

NOTICE OF INTENT

TO ESTABLISH A NEW HEALTH FACILITY OR AGENCY

This is not an application for licensing. The Department will use this information to assist you in the development of your project and to expedite the application process.

A. PROJECT NAME (NOT REQUIRED IF NOT KNOWN):

Proposed Name

Telephone #

Address

B. CONTACT (OWNER):

Name

Telephone #

Mailing Address

C. MANAGEMENT GROUP (IF APPLICABLE):

Name

Telephone #

Mailing Address

D. CHECK THE FACILITY OR SERVICE YOU INTEND TO PROVIDE:

- | | | | |
|--------------------------------------------------------|----------------|----------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Birthing Center | Capacity _____ | <input type="checkbox"/> Small Health Care Facility - Type 'N' | Capacity _____ |
| <input type="checkbox"/> Ambulatory Surgical Center | Capacity _____ | <input type="checkbox"/> Abortion Clinic | |
| <input type="checkbox"/> End Stage Renal Dialysis | Capacity _____ | <input type="checkbox"/> Hospital | |
| <input type="checkbox"/> Small Health Care Facility | Capacity _____ | <input type="checkbox"/> Home Health Agency | |
| <input type="checkbox"/> Nursing Care Facility | Capacity _____ | <input type="checkbox"/> Home Health Agency - Personal Care | |
| <input type="checkbox"/> Assisted Living - Type I | Capacity _____ | <input type="checkbox"/> Hospice | <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient |
| <input type="checkbox"/> Assisted Living - Type II | Capacity _____ | | |
| <input type="checkbox"/> Mammography | | | |
| <input type="checkbox"/> Satellite - Describe Services | | | |
| <input type="checkbox"/> Other | | | |

E. WHAT DO YOU PLAN TO DO? (Check all that apply) ✓

- Construct a new building Modify a building
 Other

F. IF APPLICABLE, LIST PROJECT ARCHITECT

Name

Telephone #

Mailing Address

G. WHAT IS THE ANTICIPATED OPENING DATE?