APPENDIX A

ALABAMA CERTIFICATE OF NEED APPLICATION FOR PROVIDERS OF IN-HOME HOSPICE SERVICES AS OF MAY 13, 2009 SEEKING A CERTIFICATE OF NEED UNDER "NON-SUBSTANTIVE" REVIEW PROCEDURES

For Staff Use Only

INSTRUCTIONS: Please submit an original and twelve (12) copies of this form and the appropriate attachments to the State of Alabama, State Health Planning and Development Agency, 100 North Union Street, Suite 870, Montgomery, Alabama 36104. (Post Office Box 303025 Montgomery, AL 36130-3025)

Project #_____
Date Rec._____
Rec by:_____

Attached is a check in the amount of $250.00
Refer to Rule 410-1-5C-.01 of the Certificate of Need Program Rules and Regulations to determine the required filing fee.

PART ONE: APPLICANT IDENTIFICATION AND PROJECT DESCRIPTION

A._____
Name of Applicant (in whose name the CON will be issued if approved) Medicare Provider #

_____
Address City County

_____
State Zip Code Phone Number

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

_____
Address City County

_____
State Zip Code Phone Number

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

_____
Address City County

_____
State Zip Code Phone Number

D._____
Name and Title of Person Representing Proposal and with whom SHPDA should communicate

_____
Address City County

_____
State Zip Code Phone Number

_____
E-Mail Address

I. APPLICANT IDENTIFICATION (continued)

E. Type Ownership and Governing Body

1. Individual (___)
2. Partnership (___)
3. Corporate (for profit) (___) _____ Name of Parent Corporation
4. Corporate (non-profit) (___) _____ Name of Parent Corporation
5. Public (___)
6. Other (specify) (___) _____

F. Names and Titles of Governing Body Members and Owners of This Facility

OWNERS	GOVERNING BOARD MEMBERS
_____	_____
_____	_____
_____	_____

II. PROJECT DESCRIPTION

A. Please attach a copy of the current ADPH licenses associated with the Medicare Provider Number under which this application is submitted.[1] List all counties in which Applicant provided in-home hospice services under the Medicare Provider Number, and ADPH license, as of May 13, 2009, or the preceding twelve months, for which this CON is sought.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Evidence of Continuing Ability to Meet Licensure Standards:

1. Prior to May 13, 2009, has applicant received pending notice of license revocation, probation or non-renewal of licensure from the ADPH relating to its in-home hospice operations?

☐ Yes ☐ No

If yes, please describe the nature of such notice in a separate attachment (with appropriate redaction of patient information, as needed).

2. Please describe the Applicant's quality of care and compliance programs.

C. Applicant is the sole hospice provider under common control applying for such counties.

☐ Yes ☐ No

[1] Under Ala. Admin. Code 410-2-3-.10(2)(b), need is presumed for any Applicant that has provided in-home hospice service pursuant to an ADPH license as of May 13, 2009, or the preceding twelve months. Pursuant to Ala. Admin. 410-1-5C-.01, for purposes of this application, an entity shall be considered a separate hospice provider for purposes of each Medicare Provider Number held.

III. EXECUTIVE SUMMARY OF THE PROJECT (brief description). Include all counties where services have been established under the current ADPH license associated with this application. (Attach additional sheets as necessary)

IV. COST

By checking yes, the Applicant confirms that it will not incur capital expenditures in excess of $500,000 associated with this project.[2]

☐ Yes

V. UTILIZATION DATA AND FINANCIAL INFORMATION

Attach separate sheets if additional space needed.

I. Utilization	County	*2007	*2008	1/01/2009-5/13/2009
A. Number of hospice patients served by county subject to this application				
	TOTAL PATIENTS:			

*Calendar Years

[2] Applies only to new capital expenditures that have, or may be incurred in the twelve months after May 13, 2009, in order to maintain such services that were being provided prior to that date.

