Form APA-3
11/96

CERTIFICATION OF ADMINISTRATIVE RULES
FILED WITH THE LEGISLATIVE REFERENCE SERVICE
JERRY L. BASSET, DIRECTOR

(Pursuant to Code of Alabama 1975, § 41-22-6, as amended).

I certify that the attached is/are a correct copy/copies of rule/s as promulgated and adopted on the 17th day of July, 2013, and filed with the agency secretary on the 24th day of July, 2013.

AGENCY NAME: State Health Planning and Development Agency
(Certificate of Need Review Board)

__X__ Amendment; _____ New; _____Repeal; (Mark appropriate space)

Rule No. Appendix A

(If amended rule, give specific paragraph, subparagraphs, etc., being amended)

Rule Title: Request for Determination of Exemption Status for Replacement of Existing Equipment

ACTION TAKEN: State whether the rule was adopted without changes from the proposal due to written or oral comments;

No public comments were received; the rule was adopted without changes and as published for comment in the Alabama Administrative Monthly.

NOTICE OF INTENDED ACTION PUBLISHED IN VOLUME XXXI

ISSUE NO. 8, DATED May 31, 2013.

Statutory Rulemaking Authority: Code of Alabama, 1975 §§ 22-21-271 and -274.

(Date Filed)
(For LRS Use Only)

REC'D & FILED

JUL 24 2013

LEGISLATIVEREFSERVICE

Alva M. Lambert

Alva M. Lambert, Executive Director
State Health Planning and Development Agency
(Certifying Officer or his or her Deputy)

(NOTE: In accordance with § 41-22-6(b), as amended, a proposed rule is required to be certified within 90 days after completion of the notice.)

State Health Planning and Development Agency

Mailing address: Post Office Box 303025, Montgomery, Alabama 36130-3025
Street address: 100 North Union Street, Suite 870, Montgomery, Alabama 36104

Request # _____
Date Rec. _____
Received by: _____

REQUEST FOR DETERMINATION OF EXEMPTION STATUS FOR REPLACEMENT OF EXISTING EQUIPMENT

A filing fee in the amount of $_____ has been submitted with this application.

REQUESTER IDENTIFICATION (Check One) HOSPITAL (___) NURSING HOME (___)
OTHER (___) (Specify) _____

A._____
Name of requester

_____
Address City County

_____
State Zip Phone

B._____
Name of Facility/Organization (if different from A)

_____
Address City County

_____
State Zip Phone

C._____
Name of Legal Owner (if different from A or B)

_____
Address City County

_____
State Zip Phone

D._____
Name and Title of Person Representing Proposal and With Whom SHPDA Should Communicate

_____
Address City County

_____
State Zip Phone

DESCRIPTION OF EQUIPMENT TO BE REPLACED **DESCRIPTION OF PROPOSED NEW EQUIPMENT**

A. Manufacturer:

Serial #

B. Model:

C. Name of equipment:

D. Fair market value of equipment at present:

E. Cost of equipment (include written price quote):

F. Describe use of current equipment:

Describe use of proposed equipment:

G. List any attachments or additional procedures associated with this equipment that could not be performed by old equipment:

H. Can any procedures be performed with the proposed new equipment that cannot be performed with the replaced equipment? If yes, describe in detail:

I. Location of existing equipment (include room #):

J. List specially trained or qualified personnel necessary for operation of equipment:

K. What use will be made of old equipment when replaced?
(Trade in on new equipment, used as back up, save for parts, etc.)

L. List job titles of any additional personnel that will be required to operate the new equipment.

M. Describe any renovation or new construction that will be necessary for the installation of the replacement equipment and cost.

N. Describe any new annual operating cost associated with this project such as maintenance contracts, salaries of new employees hired due to equipment, etc.

III. COST

A. Equipment costs $_____
(Costs have to be supported by price quote on manufacturer's stationery or letterhead.) Cost of equipment only; do not list lease cost.

B. Less trade-in of old equipment $_____

C. Total cost of equipment $_____

Calculation of fee for this determination:
Multiply dollar amount in III.C. (total cost of equipment) times 1% (the application fee for a Certificate of Need); 20% of this amount is the application fee for non-rural hospitals.
For rural hospitals, the application fee is 25% of the application fee as calculated above for non-rural hospitals.

Include manufacturer's literature on old equipment, if available, and on the new equipment.

Include any other information pertinent to the determination.

The Executive Director may request any other information which is relevant to his decision.

IV. CERTIFICATION

I certify that the information provided herein is true and correct and that there is no additional information which would be pertinent to this application which has not been provided. Further, I understand that any misrepresentation on this application or failure to include relevant information may void any favorable determination secured by such misrepresentation or omission.

_____
Signature of Applicant

_____
Applicant's Name and Title
(Type or Print)

Sworn to and subscribed before me this

_____ day of _____, 20 _____.

_____
Notary Public (affix seal on original)