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Initials _____

**WASHINGTON STATE CERTIFICATE OF NEED PROGRAM
RCW 70.38 AND WAC 246-310**

**APPLICATION FOR CERTIFICATE OF NEED HOME HEALTH CARE PROJECTS
(Excludes amendments)**

Certificate of Need applications must be submitted with a fee in accordance with the instructions on page 2 of this form.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310 adopted by the Washington State Department of Health. I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer: Date:	Person To Whom Questions Regarding This Application Should Be Directed: Telephone Number:
Legal Name of Applicant: Address of Applicant: Telephone Number:	Type of Project (check all that apply): <input type="checkbox"/> New Agency <input type="checkbox"/> Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County <input type="checkbox"/> Existing Licensed-Only Home Health Agency to Become Medicare Certified/Medicaid Eligible.
Project Summary: Estimated capital expenditure: \$ _____	

INSTRUCTIONS FOR SUBMISSION:

1. Mail an original and one copy of the completed application, with narrative portion to:

Physical Address:

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

To mail overnight, UPS or FedEx

**Department of Health
Certificate of Need Program
310 Israel Road SE
Olympia, Washington 98501**

The application must be accompanied by a check, payable to: *Department of Health.*

2. COMPLETE THE FOLLOWING PRIOR TO SUBMISSION FOR REVIEW:

TOTAL AMOUNT OF FEE ACCOMPANYING THIS APPLICATION:

REVIEW FEE: \$ 21,001

APPLICANT NAME: _____

APPLICATION INFORMATION INSTRUCTIONS:

These application information requirements are to be used in preparing a Certificate of Need application. The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 70.38.115 and WAC 246-310-210, 220, 230, and 240.

- The application is to be submitted together with a completed, signed Certificate of Need application face sheet and the appropriate review and processing fee. Please send an original and one copy to:

Physical Address:

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

To mail overnight, UPS or FedEx

**Department of Health
Certificate of Need Program
310 Israel Road SE
Olympia, Washington 98501**

- Please note that a **Letter of Intent** must be submitted for all projects, within a minimum of 30 days and a maximum of 6 months, prior to submission of the application. If a Letter of Intent is not received prior to application submission, the department will consider the application the Letter of Intent and no further action will be taken until the end of the 30 day Letter of Intent period.
- Please make the narrative information complete and concise. Data sources are to be cited Extensive supporting data, that tends to interrupt the narrative, should be placed in the appendix.
- DO NOT bind the application.
- Please number **ALL** pages consecutively.
- All cost projections are to be in non-inflated dollars. Use the current year dollar value for all program data and projections. **DO NOT** inflate these dollar amounts.
- Capital expenditures should not include contingencies. Certificate of Need statutes and regulations allow a 12 percent or \$50,000.00 (*whichever is greater*) margin before an amendment to an approved Certificate is required.
- All subsequent correspondence in relation to the application must be submitted with an original and one copy.

Please contact Facilities and Services Licensing, Department of Health, for information on licensure requirements.

I. APPLICANT DESCRIPTION:

A. Provide the legal name(s) of applicant(s).

Note: The term "applicant" for this purpose is defined as any person or individual with a ten percent or greater financial interest in a partnership or corporation or other comparable legal entity that engage in any undertaking which is subject to review under provisions of RCW 70.38.

B. For each licensed applicant, please provide the professional license number and specialty represented. If the license was not issued by Washington State, please identify the state it was issued.

C. For existing facilities, provide the name and address of the facility.

Note: The term "existing facility" for this purpose is defined as a home health agency that is currently providing licensed only home health care services OR a home health agency that is seeking to expand its Medicare certified service area.

D. Identify the type of ownership (public, private, corporation, non-profit, etc.).

E. Provide the name and address of *owning* entity at completion of project (unless same as applicant).

F. Provide the name and address of *operating* entity at completion of project (unless same as applicant).

G. Identify the corporate structure and related parties. Attach a chart showing organizational relationship to related parties.

H. Provide a general description and address of each facility and other related business (es) owned and/or operated by applicant (include out-of-state facilities, if any).

I. For existing facilities, identify the geographic primary service area.

J. Identify the facility licensure/accreditation status.

K. Is the applicant reimbursed for services under Titles XVIII, and XIX of Social Security Act?

L. If applicable, identify the medical director and provide his/her professional license number, and specialty represented.

M. If applicable, please identify whether the medical director is employed directly by or has contracted with the applicant. If services are contracted, please provide a copy of the contract.

