Text

Description automatically generated with medium confidence

Georgia Certificate of Need

Request for Letter of Determination - Equipment

|  |  |
| --- | --- |
| FOR OFFICE OF HEALTH PLANNING USE ONLY | |
| **REQUEST NUMBER**    **DET-EQT** | ***DATE STAMP*** |

**GENERAL INFORMATION:**

This Letter of Determination – Equipment (“DET-EQT”) request form is the required document that the Department reviews in the analysis and evaluation of the proposed acquisition, replacement or repair of diagnostic, therapeutic, or other imaging equipment in accordance with O.C.G.A. §§ 31-6-47(a)(10) and (28). **ALTERATIONS TO THIS FORM ARE EXPRESSLY PROHIBITED EXCEPT WHERE A RESPONSE IS REQUESTED FROM THE APPLICANT AS DENOTED BY A TEXTBOX OR CHECKBOX.**

1. **DO NOT PLACE ANY DOCUMENTS OR ATTACHMENTS IN FRONT OF THIS COVER PAGE.**
2. Requests for letters of determination must be submitted electronically at the following website: <https://dch.georgia.gov/office-health-planning-applications-and-requests-forms-0>.
3. The filing fee of $250 shall be remitted by certified check or money order made payable to the “State of Georgia Department of Community Health” or by credit/debit card via the Department’s website, as available. **A copy of the certified check or money order, or payment receipt for any credit/debit card payment, must be included with your web portal submission.**
4. The Department will make every attempt to review the information submitted and issue a letter of determination within 60 days of receipt.

|  |  |
| --- | --- |
| **PLEASE COMPLETE THE FOLLOWING TABLE TO VERIFY PROPER SUBMISSION OF YOUR REQUEST** | |
| **Requesting Party:** | |
| 1. Did you submit this form via the Department’s web portal? | **Yes**  **No** |
| 1. Have you remitted a $250.00 certified check or money order made payable to “State of Georgia Department of Community Health” or submitted a payment receipt for any credit/debit card payment along with a copy of the web portal submission confirmation form? | **Yes**  **No** |

**Instructions**

1. Please read all instructions and review this DET-EQT Request form in its entirety before attempting to complete and submit it.
2. A requesting party may submit additional information, such as a general overview of the project as **Exhibit 1**. This information may be in the form of a letter on 8 ½ by 11-inch sheets of paper.
3. This DET-EQT form **must** be typewritten or completed in this MS Word document. Handwritten responses must not be submitted and will not be accepted.
4. Throughout this DET-EQT Request form, the following symbols are utilized for emphasis:

☞ Emphasizes important instructions or notes that should be adhered to.

1. Any exhibits or appendices should be uploaded with this form.
2. Please submit the following items to the address below: a copy of the web portal submission confirmation form; and, the $250.00 filing fee in the form of a certified check or money order made payable to the “State of Georgia Department of Community Health” or a payment receipt for any credit/debit card payment made, as available.

Department of Community Health

Office of Health Planning

DET-EQT Request

2 Martin Luther King Jr. Drive, S.E.

East Tower, 16th Floor

Atlanta, Georgia 30334

1. All submissions must be via the Department’s web portal. Faxed or mailed copies of this DET form and any supporting documents and information should not be submitted.

**Section 1 – Requesting Party Identification**

**1.** Please complete the following information identifying the party requesting this determination. This should be the legal entity or person that is acquiring, replacing, or repairing the equipment. The Contact Person should be an individual directly affiliated with the Requesting Party and not a consultant or attorney.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **REQUESTING PARTY** | | | | |
| Legal Entity or Person: | | | | |
| Address 1: | | | | |
| Address 2: | | | | |
| City: | State: | | | Zip: |
| County: | | | | |
| **CONTACT PERSON** | | | | |
| Name: | | | Title: | |
| Address 1: | | | | |
| Address 2: | | | | |
| City: | State: | | | Zip: |
| Phone: | | Email: | | |

**2.** Describe the entity that will acquire and use the equipment that is the subject of this DET-EQT Request.

|  |
| --- |
| ENTITY TYPE |
| Hospital |
| Individual Private Physician |
| Single Group Practice of Physicians |
| Other, specify: |

3. If the equipment will be located and used at a hospital-based outpatient imaging center, will the equipment be solely used on the hospital’s patients, billed for in the name of the hospital, and will the imaging center operate under the hospital’s license? Select N/A if the Requesting Party is not a hospital, or if the project does not involve an outpatient imaging center.

YES  NO  N/A

1. If the equipment will be acquired by an individual private physician or a single group practice of physicians, will the equipment be used exclusively on patients of the individual private physician or single group practice of physicians, and will the individual private physician or a member of the single group practice of physicians be physically present at the practice location where the equipment is located at least 75 percent of the time the equipment is in use? Select N/A if the Requesting Party is not a physician or a single group practice of physicians.

YES  NO  N/A

5. Does the Requesting Party have Legal Counsel to whom legal questions regarding this request may be addressed?

YES  NO

If YES 🡺 Identify the lead attorney on the next page.

If NO 🡺 Continue to the next question.

|  |  |  |  |
| --- | --- | --- | --- |
| LEGAL COUNSEL | | | |
| Name: | | | |
| Firm: | | | |
| Address: | | | |
| City: | State: | | Zip: |
| Phone: | | Email: | |

6. Did a Consultant prepare and/or provide information in this DET-EQT request?  YES  NO

If YES 🡺 Identify the Consultant below.

