

Letter of Intent Form - Batching Cycle

Georgia Certificate of Need

FOR CERTIFICATE OF NEED OFFICE USE ONLY

LETTER NUMBER

DATE STAMP

LO#

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.

- | | |
|---|---|
| <input type="checkbox"/> Adult Open Heart Surgery | <input type="checkbox"/> Megavoltage Radiation Therapy |
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Pediatric Cardiac Cath/Open Heart Surgery |
| <input type="checkbox"/> Freestanding Birthing Centers | <input type="checkbox"/> PET Scanner Services |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Psych/Substance Abuse Services |
| <input type="checkbox"/> Intermediate Care Facilities | <input type="checkbox"/> Perinatal Service : |
| <input checked="" type="checkbox"/> Inpatient Physical Rehabilitation | <input type="checkbox"/> Neonatal Intermediate <input type="checkbox"/> Neonatal Intensive Care |
| <input type="checkbox"/> Skilled Nursing Facilities | <input type="checkbox"/> Obstetrical Services |

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 Office 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
Office of Health Planning
2 Peachtree Street, NW, 5th Floor
Atlanta, Georgia 30303**

Requesting Party Identification

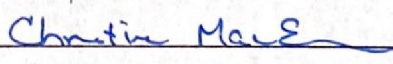
1. Please complete the following information identifying the party submitting this Letter of Intent.

Legal Applicant – Name and Address		
Legal Entity or Person: Rehabilitation Hospital of Atlanta, LLC		
d/b/a (if applicable):		
Address 1: 1800 Howell Mill Road		
Address 2: Suite 850		
City: Atlanta	State: GA	Zip: 30318
County: Fulton		
Parent Organization: Piedmont Encompass Rehabilitation Hospitals, LLC		
 CONTACT PERSON (Person to whom inquiries concerning this Letter of Intent may be addressed)		
Name: Christine Macewen		Title: Executive Director, Corporate Development
Address 1: 1800 Howell Mill Road		
Address 2: Suite 300		
City: Atlanta	State: GA	Zip: 30318
Phone: 404.425.1307		Fax:
E-mail: Christine.macewen@piedmont.org		
 Name, address of facility, if different from legal applicant		
Name: Rehabilitation Hospital of Atlanta		Title:
Address 1: 1968 Peachtree Road NW		
Address 2:		
City: Atlanta	State: GA	Zip: 30309

Proposed Project Site Location		
Name, if applicable:		
Address 1: 1968 Peachtree Road NW		
Address 2:		
City: Atlanta	State: GA	Zip: 30309
County: Fulton		
Brief Summary/ Description of Proposal		
Description of Proposal (300 words or less). <i>Please include the applicant's current service area, if applicable.</i>		
<p>The Applicant proposes to establish a 40-bed freestanding Comprehensive Inpatient Physical Rehabilitation Program ("CIPR") to meet the identified gap in care for service area residents. The application is responsive to the exception to need criteria.</p>		

Planning Area (if applicable):			
SSDR # <input type="checkbox"/>	Neonatal Intensive Care # <input type="checkbox"/>	HPA # <input type="checkbox"/>	Inpatient Physical Rehabilitation # <input type="checkbox"/>
New Service? <input checked="" type="checkbox"/> Expanded Service? <input type="checkbox"/> Total Projected Cost \$22,000,000			

Proposed Service Area (List All Counties you propose to serve, if applicable)					
Fulton	DeKalb	Cobb	New ton	Henry	Cow eta
Fayette	Clayton	Gw innett	Rockdale	Cherokee	Gilmer
Pickens	Carroll	Douglas	Forsyth		

Signature: (Print Name and Sign) Christine R. MacEwen 

Date: m/d/yyyy 10/19/2020



Use this form to upload and submit all Certificate of Need applications and forms.

Requesting Party Identification

Requesting Party Name * Rehabilitation Hospital of Atlanta, LLC
Legal entity or person

Address 1: 1800 Howell Mill Rd.

Address 2: Suite 850

City: Atlanta

State: Georgia

Zip: 30318

County: Fulton

Contact Name: * Christine R. Macewen

Contact Email: * christine.macewen@piedmont.org

Application or Form Submission

Application/Form or Letter Type * CON Batching Application Letter of Intent
Select the type of application or form that you are submitting.

GENERAL INFORMATION:

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Prospective applicants must submit a Letter of Intent only for a service as called for and specified in the applicable [Batching Cycle Public Notice](#).

Services: Check the **one** service for which you are submitting this Letter of Intent Form

Fall Batching Cycle Services

- | | |
|--|--|
| <input type="radio"/> Ambulatory Surgery Center | <input type="radio"/> Home Health Agency |
| <input type="radio"/> Intermediate Care Facilities | <input checked="" type="radio"/> Inpatient Physical Rehabilitation |
| <input type="radio"/> Skilled Nursing Facilities | <input type="radio"/> Obstetrical Services |
| <input type="radio"/> Perinatal Service: | |

File Upload * Rehabilitation Hospital Atlanta_LOI_10.19.pdf 601.54KB

[Click to browse and attach an electronic copy of your application/form and any other required attachments.](#)

Additional attachments such as the check image should be included as a secondary or last page of the CON form or uploaded as separate files. Please do not add any pages before the first page of the CON form.

Submission Date/Time 10/19/2020
02:27:06 PM

Attestation

I state, certify and attest that this application for Certificate of Need, the contained statements and all addenda, appendices, or attachments hereto are true and complete to the best of my knowledge and belief, and that I possess the authority to submit this application. I further state, certify and attest that with this submission, I have included a copy of the check or money order that will be remitted to the State of Georgia in connection with the filing fee associated with this application for Certificate of Need in the amount determined by the applicable fee schedule. I understand that with any failure to remit the required filing fee, the Department reserves the right to cease to review any pending Certificate of Need application. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Enter the text you want this field to display

Signature *

William R. Williams, Jr. Esq. State Counsel, Attorney for RFLM

Signature Date *

10/19/2020