N. For existing facilities, please provide the following information broken down by discipline (i.e., RN/LPN, OT, PT, home health aide, social worker, etc.) for each county currently serving:

1. Total number of home health *visits* per year for the last three years; and
2. Total number of unduplicated home health *patients* served per year for the last three years.

II. PROJECT DESCRIPTION

Include the following elements in the project description. An amendment to a Certificate of Need is required for certain project modifications as described in WAC 246-310-100(1).

- A. Provide the name and address of the proposed facility.
- B. Describe the project for which Certificate of Need approval is sought.
- C. List new services or changes in services represented by this project. In the following table, please indicate (by marking an 'X' in the appropriate column) which services would be provided directly by the agency and which services would be contracted.

	Direct	Contracted
Skilled Nursing		
Physical Therapy		
Occupational Therapy		
Speech Therapy		
Medical Social Work		
Home Health Aide		
Medical Director		
Respite Care		
IV Therapy		
Other (list):		

- D. General description of types of patients to be served by the project.
- E. List the equipment proposed for the project:
 1. Description of equipment proposed; and
 2. Description of equipment to be replaced, including cost of the equipment, disposal, or use of the equipment to be replaced.
- F. Provide drawings of proposed project:
 1. Single line drawings, *approximately to scale*, of current locations which identify current department and services; and
 2. Single line drawings, *approximately to scale*, of proposed locations which identify proposed services and departments; and
 3. Total net and gross square feet of project.
- G. Identify the anticipated dates of both commencement and completion of project.
- H. Describe the relationship of this project to the applicant's long-range business plan and long-range financial plan (if any).
- I. Provide documentation that the applicant has sufficient interest in the site or facility proposed. "*Sufficient interest*" shall mean any of the following:
 1. Clear legal title to the proposed site; or
 2. A lease for at least one year with options to renew for not less than a total of three years; or
 3. A legally enforceable agreement (i.e., draft detailed sales or lease agreement, executed sales or lease agreement with contingencies clause) to give such title or such lease in the event that a Certificate of Need is issued for the proposed project.

III. PROJECT RATIONALE

Please address each county proposing to be served separately.

A. Need (WAC 246-310-210)

1. Identify the proposed geographic service area.
2. If the proposed service area is designated as a Medically Underserved Area (MUA) as defined by HCFA or a Health Professional Shortage Area (HPSA), please provide documentation verifying the designation.
3. Identify and analyze the unmet home health service needs and/or other problems toward which this project is directed.
 - A. Identify the unmet home health needs of the patient population in the proposed service area(s). *Note that the unmet patient need should not include physical plant deficiencies and/or increase facility operating efficiencies.*
 - B. Identify the negative impact and consequences of unmet home health needs and deficiencies.
4. Define the types of patients that are expected to be served by the project. The types of patients expected to be served can be defined according to specific needs and circumstances of patients (i.e., culturally diverse, limited English speaking, etc.) or by the number of persons who prefer to receive the services of a particular recognized school or theory of medical care.
5. For existing facilities, include a patient origin analysis for at least the most recent three-month period, if such data is maintained, or provide patient origin data from the last statewide patient origin study. Patient origin is to be indicated by zip code. Zip codes are to be grouped by city and county, and include a zip code map illustrating the service area.
6. For existing facilities, please identify the number of patients currently receiving skilled services, broken down by type(s) of services (i.e., skilled nursing).
7. Please provide utilization forecasts for the following, broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) for each county proposing to serve:
 - A. Total number of home health *visits* per year for the first three years; and
 - B. Total number of unduplicated home health *patients* served per year for the first three years.
8. Provide the complete step-by-step quantitative methodology used to construct each utilization forecast. All assumptions related to use rate, market share, intensity of service, and others must be provided.
9. Provide detailed information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on other facilities and services which "*compete*" with the applicant.

