

# APPLICATION FOR CERTIFICATE OF NEED

## ACQUISITION OF EQUIPMENT

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1. Name of Facility: \_\_\_\_\_

2. Address: \_\_\_\_\_  
Street City County Zip

3. Person Responsible for the Project: \_\_\_\_\_  
Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_  
email: \_\_\_\_\_

4. If the applicant is a group or partnership (or a member of one), attach a list of the names of the members and the specialties of each. Identify those members who will be directly involved in the professional use of the proposed piece of equipment.

### **DESCRIPTION OF PROJECT**

5. Attach a narrative description of the proposed project. Specify the anticipated manufacturer, model and cost.

6. Indicate the anticipated start date for offering of services. \_\_\_\_\_.

### **NEED DETERMINATION**

7. Attach a statement describing what you consider to be the geographical service area for this project. Also attach a statement describing what you identify to be the existing target patient population for this project in the area described.

8. Attach a table or statement indicating your number of patients related to the service to be provided by the proposed project, by patient origin (county of residence):

- For each of the three most recent years; and
- For each of the three years after the service is offered. (Include a list of assumptions used in this forecast and support for the assumptions).

9. Attach a statement describing the need for the proposed project, and the need of the population served or to be served by this project. Indicate the methodology, assumptions and data used in your determination.

10. Attach a statement describing any provision made for future expansion either in this acquisition or in existing facilities and/or equipment.

11. If the proposed project involves replacement equipment, attach a statement describing the age, condition, life expectancy and intended use or disposition of the equipment being replaced.
12. On an attachment, list the names and addresses of other affected or potentially affected provides of the service similar to the one for which you are seeking a certificate of need and serving the patient population(s) identified in Question #7. For each of these providers, specify the following data and describe your efforts to obtain it.
  - a. Relevant historical utilization data for each of the three (3) most recent years; and
  - b. Relevant expected utilization data for each of the three (3) years following offering of the service.
13. Attach a statement describing what arrangements between your facility and other health care facilities have been made or proposed to refer patients, share services and coordinate programs related to the proposed project.

#### **AVAILABILITY OF PERSONNEL**

14. Attach a statement describing in detail any changes in staffing produced by this project. If additional personnel will be needed as a result of the proposed project, attach a statement describing either what evidence there is that these personnel will be available or the plans you have for recruiting them.
15. Attach a statement describing the training and experience of the personnel who will make professional use of the proposed piece of equipment.

#### **FINANCIAL FEASIBILITY**

16. Attach a statement indicating the manner of acquisition, the estimated purchase price of the equipment or fair market value if leased, and the estimated useful life.
17. Attach a schedule of leases, if any, associated with the proposed project. Indicate the term of lease, yearly lease payment, any prepayments, and if the lease is renewable or if there is a purchase option.
18. Indicate the amounts for project financing by the following breakdown. Attach a description of asterisked items.



**CERTIFICATION**

I, the undersigned, certify that:

I have read Chapter 135.61-83, Code of Iowa and the Administrative Rules (IAC 641—202 and 203) promulgated pursuant thereto, and

I have read this application, including all exhibits and attachments, and the information therein is, to the best of my knowledge and belief, accurate and true.

\_\_\_\_\_  
Signature of Owner or  
Chairperson, Board of Directors

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Position or Title

\_\_\_\_\_  
Date

If you wish to designate an official representative to act on your behalf, as addressee for written notifications and to speak for you before the Health Facilities Council, specify below:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_