REQUEST FOR DETERMINATION OF EXEMPTION STATUS FOR REPLACEMENT OF EXISTING EQUIPMENT

Request #: _____
Date Rec. _____
Received by: _____

Instructions: Please submit an original and two (2) copies of this form and the appropriate attachments to:

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

Attached is a check in the amount of: $_____

I. 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

II. 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 and 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:

II. DESCRIPTION OF EQUIPMENT TO BE REPLACED DESCRIPTION OF PROPOSED NEW EQUIPMENT (Continued)

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) by 1%.
Multiply this sum times 10% for the application fee.

The maximum fee is $12,000 (indexed), or a maximum of $4,000 if the applicant has had an average daily census comprised of 50% or more Medicaid patients within the last year prior to the filing of this request. A rural hospital will not be required to submit an application fee.

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)