- a. Identify all existing providers of services (licensed only and certified) similar to those proposed and provide utilization experience of those providers that demonstrates that existing services are not available to meet all or some portion of the forecasted utilization.
 - b. If existing services are available, demonstrate that such services are not accessible. Unusual time and distance factors, among other things, are to be analyzed in this section.
 - c. If existing services are available and accessible, justify why the proposed project does not constitute an unnecessary duplication of services.
10. Document the manner in which low-income persons, racial and ethnic minorities, women, people with disabilities, and other under-served groups will have access to the services proposed.
11. Please provide copies (draft is acceptable) of the following documents:
- a. Admissions policy; and
 - b. Charity care policy; and
 - c. Patient referral policy, if not addressed in admissions policy.
12. As applicable, substantiate the following special needs and circumstances that the proposed project is to serve.
- a. The special needs and circumstances of entities such as medical and other health professions' schools, multi-disciplinary clinics, and specialty centers that provide a substantial portion of their services, resources, or both, to individuals not residing in the health services areas in which the entities are located or in adjacent health services areas.
 - b. The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.
 - c. The special needs and circumstances of osteopathic hospitals and non-allopathic services with which the proposed facility/service would be affiliated.

B. Financial Feasibility (WAC 246-310-220)

WAC 246-310-990(2) defines “total capital expenditure” to mean the total project costs to be capitalized according to generally accepted accounting principles. These costs include, but are not limited to, the following: legal fees; feasibility studies; site development; soil survey and investigation; consulting fees; interest expenses during construction; temporary relocation; architect and engineering fees; construction, renovation, or alteration; total costs of leases of capital assets; labor; materials; fixed or movable equipment; sales taxes; equipment delivery; and equipment installation.

1. If applicable, provide the proposed capital expenditures for the project. These expenditures should be broken out in detail and account for at least the following:
 - Land acquisition;
 - Site survey, tests, and inspections
 - Construction contract;
 - A financial feasibility study, architectural fees/engineering fees/consulting fees;
 - Fixed equipment (not in construction contract);
 - Movable equipment;
 - Freight and delivery charges;
 - Sales tax;
 - Cost of tuning up and trial runs;
 - Reconditioning costs (in case of used asset);
 - Cost of title investigations, legal fees, brokerage commissions;
 - Other activities essential to the acquisition, improvement, expansion, or replacement of plant and equipment due to the project; and
 - Financing cost statement, including interim interest expense, reserve account, interest expense, and other financing costs.
2. Explain in detail the methods and sources used for calculating estimated capital expenditures.
3. Document the project impact on: (a) Capital costs (b) Operating costs and charges for health services.
4. Provide the total estimated operating revenue and expenses for the first three years of operation (*please show each year separately*) for the items on the following page, as applicable. **Include all formulas and calculations used to arrive at totals on a separate page.**

Revenue

Medicare
Medicare Managed Care
Medicaid
Healthy Options [BHP]
Private Pay
Third Party Insurance
Other [CHAMPUS, Veterans, etc.]
Non-operating Revenue [United Way, etc.]
Deductions from Revenue:

(Charity)
(Provision for Bad Debt)
(Contractual Allowances)

Expenses

Advertising
Allocated Costs
B & O Taxes
Depreciation and Amortization
Dues and Subscriptions
Education and Training
Employee Benefits
Equipment Rental
Information Technology/Computers, Repairs and Maintenance
Insurance, Payroll Taxes
Interest, Purchased Services (utilities, other)
Legal and Professional
Licenses and Fees, Rental/Lease
Medical Supplies, Travel (patient care, other)
Salaries and Wages (DNS, RN, OT, clerical, etc.)
Postage, Supplies and Telephone/Pagers

5. Please note: according to revised HCFA regulations, home health agencies must have enough reserve funds (determined by an authorized fiscal intermediary) to operate for three months after becoming Medicare/Medicaid certified. Please provide the following information in relation to this requirement:
 - A. Provide the name and address of the fiscal intermediary you will be using to determine capitalization; and
 - B. Provide a copy of the forms you are providing to the fiscal intermediary.
6. Identify the source(s) of financing (*loan, grant, gifts, etc.*) for the proposed project. Provide all financing costs, including reserve account, interest expense, and other financing costs. If acquisition of the asset is to be by lease, copies of any lease agreements, and/or maintenance repair contracts should be provided. The proposed lease should be capitalized with interest expense and principal separated. For debt amortization, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.
7. Provide documentation that the funding is, or will be, available and the level of commitment for this project.
8. Provide a cost comparison analysis of the following alternative financing methods: purchase, lease, board-designated reserves, and interfund loan or bank loan. Provide the rationale for choosing the financing method selected.
9. Provide a pro forma (projected) balance sheet and expense and revenue statements for the first three years of operation.
10. Provide a capital expenditure budget through the project completion and for three years following completion of the project.
11. Identify the expected sources of revenue for the applicant's total operations (e.g., Medicare, Medicare Managed Care, Medicaid, Healthy Options, Blue Cross, Labor and Industries, etc.) for the first three years of operation, with anticipated percentage of revenue from each source. Estimate the percentage of change per year for each payer source.
12. If applicant is an existing provider of health care services, provide expense and revenue statements for the last three full years.
13. If applicant is an existing provider of health care services, provide cash flow statements for the last three full years.
14. If applicant is an existing provider of health care services, provide balance sheets detailing the assets, liabilities, and net worth of facility for the last three full *fiscal* years.
15. For existing providers, provide actual costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source for each county proposing to serve.
16. Provide anticipated costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source for each county proposing to serve.
17. Indicate the addition or reduction of FTEs with the salaries, wages, and employee benefits for each FTE affected, for the first three years of operation. Please list each discipline separately.

