

APPENDIX A

**ALABAMA CERTIFICATE OF NEED  
APPLICATION FOR PROVIDERS OF  
IN-HOME HOSPICE SERVICES LICENSED BY ALABAMA DEPARTMENT  
OF PUBLIC HEALTH, WHO HAD NOT PROVIDED SERVICE  
BY MAY 13, 2009, OR DURING THE PRECEDING TWELVE MONTHS**

For Staff Use Only

INSTRUCTIONS: Please submit an original and twelve (12) copies of this form and the appropriate attachments to the State of Alabama, State Health Planning and Development Agency, 100 North Union Street, Suite 870, Montgomery, Alabama 36104 (Post Office Box 303025, Montgomery, AL 36130-3025)

Project # \_\_\_\_\_  
Date Rec. \_\_\_\_\_  
Rec by: \_\_\_\_\_

Attached is a check in the amount of \$250.00  
Refer to Emergency Rule 410-1-5C-.02ER of the *Alabama Certificate of Need Program Rules and Regulations* to determine the required filing fee.

**I. APPLICANT IDENTIFICATION AND PROJECT DESCRIPTION**

A. \_\_\_\_\_  
Name of Applicant (in whose name the CON will be issued if approved) Medicare Provider #

Address City County

State Zip Code Phone Number

B. \_\_\_\_\_  
Name of Facility/Organization (if different from A)

Address City County

State Zip Code Phone Number

C. \_\_\_\_\_  
Name of Legal Owner (if different from A or B)

Address City County

State Zip Code Phone Number

D. \_\_\_\_\_  
Name and Title of Person Representing Proposal and with whom SHPDA should communicate

Address City County

State Zip Code Phone Number

\_\_\_\_\_  
E-Mail Address

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**I. APPLICANT IDENTIFICATION** (continued)

E. Have changes occurred in the ownership type of this provider since the filing of the previous Certificate of Need (CON) application to provide in-home hospice services? If so, attach a separate sheet identifying the change in ownership type.

Yes             No

F. Have changes occurred in the governing board members and owners of this provider since the filing of the previous CON application to provide in-home hospice services? If so, attach a separate sheet identifying the current governing board members and owners.

Yes             No

**II. PROJECT DESCRIPTION**

A. Certificate of Need number \_\_\_\_\_ was issued on \_\_\_\_\_ for the provision of in-home hospice services in the following counties:<sup>1</sup>

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Copies of Letter(s) of Non-Reviewability granted under Ala. Code § 22-21-29(d) (1975) associated with this Medicare Provider Number, under which this application is submitted, and for which CON authority has not been previously granted, are attached. Additional counties requested to be included in the referenced CON authorization and in which service had not been provided by May 13, 2009, or during the preceding twelve (12) months, are listed below. Please also attach a copy of the Alabama Department of Public Health (ADPH) licenses encompassing each such county.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. Evidence of Continuing Ability to Meet Licensure Standards:

1. Has the applicant received pending notice of license revocation, probation or non-renewal of licensure from the ADPH relating to its in-home hospice operations?

Yes             No

<sup>1</sup> Pursuant to Ala. Admin. Code r. 410-2-3-.10(6)(f)3., for purposes of this application, an entity shall be considered a separate hospice provider for purposes of each Medicare Provider Number held.

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If yes, please describe the nature of such notice in a separate attachment (with appropriate redaction of patient information, as needed).

2. Are the quality of care and compliance programs outlined in the previous CON application filed for in-home hospice services still in effect? If not, attach a separate sheet identifying changes occurring since the filing of the previous CON application.

Yes             No

- D. Applicant is the sole hospice provider under common control applying for such counties.

Yes             No

### III. COST

By checking yes, the Applicant confirms that it will not incur capital expenditures in excess of \$500,000 associated with this project.

Yes

### IV. ACKNOWLEDGEMENT AND CERTIFICATION BY THE APPLICANT

- I. **ACKNOWLEDGEMENT.** In submitting this application, the Applicant understands and acknowledges that:

A. The rules, regulations and standards for health facilities and services promulgated by the SHPDA have been read, and the Applicant will comply with same.

B. Upon the granting of a CON pursuant to this application, and licensure by the ADPH, the Applicant shall agree to provide services only in the counties encompassed by the CON, which shall result in the automatic vesting of the CON.

C. Applicants seeking a CON herein under the non-substantive review procedures authorized by Ala. Admin. Code r. 410-2-3-.10(6)(f)3. shall be granted a single CON encompassing all of the counties proposed to be served under a single Medicare Provider Number. Such CON authority may not be subsequently divided, e.g., a hospice provider may not separate such authority into separate CONs for future disposition. Any action to transfer or assign the certificate in violation of this or any other restriction found in Alabama law or the SHPDA rules will render it null and void.

D. Pursuant to Ala. Admin. Code r. 410-2-3-.10(6)(f)5., the granting of a CON under this provision shall be conditioned on timely compliance with any data request issued on an annual basis by the SHPDA staff in conjunction with the adoption of long-term need methodology.

E. Pursuant to Ala. Admin. Code r. 410-2-3-.10(6)(f)5., a hospice services provider that obtains a CON and subsequently fails to substantially comply on a timely basis (subject to any authorized extensions) to an annual data request from the SHPDA staff adopted in conjunction with long-term need methodology shall be assumed to have ceased operations as of the end of such period until the provider complies fully with all outstanding SHPDA data requests. Any provider that has deemed to have ceased operations under such provision shall be prohibited from submitting any CON application for additional authority or from seeking consideration by SHPDA of such facility's utilization data to oppose another provider's CON application. In accordance with Ala. Admin. Code r. 410-1-11-.08(2), should such cessation of operation continue for an uninterrupted period of twelve (12) months or longer, the provider's CON shall be deemed abandoned. SHPDA

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shall report to the ADPH any provider who is deemed to have abandoned its CON under this section.

- F. **The Applicant will notify SHPDA when a project is started, completed, or abandoned.**
- G. The Applicant must comply with all state and local building codes, and failure to comply will render the CON null and void.
- H. The Applicants and their agents will construct and operate in compliance with appropriate state licensure rules, regulations, and standards.
- I. Projects are limited to the work identified in the CON as issued.
- J. Any expenditure in excess of the amount approved on the CON must be reported to SHPDA and may be subject to review.
- K. The Applicant will comply with all state statutes for the protection of the environment.
- L. The Applicant was licensed by the ADPH to provide in-home hospice services in a county based upon a Letter(s) of Non-Reviewability issued by SHPDA under ALA. CODE § 22-21-29(d) (1975 as amended) listing said county, but had not provided service therein by May 13, 2009, or during the preceding twelve (12) months.
- M. The Applicant is not presently operating with a probational (except as may be converted by this application) or revoked license.

**II. CERTIFICATION**

The information contained in this application is true and correct to the best of my knowledge and belief, and I agree to be bound by the restrictions contained herein.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Applicant's Name and Title  
(Type or Print)

\_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Alabama Notary Public (Affix seal on Original)

**Author:** Alva M. Lambert

**Statutory Authority:** § 22-21-267, 271, 275, Code of Alabama, 1975

**History:** Adopted, March [ ], 2010