COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL
DIVISION OF CERTIFICATE OF NEED

# Request for Advisory Opinion

**REQUESTER:**

Name: _____

Street: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

**FACILITY INVOLVED**:

Name: _____

Street: _____

City, State, Zip: _____

Please be advised that this form is used only to request an advisory opinion on certificate of need requirements. In the following sections, answer every question as completely as possible. Complete information will result in a prompt consideration.

DESCRIPTION OF PROJECT (i.e. project description, type of service, equipment, etc.)

Please provide the following information. If additional space is required, please attach separate sheets.

1. Summarize the proposal. In your description, indicate whether the proposal is for a new service, or a change or expansion of an existing service.

2. What specific services will be provided and by whom? Will these services be provided directly or through a contract?

3. Where will the proposed services be provided? (i.e. patients' homes, nursing homes, hospitals, etc.) Will any hospital inpatients be treated?

4. Who will bill for services? Will the patient be billed directly for these services? If not, please explain.

5. Will any major medical equipment be acquired or leased that exceeds the major medical equipment expenditure minimum found on the Office of Inspector General, Division of Certificate of Need Web site, https://chfs.ky.gov/agencies/os/oig/dcn? If so, please describe the type of equipment and the purchase price or fair market value.

6. Please indicate the ownership of the proposed project:

| | | | |
|---|---|---|---|
| Physician | _____ | For Profit Corporation | _____ |
| Non-Profit Corporation | _____ | Partnership – Limited | _____ |
| Limited Liability Corporation | _____ | Partnership – General | _____ |
| Limited Liability Partnership | _____ | Sole Proprietorship | _____ |
| Governmental | _____ | Professional Service Corp | _____ |
| Other | _____ | | |

If "other", please explain:

7. Please provide the estimated cost of this project:

_____
(Signature of Requester) (Date)

**COMPLETE AND RETURN TO**:

OFFICE OF INSPECTOR GENERAL
DIVISION OF CERTIFICATE OF NEED
275 EAST MAIN STREET 5EA
FRANKFORT, KY 40621
Phone: (502) 564-9592
Email: CON@ky.gov
Fax: (502) 564-6546