18. Please describe how the project will cover the costs of operation until Medicare reimbursement is received. Provide documentation of sufficient reserves.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

1. Please provide the current and projected number of employees for the proposed project, using the following:

Staff	Current FTE		Year 1		Year 2		Year 3	
	FTE	Contracted	FTE	Contracted	FTE	Contracted	FTE	Contracted
RN								
LPN								
HH Aide								
NURSING TOTAL								
Admin								
Medical Director								
DNS								
Business/Clerical								
ADMIN. TOTAL								
PT								
OT								
Speech Therapist								
Med Social Work								
Other (specify):								
ALL OTHERS TOTAL								
TOTAL STAFFING								

2. Please provide your staff to visit ratio.

Type of Staff	Staff / Visit Ratio
Skilled Nursing (RN & LPN)	
Physical Therapist	
Occupational Therapist	
Medical Social Worker	
Speech Therapist	
Home Health Aide	
Other (list)	
Total	

3. Explain how this ratio compares with other national or state standards of care and existing providers for similar services in the proposed service area.
4. Identify and document the availability of sufficient numbers of qualified health manpower and management personnel. If the staff availability is a problem, describe the manner in which the problem will be addressed.

5. Please identify, and provide copies of (if applicable) the in-service training plan for staff. (Components of the training plan should include continuing education, home health aide training to meet Medicare criteria, etc.).
6. Describe your methods for assessing customer satisfaction and quality improvement.
7. Identify your intended hours of operation. In addition, please explain how patients will have access to services outside the intended hours of operation.
8. Identify and document the relationship of ancillary and support services to proposed services, and the capability of ancillary and support services to meet the service demands of the proposed project.
9. Explain the specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health service resources serving your primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.
10. Fully describe any history of the applicant entity and principles in Washington with respect to criminal convictions, denial or revocation of license to operate a health care facility, revocation of license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program. If there is such history, provide clear, cogent, and convincing evidence that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.
 - a) Have any of the applicants (see definition of applicant on page 4 of this application) been adjudged insolvent or bankrupt in any state or federal court?
 - b) Have any of the applicants been involved in a court proceeding to make judgment of insolvency or bankruptcy with respect to the applicant).
11. List the licenses and/or credentials held by the applicant(s) and principles in Washington, as well as other states, if applicable. Include any applicable license numbers.
12. Provide the background experience and qualifications of the applicant(s).
13. For existing agencies, provide copies of the last three licensure surveys as appropriate evidence that services will be provided (a) in a manner that ensures safe and adequate care, and (b) in accordance with applicable federal and state laws, rules, and regulations.

D. Cost Containment (WAC 246-310-240)

1. Identify the exploration of alternatives to the project you have chosen to pursue, including postponing action, shared service arrangements, joint ventures, subcontracting, merger, contract services, and different methods of service provision, including different spatial configurations you have evaluated and rejected. Each alternative should be analyzed by application of the following:

- Decision making criteria (*cost limits, availability, quality of care, legal restriction, etc.*):
 - Advantages and disadvantages, and whether the sum of either the advantages or the disadvantages outweighs each other by application of the decision-making criteria;
 - Capital costs;
 - Staffing impact.
2. Describe how the proposal will comply with the Medicare conditions of participation, without exceeding the costs caps.
 3. Describe the specific ways in which the project will promote staff or system efficiency or productivity.
 4. If applicable, in the case of construction, renovation, or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction. Include an inventory of net and gross square feet for each service and estimated capital cost for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.
 5. If applicable, in the case of construction, renovation or expansion, an analysis of the capital and operating costs of alternative methods of energy consumption, including the rationale for choosing any method other than the least costly. For energy-related projects, document any efforts to obtain a grant under the National Energy Conservation Act.