ Name of Each Member and Managing Member, Officers, and/or Directors ▪ Letter of Good Standing from Secretary of State

II. PROJECT DESCRIPTION

1. Describe in detail ALL of the characteristics of the project. Be sure to include any changes in the project since original approval. Specifically, discuss:

   a. Reason for expiration.

   b. How long has the CON been expired.

   c. Status of project at time of expiration and current status of project.

   d. Continued need for project.

   e. Applicant's ability to complete the project.

   f. Timeline for completion of the project.

2. Attach a copy of the original Application.

III. COMPLIANCE WITH STATE HEALTH PLAN, POLICIES, AND PROCEDURES

1. Describe how the project complies with the health care needs addressed in the current *State Health Plan.* **Note: CON applications will be reviewed under the State Health Plan that is in effect at the time the application is received by the Department. Prior approved projects must continue to be in compliance with the Plan in effect at the time the original project was approval.**

2. Describe how the proposed project complies with the *Mississippi Certificate of Need Review Manual*, all adopted policies and procedures of the Mississippi State Department of Health, statute and federal regulations, if applicable.

IV. CERTIFICATION

Complete and submit original Certification Page for this project.

MISSISSIPPI STATE DEPARTMENT OF HEALTH
CERTIFICATION

APPLICANT: ____

TITLE OF PROPOSED PROJECT: ______________________________________

TOTAL CAPITAL EXPENDITURE: ______________________________________

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 a 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 a Certificate of Need, and if it finds that the application contains distorted facts or misrepresentation or does not reveal truth or accuracy, the Department may refrain from further review of the application and consider it rejected. It is further understood that if a Certificate of Need is issued based upon evidence contained in this application, such Certificate may be revoked, canceled or rescinded if the Department of Health determines its findings were based on evidence, not true, factual, accurate, and correct.

I (we) certify that no revision or alteration of the proposal submitted will be made without obtaining prior written consent of the Department of Health. **Furthermore, I (we) will furnish to the Department of Health a progress report on the proposal every six (6) months until the project is completed.**

______________________________ ______________________________

Print or Type Name Signature

______________________________ ______________________________

Title Facility Name (if Different)

STATE OF ______________________________

COUNTY OF ______________________________

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

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Notary Public

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My Commission Expires