

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

Request # _____
Date Rec. _____
Received by: _____

**REQUEST FOR DETERMINATION OF EXEMPTION STATUS
FOR REPLACEMENT OF EXISTING EQUIPMENT**

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

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

DESCRIPTION OF EQUIPMENT TO BE REPLACED DESCRIPTION OF PROPOSED NEW EQUIPMENT

A. Manufacturer:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Serial #

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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:

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:

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) times 1% (the application fee for a Certificate of Need); 20% of this amount is the application fee for non-rural hospitals.

For rural hospitals, the application fee is 25% of the application fee as calculated above for non-rural hospitals.

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)