Request No. _____
Date Received _____
Received By _____

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

100 NORTH UNION STREET, SUITE 870MONTGOMERY,
ALABAMA 36104

REQUEST FOR DETERMINATION OF EXEMPTION STATUS FOR REPLACEMENT OF EXISTING EQUIPMENT

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

Requestor Identification (Check one)

☐ Hospital ☐ Nursing Home ☐ Other (Specify) _____

A. _____
Name of Requestor

_____
Address City County

_____
State Zip Phone Number

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

_____
Address City County

_____
State Zip Phone Number

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

_____
Address City County

_____
State Zip Phone Number

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

_____
Address City County

_____
State Zip Phone Number

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

A. Manufacturer:

B. Serial Number:

C. Model:

D. Name of Equipment:

E. Fair Market Value of Equipment at Present:

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

F. Describe Use of Current Equipment:

G. Describe Use of Proposed Equipment:

H. List any attachments or additional procedures associated with this new equipment not 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 Number):

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, 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.

COST

A. Equipment Costs $ _____
Cost of equipment ONLY; do not list lease cost.
(Costs must be supported by price quote on manufacturer's stationary/letterhead).

B. Less Trade-In of Old Equipment -$ _____

C. Total Cost of Equipment $ _____

Calculation of fee for this Determination:

Multiply dollar amount in COST section (C. Total Cost of Equipment) by one percent (1%) (the application fee for a Certificate of Need);

- Non-Rural Hospitals:
  Twenty percent (20%) of the calculation obtained above.

- Rural Hospitals:
  Twenty-five percent (25%) of the calculation obtained above.

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 their decision.

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

_____
Printed Name of Applicant

_____
Title of Applicant

Sworn to and subscribed before me this

_____ day of _____, 20_____.

_____
Notary Public (SEAL)

My Commission Expires _____