Program Review Fee – Worksheet
Health Facility Identification

For OIG Office Use Only

Received ___/___/_____ Project # LH _____-_____

Amount $_____ Facility ID _____

Check #_____ Level of Care _____

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1. Project Description_____

(Please attach narrative detailing program requirements of project)

2. Contact Information

a. Contact Name _____
(Architect, Engineer, etc.)

b. Firm _____

c. Address _____

d. City/State/Zip _____ e. Phone _____

3. Facility Information

a. Facility Name* _____

(The licensed entity under which this project will operate) **If this is a new facility yet to be licensed check here* ☐

b. Address _____

c. City/State/Zip _____ d. Phone _____

e. Facility Owner _____
(If different from above)

f. Address _____

g. City/State/Zip _____ h. Phone _____

4. Project Information (check all that apply)

☐ Project within a Licensed Facility	☐ Addition (New Construction)	☐ Copy of CON, if required
☐ Contiguous/Connected to Licensed Facility	☐ Renovation Only	☐ State Owned Facility
☐ New Freestanding Structure	☐ Renovation & Addition	☐ Licensure Bed Change

5. Fee Calculation

Instructions: When calculating the gross square feet in a project, one should measure the outside dimensions of the exterior walls involved. Please submit the completed worksheet to our Division along with a check for the appropriate amount. **The check should be made payable to the Kentucky State Treasurer** and accompany the first submission of the Design Documents.

New Construction (including Additions, Renovations, Licensed Bed Changes and Change of Room Function):

Gross Sq. Ft. _____ X $0.10 per Sq. Ft. = $_____

Minimum fee of $200 for all reviews.

The above fee schedule will cover the entire review process, including all construction inspections.

TOTAL FEE AMOUNT: $_____

Return This Form, Applicable Fee, and One Set of Design Documents to:

Office of Inspector General
Division of Health Care
275 East Main Street 5E-A
Frankfort, Kentucky 40621