If NO 🡺 Continue to the next question.

|  |  |  |  |
| --- | --- | --- | --- |
| CONSULTANT | | | |
| Name: | | | |
| Firm: | | | |
| Address: | | | |
| City: | State: | | Zip: |
| Phone: | | Email: | |

7. Does the Requesting Party wish to designate and authorize an individual other than the Requesting Party Contact listed in response to Question 1 to act as the representative of the Requesting Party for purposes of this request?

YES  NO

If YES 🡺 Please complete the information in the following table. By doing so, the Requesting Party authorizes the representative to submit this DET-EQT request; to provide the Department of Community Health with all information necessary for a determination on this request; to enter into agreements with the Department of Community Health in connection with this request; and to receive and respond, if applicable, to notices in matters relating to this request.

If NO 🡺 Continue to the next question.

|  |  |  |  |
| --- | --- | --- | --- |
| AUTHORIZED REPRESENTATIVE | | | |
| Name: | | | |
| Firm: | | | |
| Address: | | | |
| City: | State: | | Zip: |
| Phone: | | Email: | |

☞ NOTE: *The authorization provided on the previous page will remain in effect for this request until written notice of termination is sent to the Department of Community Health that references the specific request number. Any such termination must identify a new authorized representative. Also, if the authorized representative’s contact information changes at any time, the Requesting Party must immediately notify the Department of Community Health of any such change.*

### 8. Does the Requesting Party have any lobbyist employed, retained, or affiliated with the Requesting Party directly or through its contact person or authorized representative?

YES  NO

If YES 🡺 Please complete the information in the table below for each lobbyist employed, retained, or affiliated with the Requesting Party. Be sure to check the box indicating that the Lobbyist has been registered with the State Ethics Commission. Executive Order 10.01.03.01 and Ga. Comp. R. & Regs. r. 111-1-2-.03(2) require such registration.

### If NO 🡺 Continue to the next question.

|  |  |  |
| --- | --- | --- |
| LOBBYIST DISCLOSURE STATEMENT | | |
| Name of Lobbyist | **Affiliation with Requesting Party** | **Registered with State Ethics Commission?** |
|  | Employed  Other Affiliation | Yes  No |
|  | Employed  Other Affiliation | Yes  No |
|  | Employed  Other Affiliation | Yes  No |
|  | Employed  Other Affiliation | Yes  No |
|  | Employed  Other Affiliation | Yes  No |
|  | Employed  Other Affiliation | Yes  No |
|  | Employed  Other Affiliation | Yes  No |
|  | Employed  Other Affiliation | Yes  No |
|  | Employed  Other Affiliation | Yes  No |
|  | Employed  Other Affiliation | Yes  No |

### Section 2 – Equipment Information

**9.** Complete the following line-item sheet for the equipment that is the subject of this DET-EQT Request.

|  |  |
| --- | --- |
| EQUIPMENT LINE-ITEM SHEET | |
| Type of Request | Select **ONE** of the following exemptions for the equipment:  The acquisition of equipment pursuant to O.C.G.A. § 31-6-47(a)(10)  The replacement or repair of equipment pursuant to O.C.G.A. § 31-6-47(a)(10)  The acquisition of equipment pursuant to O.C.G.A. § 31-6-47(a)(28) |
| Type of Equipment | MRI    *Select one of the following:*  Fixed  Mobile  Manufacturer:  Year and Model:  Method of Acquisition:  Purchase  Lease  Other: Explain |
| CT Scanner  *Select one of the following:*  Fixed  Mobile  Manufacturer:  Year and Model:  Method of Acquisition:  Purchase  Lease  Other: Explain |
| Other:  *Select one of the following:*  Fixed  Mobile  Manufacturer:  Year and Model:  Method of Acquisition:  Purchase  Lease  Other: Explain |
| Other:  *Select one of the following:*  Fixed  Mobile  Manufacturer:  Year and Model:  Method of Acquisition:  Purchase  Lease  Other: Explain |
| Proposed Location of Equipment | *Address Line 1:*  *Address Line 2:*  *City:*  *State:*  *Zip:*  *County:* |
| Proposed Dates | *Date of Acquisition:*  *Date of First Use:* |
| Total Cost *(only include the cost of the equipment itself)* |  |

# Section 3 – Proposal Description

### 10. Please provide a detailed description of the proposed action and additional information to support your request for an exemption in the space provided below.

|  |
| --- |
|  |

Section 4 – Certification

By signing below,

1. I hereby certify that the contained statements and all addenda, appendices, exhibits, or attachments hereto are true and complete to the best of my knowledge and belief and that I possess the authority to submit this request and bind the Requesting Party to promises made herein;
2. I understand that a representative of the Office of Health Planning may make a direct request of me for additional information in order to issue a Letter of Determination; and
3. I further understand that if issued a Letter of Determination, the Requesting Party is bound to any representations that have been made within this request and any and all supplemental information.
4. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Uniform Electronic Transactions Act.

|  |  |
| --- | --- |
| REQUESTING PARTY CERTIFICATION | |
| Signature of Authorized Signatory: | |
| *Name:* | |
| *Title:* | *Date:* |