For DHHSUse Only
DHHS Application Number
Date Submitted
Facility Number
Sub-Area/Planning Area

APPLICATION FOR EMERGENCY CERTIFICATE OF NEED

Michigan Department of Health & Human Services

CERTIFICATE OF NEED

South Grand Building, 4th Floor
P.O. Box 30195
Lansing, Michigan 48909

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

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.	The Department of Health & Human Services is an equal opportunity employer, services and programs provider.

1. **Legal** Name of **Applicant**

2. Current Licensed Name of Facility or Current Name of Center	County

3. Proposed Licensed Name of Facility or Proposed Name of Center

4. Facility/Center Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

5. FACILITY TYPE: *(Check one)*

- ☐ Freestanding Surgical Outpatient Facility (FSOF)
- ☐ Health Maintenance Organization (HMO)
- ☐ Nursing Home
- ☐ Hospital
- ☐ Long-Term (Acute) Care (LTAC) Hospital
- ☐ Hospital Long-Term -Care Unit (HLTCU)
- ☐ Psychiatric Hospital
- ☐ Inpatient Psychiatric Unit
- ☐ Other – Not a Licensed Health Facility *(Specify):*

6. Name of Current **Owner of Facility/Center**

Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

7. Name of Current **Owner of Land**

Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

8. Name of **Current Licensee**

Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

9. Name of **Proposed Licensee:**

CERTIFICATIONS

EMERGENCY CERTIFICATE OF NEED

A. **I certify** that to the best of my knowledge and belief, the information and attachments submitted are true and correct. **I further certify** that no revisions will be made to the approved project without first notifying and receiving approval from the Department of Health & Human Services to make such revisions, and providing such information to the Department, and where applicable, to the Alliance for Health.

B**. I certify** that there are sufficient funds available to meet the operating expenses of the project.

C. **I understand** that the Emergency Certificate of Need application process, decision, and subsequent operation of the project (if approved) are subject to the applicable laws, rules, and CON Review Standards**.**

D. **I understand** that a signed certification form agreeing to comply with the CON Review Standards applicable to this project must be included in this application.

CERTIFICATION ACCEPTANCE

Signature of Authorized Agent *(Blue ink only)*	Date Signed

Submitted to Project Review Coordinator for DHHS on:	Date Deemed Received/Complete by DHHS:
Decision ☐ **APPROVED**	☐ **DENIED**
Date of Decision	For the Department of Health & Human Services by:

CERTIFICATE OF APPOINTMENT FOR AUTHORIZED AGENT

Michigan Department of Health & Human Services

Proposed Name of Facility/Center		County	
Facility/Center Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

Notice is hereby given to the Michigan Department of Health & Human Services that

_____

[Legal name of applicant entity (same as Page 1, Item #1)]

has appointed and authorized the following person to act on behalf of the applicant entity.

Agent Name	Title		
Name of Agent's Organization			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Agent's Telephone Number Extension	Agent's Fax Number Extension		
Agent's E-Mail Address			

The above named agent is authorized to do the following:

A. submit this Emergency Certificate of Need application and make amendments thereto,

B. provide the Department with all information necessary for a determination with respect to this Emergency Certificate of Need application,

C. enter into agreements with the Department in connection with this Emergency Certificate of Need, and

D. receive notice and service of process in matters relating to this Emergency Certificate of Need.

This appointment will remain in effect for this application until written notice of termination is sent to the Michigan Department of Health & Human Services that references the specific CON application number. The termination notice must identify a new authorized agent.

Typed Name	Signature of Individual Legally Authorized to Appoint Agent *(Blue Ink)*
Title	Date:

CONTACT PERSONS: Identify those individuals whom may be contacted by DHHS to answer questions:

FINANCIAL DATA: (Person's Name)	ALL OTHER DATA: (Person's Name)
Telephone Number Extension	Telephone Number Extension
E-mail Address	E-mail Address

EMERGENCY PROJECT DESCRIPTION

1. Provide a concise narrative description of the project, including its physical elements. At a minimum, include specific information about:

   A. the description of the emergency and the impact on the covered clinical service(s) and/or health facility;
   B. location(s) and, where applicable, a breakdown by floors, departments, or services;
   C. the total square footage of new construction or renovation and how the size of affected departments will increase or decrease; and
   D. the total square footage to be leased or purchased.

   (Use Additional Sheets as Needed)

2. If the applicant is from outside of Michigan, **attach** a copy of the document that authorizes that entity to do business in Michigan.

3. **Attach** a copy of the following:

   A. Filed Ownership papers, i.e., Articles of Incorporation, proof of Partnership, proof of Limited Liability Company, proof of Sole Proprietorship, etc.
   B. Facility's current license.
   C. Lease/purchase agreements, if applicable.
   D. A signed affidavit attesting that the request for an Emergency Certificate of Need meets each of the requirements of MCL 333.22235(1)(a) – (d).

PROJECT TIMETABLE

1. Date for determination of methods of financing and ability to finance ..... _____
2. Date of obligation for capital expenditure *(see ❶ below)* ..... _____
3. Date of initiation of construction/renovation, if applicable ..... _____
4. Date equipment will be installed, if applicable ..... _____
5. Date of completion of construction *(see ❷ below)*, if applicable ..... _____
6. Date services associated with this project will begin..... _____

❶ An obligation for a capital expenditure shall be deemed to have been incurred by or on behalf of an institution:

A. When an enforceable contract is entered into by such institution or by a person representing such institution, for the construction, acquisition, lease, and/or financing of a capital asset;
B. Upon the formal, internal commitment of funds by such institution for a force account expenditure that constitutes a capital expenditure; or
C. In the case of donated property, the date the gift is completed in accordance with applicable Michigan laws.

❷ If major components of the project will be completed and become operational prior to the overall completion of the project, indicate below the anticipated dates of completion for each component.

COMPONENT / DEPARTMENT	Anticipated Completion Date

FINANCIAL SECTION

INSTRUCTIONS:

1. Complete each line item as shown on the form. For those items not applicable enter "0" or "N/A."
2. All estimated costs, including the effects of inflation, must be based on the projected midpoint of construction.
3. The Total Project Costs must equal the Total Sources of Funds.
4. Attach a copy of the proposed purchase agreement or lease agreement as applicable to this project. (The lease costs must include all renewable option periods. If the renewable options are infinite, include costs for at least 20 years.)
5. Include physical plant "fixed equipment" in Item 6.

PROJECT COSTS	Amount
1. Movable Equipment	
2. Lease (length or terms of lease x cost/month)	
3. Land Purchase	
4. Building Purchase	
5. Financing Costs (bond discount, debt service reserve fund, other debt issue costs)	
6. Construction/Renovation	
7. **TOTAL PROJECT COSTS**	
SOURCES OF FUNDS	**Amount**
8. Proceeds from bond issue and or other mortgages **(Specify)**	
9. Cash	
10. Anticipated funds from future operations (lease costs)	
11. Other **(Specify)**	
12. TOTAL SOURCES OF FUNDS	

NOTE: CHANGES FROM THE ABOVE STATED CATEGORY OF FUNDS REQUIRE DHHS APPROVAL.