



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

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Division of Health Planning
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2009 DCH PROGRAM NARRATIVE FORM

PLEASE PRINT OR TYPE ALL INFORMATION

FAILURE TO FILL IN ALL ITEMS WILL DELAY ACCEPTANCE OF FINAL PLANS FOR REVIEW AND APPROVAL.

Date Submitted: _____

PLANS WILL NOT BE LOGGED IN FOR REVIEW PRIOR TO any required CON, LNR OR DET APPROVAL.

Facility Name: _____

Project Name: _____

DCH Project Authorization: (Include copy of approval with drawings submitted for final approval)
(If Required)

CON Project Number/Date Issued _____

DET Request/Date Issued _____

LNR/Date Issued _____

If a CON, DET or LNR is not required by the Georgia Department of Community Health please describe the project below:

Estimated Construction Cost: _____

Estimated Equipment Cost: _____

Estimated Start of Construction: _____

Estimated End of Construction: _____

Owners Signature:

(Not the Architect) _____
OWNER SIGNATURE

PRINT NAME

Notary statement and seal: _____

NOTARY SIGNATURE

PRINT NAME

CON = Certificate of Need and is issued to Hospitals, Nursing Homes and Ambulatory Surgery Centers.

DET = Determination Request, an official letter from DCH stating project does not require a CON.

LNR-ASC = Letter of Non-Reviewability for Physician Owned Single Specialty Ambulatory Surgery Centers with project costs less than the current CON Thresholds.

LNR-EQT = Letter of Non Reviewability for Equipment purchases less than the current CON thresholds.

DCH USE ONLY	DATE REC'D _____	PROJECT # _____
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