





Letter of Intent Form - Batching Cycle Georgia Certificate of Need



FOR CERTIFICATE OF NEED OFFICE USE ONLY

LETTER NUMBER

DATE STAMP

LOI#

2019-062

RECEIVED

OCT 28 2019

Office of Health Planning Georgia Department of Community Health

GENERAL INFORMATION:

In accordance with CON Administrative Rule 111-2-2-.08(1)(c), all parties interested in applying for the particular unmet need in a given service area must notify the Department of that party's intent to apply. This Letter of Intent Form – Batching Cycle is the required notice of intent to submit an application for Certificate of Need during the batching review cycle for the following service:

SERVICES: Check the one service for which you are submitting this Letter of Intent.								
	Adult Open Heart Surgery		Megavoltage Radiation Therapy					
	Ambulatory Surgery Center		Pediatric Cardiac Cath/Open Heart Surgery					
	Freestanding Birthing Centers		PET Scanner Services					
	Home Health Agency		Psych/Substance Abuse Services					
	Intermediate Care Facilities	\boxtimes	Perinatal Service :					
	Inpatient Physical Rehabilitation		 ☑ Neonatal Intermediate ☐ Neonatal Intensive Care ☐ Obstetrical Services 					
	Skilled Nursing Facilities							
Prospective applicants must submit a Letter of Intent only for a service as called for and specified in the applicable Batching Cycle Public Notice.								
Failure to submit the required 3-page Letter of Intent Batching Cycle Form OR failure to complete all required fields on the form will result in non-acceptance of the Letter of Intent.								
If the due date for the Letter of Intent falls on a weekend or holiday – when the Division of Health Planning is closed – the Letter of Intent will be accepted on the first business day following the weekend or holiday and is termed the "Rollover Day". Rollover Days will be specified on the Batching Cycle Public Notice in most instances.								
This application must be typewritten or completed and printed in this MS Word format. Handwritten responses must not be submitted and will not be accepted.								

Submit the original form to:

Certificate of Need Program
Letter of Intent
Georgia Department of Community Health
Health Planning Division
2 Peachtree Street, NW, 5th Floor
Atlanta, Georgia 30303

Requesting Party Identification

1. Please complete the following information identifying the party submitting this Letter of Intent.

Legal Applicant – Name and Address									
Legal Entity or Person: Northeast Georgia Medical Center, Inc.									
d/b/a (if applicable):									
Address 1: 743 Spring Street									
Address 2:									
City: Gainesville	State: Georgia			Zip: 30501					
County: Hall									
Parent Organization: Northeast Georg	ia Health System,	, Inc.							
CONTACT PERSON (Person to whom inquiries concerning this Letter of Intent may be addressed)									
Name: Linda Berger		Title: Director of							
Address 1: 1480 Jesse Jewell Parkwa	Address 1: 1480 Jesse Jewell Parkway								
Address 2:									
City: Gainesville	State: Georgia			Zip: 30501					
Phone: (770) 219-6631		Fax:	(770) 219-5437						
E-mail: Linda.Berger@nghs.com									
Name, address of facility, if different from legal applicant									
Name: Same as legal applicant			Title:						
Address 1:									
Address 2:									
City:	State:			Zip:					

Proposed Project Site Location									
Name, if applicable Northeast Georgia Medical Center – South Hall Campus									
Address 1: 1400 River Place									
Address 2:									
City: Braselton	State: Georgia	Zip: 30517							
County: Hall									
Brief Summary/ Description of Proposal									
Description of Proposal (300 words or less). Please include the applicant's current service area, if applicable. Northeast Georgia Medical Center, Inc. proposes the addition of six neonatal intermediate care beds at the South Hall Campus of Northeast Georgia Medical Center. The project will meet one or more of the need exceptions set forth in Rule 111-2-224(3)(b).									
Planning Area (if applicable): SSDR # 2 Neonatal Intensive Care # HPA # Inpatient Physical Rehabilitation # New Service? Expanded Service? Total Projected Cost \$20,000,000									
Proposed Service Area (List All Counties you propose to serve, if applicable)									
Hall Banks		Gwinnett	Forsyth						
Signature: (Print Name and Sign) Linda Berger Date: m/d/yyyy 10/25/2019									

Letter of Intent Form CON 2011A September 23, 2011 Page 3 of 3