



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) _____

E-MAIL 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

- OWNERSHIP TYPE:**
- 1. Private for profit hospital
 - 2. Proprietary hospital system
 - 3. Non profit hospital
 - 4. Non-profit hospital system
 - 5. Local government hospital
 - 6. State hospital
 - 7. Private for profit nursing home
 - 8. Proprietary nursing home chain
 - 9. Non-profit nursing home
 - 10. Local government nursing home

CON PROPOSED TO BE TRANSFERRED:

_____ Date Issued
CON Number

CURRENT HOLDER OF THE CON:

- PROJECT APPROVED BY THE CON:**
- 1. Establish a new service or bed type
 - 2. Expand an existing service or bed type
 - 3. Other change: _____

- APPLICANT TYPE:**
- 1. General hospital
 - 2. Psychiatric hospital
 - 3. Rehabilitation hospital
 - 4. Children's hospital
 - 5. Nursing home
 - 6. Sheltered nursing home
 - 7. Long term care hospital
 - 8. State ICF/DD
 - 9. Community ICF/DD
 - 10. Other facility
 - 11. Hospice

PROJECT COSTS:

Capital Expenditures _____
Operating Costs _____

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

- | | | |
|---------------------------|--|--------------------------------------|
| _____ General Acute Care | _____ Psychiatric - Child/Adolescent | _____ Long Term Care Hospital |
| _____ NICU Level II | _____ Substance Abuse – Adult | _____ Nursing Home |
| _____ NICU Level III | _____ Substance Abuse - Child/Adolescent | _____ Freestanding Inpatient Hospice |
| _____ Psychiatric – Adult | _____ Rehabilitation | |

ADDITIONAL PROJECT DETAILS/REMARKS:

AHCA Use Only:
CON Number _____
Date Received _____
Fee Received _____