MISSISSIPPI STATE DEPARTMENT OF HEALTH

Certificate of Need (CON)

Progress Report/Six-Month Extension Request/Final Report

One (1) original Six Month Extension (SME) application with the Certification Page must be mailed, or hand delivered to the Mississippi State Department of Health, and a complete copy of the application and attachments should be emailed to https://heppe.com/HPRD@msdh.ms.gov. Be sure to include the following words in the subject line of the e-mail: **SME application submission.** Please provide a Table of Contents referencing the Exhibits along with dividers or tabs to distinguish the appropriate Exhibit documentation. Please provide updated details of the project and attach the previous approved SME Report with Application (if applicable).

The original application including attachments and filing fee should be mailed or hand delivered to the following address:

Division of Health Planning and Resource Development Mississippi State Department of Health - Office of Health Protection 143-B Le Fleur's Square Jackson, MS 39211

Note: (CONFIDENTIAL Information)

If the CON Application contains information deemed CONFIDENTIAL, please submit a statement (the statement must provide an explanation as to why the applicant considers the information specified to be deemed CONFIDENTIAL); clarifying why the allocated information is deemed CONFIDENTIAL.

CONFIDENTIAL information must be submitted under a separate cover, isolated from the CON application.

Note: ALL Six- Month Extensions must be received thirty (30 Days Prior to Expiration Date)

Rej	port/	Request Type: [] Six-Month Progress Report (\$1,000.00 Filing Fee)				
		[] Six-Month Extension Request (\$2,500.00 Filing Fee)				
		[] Final Report (\$1,000.00 Filing Fee)				
1.	co	N Information				
	a.	CON Review #: CON#:				
	b.	Facility Name:				
	c.	Project Title:				
	d.	Effective Date: Expiration Date:				
	e.	Current Extension Period Expiration Date:				
	f.	CON Holder Name:				
		Address:				

		_			
g.	CON C	ontact Person:			
		Address:			
		Telephone:			
		Email Address:			
h.	Attach a	a photocopy of the or	iginal Certifica	ate of Need.	
i.	Capital	Expenditure Autho	orized:	\$	
j.	Capital	Expenditure Made	to Date:	\$	
	cumenta dertaken		ent of Constr	ruction or Other Preparation Substantially	
A.	Describe any changes in the individual business or corporate officers and directors since the original approval.				
В.	Describe any agreements in existence, being planned, or that have occurred since original approval Attach a copy of current partnership agreement or articles of incorporation, if different from that provided in the original application.				
C.	C. Provide documentation for activities accomplished during the pre-construction phase of the projection including, but not limited to, the following:				
	1.	Acquisition of land/	property (title	e, evidence of payment, etc.).	
	2.	Completion of topo			
	3.	Site preparation (co	ntractor selecti	ion, contract, evidence of payment, etc.)	
	4.	Completion of site of	levelopment p	lan(s)	
	5.	statement of partial to Health Facilities	completion of Licensure and	nitect selection, contract, evidence of payment, plans/drawings, letter evidencing submission of plans Certification, Division of Fire Safety, letter of findings, ions submitted; approval of commencement of	
	6.		obtained . If	not been obligated, provide evidence that permanent f financing has not been obtained, provide evidence of stitution or agency.	
D.	Provide	documentation of co	nstruction acti	vities <u>:</u>	
	1	Date construction of	ontract offered	for hid:	

2.

	2.	Date contract awarded:
	3.	Date any site preparation is estimated to be complete:
	4.	Percentage of work completed:
	5.	Estimated date of completion:
E.	If actual delay.	construction has not commenced, provide date it will commence and the reasons for the
F.	Provide equipme	documentation of activities to established services through the acquisition of capital ent:
	1.	Equipment purchase/ lease agreement.
	2.	Date contract signed between buyer and vendor:
	3.	Name of mobile equipment vendor:
	4.	Registration/serial number of mobile equipment vendor:
	5.	Date equipment is to be delivered:
	6.	Date equipment to be placed in service:
	7.	Have there been any changes in funding sources? [] Yes [] No
		If yes, explain:
	8.	Number of procedures performed by month:
	9.	Provide evidence that the Division of Radiological Health has approved the plans for provision of radiation therapy services, if applicable.
G.		ON is for a project involving no construction, (e.g., establishment of services), please documentation including, but not limited to, the following:
	1.	Hiring or entering contracts with necessary staff/medical professionals to provide service
	2.	Estimated date that any new staff required will be hired:
	3.	Estimated date any new service will be available to public:
	4.	Submission of a fire/life safety code inspection request.
	5.	Submission of an application for facility inspection/licensure of service.

H. Complete and sign the attached Certification page.

CERTIFICATION

STATE OF MISSISSIPPI COUNTY OF		
I (we) do solemnly swear or affirm on b, after diligent researcontained in this foregoing Progress Report/Sixthe best of my (our) knowledge and belief. I (we) will rely on this information and material in ma Certificate of Need, and if it finds that the report Department may refrain from further review of understood that if the Certificate of Need is extendertificate may be revoked, canceled, or rescinded its findings were based on evidence, not true, fac	ch, inquiry and study, that Month Extension Request understand that the Mississ king its decision as to the transfer contains distorted the report/request and coded based upon the evidence of the Mississippi State D	ippi State Department of Health granting of an extension of the facts or misrepresentation, the nsider it rejected. It is further e contained in this request, such
I (we) certify that no revision or alteration prior written consent of the Mississippi State I Mississippi State Department of Health a progre proposal every six (6) months until the project is	Department of Health and ss report and/or a request for	that I (we) will furnish to the
Signature	Signature	
Title	Title	
	Name of Facility	
Sworn to and subscribed before me, this the	day of	, 20
	Notary Public	
My Commission Expires		