

**State of Tennessee**

**Health Facilities Commission**

502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243

[**www.tn.gov/hfc**](http://www.tn.gov/hfc)Phone: 615-741-2364 [hsda.staff@tn.gov](mailto:hsda.staff@tn.gov)

INITIAL NOTIFICATION OF EXEMPTION OF CERTIFICATE OF NEED ACTIVITY IN COUNTY WITHOUT A LICENSED HOSPITAL

**Instructions: This form must be filed with the Health Facilities Commission by any person who intends to establish a Certificate of Need service within a county that contains no actively licensed hospital under Public Chapter 985 effective July 1, 2025. This form must be emailed to hsda.staff@tn.gov.**

|  |  |
| --- | --- |
| 1. REPORTING DATE: |  |

1. **NAME AND ADDRESS OF PROPOSED PROJECT**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | | | |
| Name |  |  |  |
|  |  |  |  |
|  | | | |
| Address |  |  |  |
|  |  |  |  |
|  | |  |  |
| City |  | State | Zip |

1. **NAME AND ADDRESS OF OWNER OF PROJECT**

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| --- | --- | --- | --- | --- |
|  |  |  | |  |
|  | | | | |
| Name |  |  | |  |
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|  | | | | |
| Address |  |  | |  |
|  |  |  | |  |
|  | |  | |  |
| City |  | State | | Zip |
|  |  |  | |  |
| Will the project be a satellite? If so, with whom? | | |  | |

1. **CONTACT PERSON OR AUTHORIZED AGENT REPORTING EXEMPTION**

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| Name |  | Title |  |
|  |  |  |  |
|  | | | |
| Email Address |  |  |  |
|  |  |  |  |
|  | | | |
| Company Name |  |  |  |
|  |  |  |  |
|  | | | |
| Address |  |  |  |
|  |  |  |  |
|  | |  |  |
| City |  | State | Zip |
|  |  |  |  |
|  | |  | |
| Phone Number |  | Fax Number |  |

1. **CHECK THE COUNTY WHERE EXEMPTION ACTIVITY TAKES PLACE:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Chester |  | Grundy |  | Moore |  | Stewart |
|  |  |  |  |  |  |  |  |
|  | Crockett |  | Jackson |  | Morgan |  | Union |
|  |  |  |  |  |  |  |  |
|  | Decatur |  | Lake |  | Perry |  | Van Buren |
|  |  |  |  |  |  |  |  |
|  | Fayette |  | Lewis |  | Pickett |  |  |
|  |  |  |  |  |  |  |  |
|  | Fentress |  | McNairy |  | Polk |  |  |
|  |  |  |  |  |  |  |  |
|  | Grainger |  | Meigs |  | Sequatchie |  |  |

1. **CHECK THE CON PROJECT TYPE REQUESTING EXEMPTION:**

*Check all that are appropriate*

|  |  |
| --- | --- |
|  | Ambulatory Surgical Treatment Center – Single Specialty |
|  |  |
|  | Ambulatory Surgical Treatment Center – Multi-Specialty |
|  |  |
|  | Cardiac Catheterization – Diagnostic |
|  |  |
|  | Cardiac Catheterization – Therapeutic |
|  |  |
|  | Cardiac Catheterization – Both Diagnostic and Therapeutic |
|  |  |
|  | Comprehensive Inpatient Rehabilitation Services |
|  |  |
|  | Acute Care Hospital |
|  |  |
|  | Long-Term Hospital |
|  |  |
|  | Outpatient Diagnostic Center |
|  |  |
|  | Positron Emission Tomography (PET) |
|  |  |
|  | Intellectual Disability Institutional Habilitation Facility – ICF/IID |
|  |  |
|  | Magnetic Resonance Imaging (MRI) |
|  |  |
|  | Relocation of existing Certificate of Need within exempted county. |
|  |  |
|  | Freestanding Emergency Department |
|  | *(Must be at least 10 miles from any actively licensed acute care hospital or FSED in another county.)*  *Provide proof of compliance using Google Maps.* |

1. **DESCRIPTION OF REQUESTED CON EXEMPTED PROJECT:**

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|  |

1. **IF THE PROJECT IS RELOCATING AN APPROVED CON, INDICATE PROJECT AND CON NUMBER:**

|  |
| --- |
|  |

1. **ACCREDITATION – WILL THE PROJECT BE ACCREDITED? If so, with whom.**

Please Check

|  |  |  |
| --- | --- | --- |
|  | (AAAASF – American Association for Accreditation Ambulatory Surgery Facilities | |
|  |  | |
|  | (ACHC) – Accreditation Commission for Health Care | |
|  |  | |
|  | (ACR) – American College of Radiology | |
|  |  | |
|  | (ACRO) – American College of Radiation Oncology | |
|  |  | |
|  | (ASTRO) – American Society for Radiation Oncology | |
|  |  | |
|  | (CARF) – Commission on Accreditation of Rehabilitation Facilities | |
|  |  | |
|  | (CCAC) – Continuing Care Accreditation Commission | |
|  |  | |
|  | (CHAP) – Community Health Accreditation Partner | |
|  |  | |
|  | (DNV) – Det Norske Veritas Healthcare’s National Integrated Accreditation for Healthcare Organizations | |
|  |  | |
|  | (HFAP) – Health Facilities Accreditation Program | |
|  |  | |
|  | (NCQA) – National Committee for Quality Assurance | |
|  |  | |
|  | (TJC) – The Joint Commission | |
|  |  | |
|  | (URAC) – Utilization Review Accreditation Commission | |
|  |  |  |
|  | Other – Specify: |  |

1. **IF NOT PLANNING TO BE ACCREDITED, PLEASE EXPLAIN BELOW:**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| 1. TARGET DATE FOR COMPLETION: |  |

(INSERT STATEMENT/ATTESTATION FOR SIGNATURE HERE)

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| Signature |  | Date |  |
|  |  |  |  |
|  | | | |
| Printed Name |  |  |  |