



# APPLICATION FOR A CERTIFICATE OF NEED Except for Transfer of a Certificate of Need

LEGAL NAME OF APPLICANT \_\_\_\_\_

FACILITY/PROJECT NAME \_\_\_\_\_

AUTHORIZED REPRESENTATIVE/CONTACT PERSON \_\_\_\_\_

CHIEF EXECUTIVE OFFICER \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

STREET ADDRESS/SITE LOCATION \_\_\_\_\_

CITY, STATE, AND ZIP CODE \_\_\_\_\_

CITY \_\_\_\_\_

TELEPHONE (AREA CODE AND NUMBER) \_\_\_\_\_

DISTRICT/SUBDISTRICT (IF APPLICABLE) \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

- COUNTY:**
- 1. Alachua
  - 2. Baker
  - 3. Bay
  - 4. Bradford
  - 5. Brevard
  - 6. Broward
  - 7. Calhoun
  - 8. Charlotte
  - 9. Citrus
  - 10. Clay
  - 11. Collier
  - 12. Columbia
  - 13. DeSoto
  - 14. Dixie
  - 15. Duval
  - 16. Escambia
  - 17. Flagler
  - 18. Franklin
  - 19. Gadsden
  - 20. Gilchrist
  - 21. Glades
  - 22. Gulf
  - 23. Hamilton
  - 24. Hardee
  - 25. Hendry
  - 26. Hernando
  - 27. Highlands
  - 28. Hillsborough
  - 29. Holmes
  - 30. Indian River
  - 31. Jackson
  - 32. Jefferson
  - 33. Lafayette
  - 34. Lake
  - 35. Lee
  - 36. Leon
  - 37. Levy
  - 38. Liberty
  - 39. Madison
  - 40. Manatee
  - 41. Marion
  - 42. Martin
  - 43. Miami/Dade
  - 44. Monroe
  - 45. Nassau
  - 46. Okaloosa
  - 47. Okeechobee
  - 48. Orange
  - 49. Osceola
  - 50. Palm Beach
  - 51. Pasco
  - 52. Pinellas
  - 53. Polk
  - 54. Putnam
  - 55. Saint Johns
  - 56. Saint Lucie
  - 57. Santa Rosa
  - 58. Sarasota
  - 59. Seminole
  - 60. Sumter
  - 61. Suwannee
  - 62. Taylor
  - 63. Union
  - 64. Volusia
  - 65. Wakulla
  - 66. Walton
  - 67. Washington

- APPLICANT TYPE:**
- 1. Hospice
  - 2. Community Nursing Home
  - 3. Sheltered Nursing Home
  - 4. Community ICF/DD
  - 5. State ICF/DD

- PROJECT TYPE:**
- 1. New Facility
  - 2. Replacement Facility
  - 3. Bed Addition
  - 4. Bed Conversion
  - 5. Freestanding Hospice Inpatient Facility

- OWNERSHIP TYPE:**
- 1. For Profit
  - 2. Not For Profit
  - 3. Nursing Home Chain
  - 4. Government

**PREVIOUS CON NUMBERS:**  
\_\_\_\_\_

**CON TRANSFERS:**  
\_\_\_\_\_

**PROJECT COSTS:**  
Capital Expenditures \_\_\_\_\_

Operating Costs \_\_\_\_\_

**NUMBER OF NEW/AFFECTED BEDS (+/-):**

\_\_\_\_\_ Community Nursing Home                      \_\_\_\_\_ Freestanding Inpatient Hospice  
 \_\_\_\_\_ Sheltered Nursing Home                      \_\_\_\_\_ ICF/DD

**ADDITIONAL PROJECT DETAILS/REMARKS:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*AHCA Use Only:*  
 CON Number \_\_\_\_\_  
 Date Received \_\_\_\_\_  
 Fee Received \_\_\_\_\_  
 LOI Date \_\_\_\_\_