|  |  |
| --- | --- |
|  | **State of Tennessee****Health Facilities Commission**502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243**www.tn.gov/hsda** Phone: 615-741-2364 hsda.staff@tn.gov |
|  |  |

**CERTIFICATE OF NEED**

**RELOCATION EXEMPTION REQUEST**

**1A. Name of Facility, Agency, or Institution**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| **Name** |  |  |  |  |  |
|  |  |  |  |  |  |
| **Street or Route** |  |  |  |  | **County** |
|  |  |  |  |  |  |
| **City** |  |  | **State** |  | **Zip** |
|  |  |  |  |  |  |
| **Website Address** |  |  |  |  |
|  |  |  |  |  |
| **License Number (If Applicable)** |  |  |  |  |

**Note**: The facility’s name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.

**2A. Submitter**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| **Name** |  |  |  |  | **Title** |
|  |  |  |  |  |  |
| **Company Name** |  |  |  | **Email Address** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **Street or Route** |  |  |  |  |  |
|  |  |  |  |  |  |
| **City** |  |  | **State** |  | **Zip** |
|  |  |  |  |  |  |
| **Association with Owner** |  |  |  | **Phone Number** |

**3A. Name of Owner of the Facility, Agency, or Institution**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| **Name** |  |  |  |  |  |
|  |  |  |  |  |  |
| **Street or Route** |  |  |  |  | **Phone Number** |
|  |  |  |  |  |  |
| **City** |  |  | **State** |  | **Zip** |

**4A. Type of Ownership of Control** *(Check One)*

 🞏 Sole Proprietorship

 🞏 Partnership

 🞏 Limited Partnership

 🞏 Corporation (For Profit)

 🞏 Corporation (Not-for-Profit)

 🞏 Government (State of TN or Political Subdivision)

 🞏 Joint Venture

 🞏 Limited Liability Company

 🞏 Other (Specify):

**5A. Legal Interest in the Site**

Check the appropriate box and submit the following documentation.

The legal interest described below must be valid on the date of the Executive Director considers the exemption request.

 🞏 Ownership (Applicant or applicant’s parent company/owner) – Attach a copy of the title/deed.

 🞏 Lease (Applicant or applicant’s parent company/owner) – Attach a fully executed lease that includes

 the terms of the lease and the actual lease expense.

 🞏 Option to Purchase - Attach a fully executed Option that includes the anticipated purchase price.

 🞏 Option to Lease - Attach a fully executed Option that includes the anticipated terms of the Option and

 anticipated lease expense.

 🞏 Other (Specify)

**EXECUTIVE SUMMARY**

**1E. Overview**

 Please provide an overview not to exceed **ONE PAGE** in total explaining each item point below.

* **Service Area** – Address if at least ninety-five percent (95%) of patients to be served are reasonably expected to reside in the same zip codes as the existing patient population.
* **Medicaid/TennCare Participation** – Address any changes as a result of the relocation.
* **Access to Consumers** – Address if the relocation will reduce or impact access to consumers, particularly those in underserved communities; those who are uninsured or underinsured; women and racial and ethnic minorities; TennCare or Medicaid recipients; and low income groups.

**2E. Patients by Zip Code**

Complete the following tables, if applicable.

**Current Location (Latest Full Year) Year \_\_\_\_\_\_\_\_\_ Beginning Month \_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Service Area ZIP Codes** | **Historical Utilization-ZIP Code Patients** | **% of Total Current Patients** |
| ZIP Code #1 |  |  |
| ZIP Code #2 |  |  |
| Etc. |  |  |
| Total |  | 95% or More |

**Proposed Location (2nd Full Year of Operation) Year \_\_\_\_\_\_\_\_\_ Beginning Month \_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Service Area ZIP Codes** | **Projected Utilization-ZIP Code Patients** | **% of Total Projected Patients** |
| ZIP Code #1 |  |  |
| ZIP Code #2 |  |  |
| Etc. |  |  |
| Total |  | 95% or More |

**3E. Payor Mix**

List the provider’s participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients that are currently being served at the current location. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the second full year of new proposed location by completing the table below.

**Payor Mix, Current Location (Latest Full Year) Year \_\_\_\_\_\_\_\_\_ Beginning Month \_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Payor Source** | **Gross Operating Revenue** | **% of Total** |
| Medicare/Medicare Managed Care |  |  |
| TennCare/Medicaid |  |  |
| Commercial/Other Managed Care |  |  |
| Self-Pay |  |  |
| Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Total |  |  |
| Charity Care |  |  |

**Payor Mix, Proposed Location (2nd Full Year of Operation) Year \_\_\_\_\_\_\_\_ Beginning Month \_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Payor Source** | **Gross Operating Revenue** | **% of Total** |
| Medicare/Medicare Managed Care |  |  |
| TennCare/Medicaid |  |  |
| Commercial/Other Managed Care |  |  |
| Self-Pay |  |  |
| Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Total |  |  |
| Charity Care |  |  |

**4E. Publication**

A proof of publication of notice of the exemption request is required in a newspaper of general circulation in both the county of the existing facility or service and the county where the service or facility is to be relocated.

**Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.**