**State of Nevada**

**Department of Health and Human Services**

**CERTIFICATE OF NEED - LETTER OF INTENT**

The Certificate of Need process is coordinated by the Primary Care Office under the authority of the Director of the Department of Health and Human Services, under Nevada Revised Statutes (NRS) 439A.100. Please email nvpco@health.nv.gov or contact (775) 684-2204 for any questions. See NAC 439A.305 for more information about the letter of intent. A completed Letter of Intent may be electronically emailed to nvpco@health.nv.gov, and if sending by mail please provide advanced notice to nvpco@health.nv.gov along with any tracking information available, so we may take appropriate action as staff are telecommuting. Mailing address: Nevada Primary Care Office, 4150 Technology Way, Suite 300, Carson City, NV 89706.

|  |  |
| --- | --- |
| Organization Name: |  |
| Street Address:  |  |
| Type of Organization (Type of Ownership/Profit Status): |  |
| Date of Incorporation: |  |
| Location of Incorporation: |  |
| Contact Person: |  |
|  Phone #: |  |
|  Email Address:  |  |
| Project Title: |  |
| Project Address: |  |
| Project County:  |  |
| County Population: |  |
| City/Town Population: |  |
| Number of Beds to be added: |  |
| Type of Beds to added: |  |

**Project Description and Major Facility, Medical Equipment, and Health Services to be Included:**

|  |
| --- |
|  |

**Please define the Medicaid Provider Types and Specialties that the facility or providers in the facility will use to bill and obtain reimbursement from Medicaid or other public agencies. (see** <https://www.medicaid.nv.gov/providers/BillingInfo.aspx>**)**

|  |
| --- |
|  |

**Square Footage of Proposed Construction Project (NAC 439A.338):**

1. The provisions of subsection 1 of NRS 439A.100 are applicable only to a project which is not dependent on or related to a larger single project.

2. The cost for construction in which no new square footage is added is not subject to a letter of approval. The cost of construction related to the existing space must be deducted from the total capital expenditure to determine the cost of the new construction subject to a letter of approval.

3. The cost of construction attributed to space for a medical office building or an office for a health practitioner to be used solely to provide routine health services as defined in NRS 439A.017 must be deducted from the total capital expenditures to determine the cost of new construction subject to a letter of approval.

|  |  |  |
| --- | --- | --- |
| Existing square footage only: |  | square feet |
| New square footage only: |  | square feet |

**Total Estimated Capital Expenditures:**

**NAC 439A.070:** Provide project information for capital expenditures made by or on behalf of a health facility including the cost of pre-developmental activities, the encumbrance of funds, leases, contractual agreements or donations for purposes which, under generally accepted accounting principles, are not properly chargeable as an expense of operation or maintenance, or both.

|  |  |  |
| --- | --- | --- |
| **Cost Category** | **Total Project Cost** | **Project Cost Related to New Construction** |
| Construction Costs: | $ | $ |
| Site Development: | $ | $ |
| Architecture & Engineering: | $ | $ |
| Furniture, Fixtures & Equipment: | $ | $ |
| Major Medical Equipment: | $ | $ |
| 10% Contingency: | $ | $ |
| **TOTAL** | $ | $ |

|  |  |
| --- | --- |
| Estimated date construction begins: |  |
| Estimated date of completion of the proposed project: |  |
| Provide a summary and schedule of anticipated future phases of construction within the proposed project: |

When is the estimated financial break-even point for the project expected to occur?

|  |
| --- |
|  |

**Required Appendix: Attach a copy of a written estimate of the cost of construction of the proposed project, by major cost categories, from an architect or contractor**

In accordance with NRS 439A.100 and accompanying regulations, I hereby certify that this Letter of Intent is correct to the best of my knowledge. I further certify that I will provide accurate and complete information necessary to the review of an application for a Letter of Approval. I understand that the information which is submitted is public information and will be made available by the Department of Health and Human Services for public review and inspection.

**Certification: This section should be completed by the person who is authorized to commit the applicant to the project and expenditure of funds to complete the project should it be approved.**

|  |  |
| --- | --- |
| This letter is filed on behalf of (Legal Applicant): |  |
| Name of Signatory: |  |
| Title: |  |
| Date: |  |
| Signed: |  |