REQUEST FOR DETERMINATION
OF EXEMPTION STATUS FOR
REPLACEMENT OF EXISTING EQUIPMENT

Instructions: Please submit an original and two (2) copies of this form and the appropriate attachments to:

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

Attached is a check in the amount of: $__________

I. 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
II. DESCRIPTION OF EQUIPMENT TO BE REPLACED DESCRIPTION OF PROPOSED NEW EQUIPMENT

A. Manufacturer:

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 and 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:
II. DESCRIPTION OF EQUIPMENT TO BE REPLACED  DESCRIPTION OF PROPOSED NEW EQUIPMENT (Continued)

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) by 1%.
Multiply this sum times 10% for the application fee.

The maximum fee is $12,000 (indexed), or a maximum of $4,000 if the applicant has had an average
daily census comprised of 50% or more Medicaid patients within the last year prior to the filing of this
request. A rural hospital will not be required to submit an application fee.

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)