

**Certificate of Need Application
Ambulatory Surgical Facility/Ambulatory Surgical Center Exemption**

(Do Not Use this form for any other type ASC project)

To be accepted Certificate of Need applications must include the appropriate fee (WAC 246-310-990.)

This is an application for a Certificate of Need under state law and rules. (RCW Chapter 70.38 and WAC 246-310). I hereby certify that the statements in this application are correct to the best of my knowledge and belief. I understand that any misrepresentation, misleading statements, evasion, or suppression of material fact in this application may be used to take actions identified in WAC 246-310-500.

My signature authorizes the Department of Health to verify any responses provided. The department will use such information as appropriate to further program purposes. The department may disclose this information when requested by a third party to the extent allowed by law.

Applicants(s)

Physician Practice or Group Practice Information:

Ambulatory Surgery Center/Facility:

Name of Physician Practice or Group Practice:

Name of Ambulatory Surgery Facility/Center:

Practice Address:

Address of Ambulatory Surgery Center/Facility:

Uniform Business Identifier Number (UBI#):

Uniform Business Identifier Number (UBI#):

Federal Tax ID (FEIN) #:

Federal Tax ID (FEIN) #:

Name and Title of Responsible Officer: **(Print)**

Name and Title of Responsible Officer: **(Print)**

Signature of Responsible Officer

Signature of Responsible Officer

Date:

Date:

Phone (enter 10 digit #):

Phone (enter 10 digit #):

Application Instructions

Ambulatory Surgical Facility/Ambulatory Surgical Center Exemption

The department will use the information in your application to determine if your project is exempt from Certificate of Need review.

Please note the following definition:

"Ambulatory surgical facility" means any freestanding entity, including an ambulatory surgery center (ASC) that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization. This term also includes an ASC that is licensed under a hospital's license but located outside of the hospital's main facility.

This term does not include a facility in the offices of private physicians or dentists, whether for individual or group practice, if the privilege of using such facility is not extended to physicians or dentists outside the individual or group practice. (WAC 246-310-010(5))

"Person" means an individual, a trust or estate, a partnership, any public or private corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.

Application Submission:

Number of Copies:

- Submit an **original and an electronic (pdf) version**
- All subsequent submissions associated with this application must be submitted with an **original and an electronic (pdf) version**.

To be accepted, the application must include:

- A completed and signed Certificate of Need application face sheet
- The review fee of **\$1,925**. Make check payable to **Department of Health**

Send application to:

Mailing Address:

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

Physical Address:

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, Washington 98501

If you have questions, call (360) 236-2955

1. Address of your clinical practice. If you have more than one practice site, please list all sites. Attach additional pages as necessary.

2. Please describe the services provided at each practice site. Attach additional pages as necessary.

3. Is your clinical practice a solo practice? group practice? other?

4. If you checked “**group practice**” in question 3, please provide a copy of the group practice agreement.

5. If you checked “**Other**” in question 3, please describe the organizational structure of clinical practice.

6. Identify persons having an ownership in the clinical practice and their respective ownership percentage(s).

Name	Percent Ownership

7. List **all** the physicians proposed to use the ASC and indicate whether they are a member/partner of the group clinical practice, employed by the clinical practice, or other. If other, describe the arrangement. Attach additional pages as necessary.

Name of Physician	Member/Partner	Employed by practice	Other

8. For each physician identified in question 7 as being employed by the clinical practice, please provide the following information:

Name of Physician	Percent of Time Employed by Applicant's Practice (i.e. 25%, 50%, or 100%)	Name of any other practice the physician is employed by	Percent of Time the Physician is employed by the other practice(s)

9. Do any physicians listed in question 7 above have other practice sites not included in questions 1 or 7 above? Yes _____ No _____

10. If the answer to question 9 above is **yes**, please list those sites and provide the following for each of those sites. Attach additional pages as necessary.

Name of Physician	Other Practice Site(s)	Percent of Time the Physician conducts business at the other practice site(s)	Description of Services Provided At Other Practice Site(s)

11. Address of the proposed ASC:

12. Describe the location of the proposed ASC in comparison to the location of the clinical practice. (Examples include: in the same building; in a separate building; within the office suites of the clinical practice).

13. Will the ASC be a separate legal entity from the clinical practice? Yes _____ No _____

14. If **yes** to question 13, identify the legal structure of the ASC. Attach additional pages as necessary.

15. Will the proposed ASC be operated under a management agreement? Yes _____ No _____

16. If the answer to question 15 above is **yes**, provide a copy of the management agreement (either executed or draft).

17. Identify the types of procedures to be performed at the ASC? Attach additional pages as necessary

18. Will a facility fee be charge for each procedure? Yes_____ No_____ Combination_____

19. If the answer to 18 is “**combination**,” please identify which procedures will be charged a facility fee.

20. Identify all persons having an ownership in the ASC and their respective ownership percentage(s).

Name	Percent Ownership

21. Will this ASC be operated under a timeshare agreement with any other ASC? Yes_____ No_____

22. If **yes** to question 21 above, please identify the other ASC or ASCs that will be a party to the timeshare agreement.

23. Please provide a copy the timeshare agreement. (A draft is acceptable, however, if the department determines the ASC as proposed is exempt, an executed copy of the timeshare agreement must be provided to the department prior to commencing operation of the ASC.) Please note, any timeshare

agreement must include the day(s) and time(s) each ASC identified in question 22, has or will have exclusive use of the ASC.