

INSTRUCTIONS FOR THIS FORM

1. This form is to be used by all applicants for a Certificate of Need except those applying for transfer of a CON.
2. Fee remittance in the CORRECT amount should be submitted concurrently with the application. Applications submitted without a fee or with an insufficient fee will be processed in accordance with Rule 59C-1.008(3), F.A.C.
 - a. Applications filed in the batch review cycle have until close of business on the day a **complete** application is submitted to submit any additional fees required, or the application will be deemed incomplete and withdrawn from further review.
 - b. Applications filed for expedited review with an insufficient fee will not be processed until the correct fee is received and will be returned in 30 days if the correct fee is not received by the agency.
3. Fee remittance is to be submitted in the form of a check payable to the Agency for Health Care Administration.
4. Fees are to be computed as follows:

<u>Proposed Expenditures</u>	<u>Fee Schedule</u>
No Expenditure	\$10,000
Any Expenditure	\$10,000 plus .015 of each dollar of proposed expenditure
Maximum Fee	\$50,000

LEGAL NAME OF APPLICANT: _____

MAILING ADDRESS: _____

TELEPHONE NUMBER: _____

IDENTIFICATION OF PROJECT: _____

TOTAL PROJECT COST (SCHEDULE 1, LINE 50) \$ _____

PROJECT COST SUBJECT TO FEE (SCHEDULE 1, LINE 51) \$ _____

APPLICATION FEE (SCHEDULE 1, LINE 26) \$ _____

**Submit to: Agency for Health Care Administration
Certificate of Need Office
2727 Mahan Drive, MS 28
Tallahassee, Florida 32308**