	County	*2007	*2008	1/01/2009-5/13/2009
B. Number of hospice service days served by county subject to this application				
	TOTAL DAYS:			

*Calendar Years

The applicant shall attach billing information verifying service for at least one patient for each county subject to this application. Form HPCE-2 for 2007 and 2008 shall also be attached to the application.

II. **Percent of Gross Revenue**

Source of Payment	2007	2008	1/01/2009-5/13/2009
ALL Kids			
Blue Cross/Blue Shield			
Champus/Tricare			
Charity Care (see note below)			
Medicaid			
Medicare			
Other Commercial Insurance			
Self Pay			
Other			
Veterans Administration			
Workman's Compensation			
TOTAL	%	%	%

Note: Refer to the Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement Number 15, Section II.

VI. CHARGE INFORMATION

A. List schedule of current charges related to this project.

B. List schedule of proposed charges after completion of this project.

PART SIX: ACKNOWLEDGEMENT AND CERTIFICATION BY THE APPLICANT

I. ACKNOWLEDGEMENT. In submitting this application, the applicant understands and acknowledges that:

A. The rules, regulations and standards for health facilities and services promulgated by the SHPDA have been read, and the applicant will comply with same.

B. Upon the granting of a CON pursuant to this application, the applicant shall provide confirmation that they are continuing to operate in the counties encompassed by the CON, which shall result in the automatic vesting of the CON.

C. Applicants seeking a CON herein under the non-substantive review procedures authorized by Ala. Admin. Code 410-2-3-.10(2)(b) and (c) shall be granted a single CON encompassing all of the counties served under a Medicare Provider Number. Such CON authority may not be subsequently divided, e.g., a hospice provider may not separate such authority into separate CONs for future disposition. Any action to transfer or assign the certificate in violation of this or any other restriction found in Alabama law or the SHPDA rules will render it null and void.

D. Pursuant to Ala. Admin. Code 410-2-3-.10(2)(c), the granting of a CON under this provision shall be conditioned on timely compliance with any data request, issued on an annual basis by the SHPDA staff in conjunction with the adoption of long-term need methodology, including any request for 2007-2009 information that may be required as part of the application process.

E. Pursuant to Ala. Admin. Code 410-2-3-.10(2)(d) an existing provider that obtains a CON that subsequently fails to substantially comply on a timely basis (subject to any authorized extensions) to an annual data request from the SHPDA staff adopted in conjunction with long-term need methodology shall be assumed to have ceased operations as of the end of such period until the provider complies fully with all outstanding SHPDA data requests. Any provider that has deemed to have ceased operations under such provision chapter shall be prohibited from submitting any CON application for additional authority or from seeking consideration by SHPDA of such facility's utilization data to oppose another provider's CON application. In accordance with Rule 410-1-11-.08(2), should such cessation of operation continue for an uninterrupted period of twelve months or longer, the provider's CON shall be deemed abandoned. SHPDA shall report to the Alabama Department of Public Health any provider who is deemed to have abandoned its CON under this section.

F. The applicant will notify the State Health Planning and Development Agency when a project is started, completed, or abandoned.

G. The applicant must comply with all state and local building codes, and failure to comply will render the Certificate of Need null and void.

H. The applicants and their agents will construct and operate in compliance with appropriate state licensure rules, regulations, and standards.

I. Projects are limited to the work identified in the Certificate of Need as issued.

J. Any expenditure in excess of the amount approved on the Certificate of Need must be reported to the State Health Planning and Development Agency and may be subject to review.

K. The applicant will comply with all state statutes for the protection of the environment.

L. The applicant is not presently operating with a probational (except as may be converted by this application) or revoked license.

I. CERTIFICATION

The information contained in this application is true and correct to the best of my knowledge and belief, and I agree to be bound by the restrictions contained herein.

_____
Signature of Applicant

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

_____day of _____ 20_____

_____
Alabama Notary Public (Affix seal on Original)

Author: Alva M. Lambert

Statutory Authority: § 22-21-267, 271, 275, Code of Alabama, 1975

History: Adopted, September [ ], 2009