INSTRUCTIONS FOR

COMPLETION OF CERTIFICATE OF NEED APPLICATION FOR DESIGNATION AS A PERINATAL FACILITY

SECTION I. GENERAL REQUIREMENTS

1. CERTIFICATE OF NEED

A. PRE-SUBMISSION

Prior to the preparation of the application materials, it is strongly recommended that the applicant discuss the proposed designation with the Maternal and Child Health Consortium for the region, and staff of the New Jersey Department of Health. All information provided on the application shall be in accordance with N.J.A.C. 8:33, N.J.A.C. 8:33C and N.J.A.C. 8:43G.

B. SUBMISSION - NEW JERSEY DEPARTMENT OF HEALTH

Submit one completed application in electronic media and 35 paper copies (no binders please) of the application forms and all required documentation to:

Mailing Address:
New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
P. O. Box 358
Trenton, NJ 08625-0358

Overnight Services (DHL, FedEx, UPS):
New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
120 South Stockton Street, 3rd Floor
Trenton, NJ 08608-1832

Applications must be submitted in conjunction with all other regional applications for facilities in accordance with the provisions set forth at N.J.A.C. 8:33C-1.1 et seq.

C. SIGNATURE

All applications must be signed by the current Chief Administrative Officer or Board Chairman of the Hospital.

D. FILING FEE

All applications must be accompanied by a certified check, cashier's check, or money order made payable to *"Treasurer, State of New Jersey."* Failure to submit the appropriate fee at the time of filing may result in rejection of the application.

Application Fee:

$7,500 (Projects $1,000,000 or less)
$7,500 + 0.25% of Total Project Cost (Projects greater than $1,000,000)

E. COMPLETENESS

1. ALL QUESTIONS REQUIRE AN ANSWER AND MUST BE COMPLETELY FILLED OUT.

2. Certificate of Need forms must be filed in sequential order. Do not re-number pages.

3. All exhibits must be identified as noted herein and attached to the back of the Certificate of Need Application form and referenced to the corresponding item in the appropriate section.

4. Identify each response in the narrative section by question number and respond in sequential order. All additional supporting documentation must be attached to the back of the Certificate of Need form after the exhibits, in Section titled "Appendix".

5. Only complete applications will be processed [N.J.A.C. 8:33-4.5(a)]. Failure to submit all required information and documentation and/or to follow the steps outlined herein when the Certificate of Need is filed may result in a determination that the application is incomplete and, as such, may not be accepted for processing.

F. MODIFICATION

No application may be altered or modified by an applicant after the deadline date for application submission. Additional information shall be permitted only in direct response to written questions submitted to the applicant by the New Jersey Department of Health.

2. MATERNAL AND CHILD HEALTH SERVICES

Application for perinatal designation will result in on-site verification of services and documentation. Questions regarding service delivery, site visits, and designation process should be directed to:

New Jersey Department of Health
Maternal, Child and Community Health Services
PO Box 364
Trenton, NJ 08625-0364
609-292-5616

3. STATE HEALTH PLANNING

Need projections are based on bed need formulas contained in N.J.A.C. 8:33C and are published in the relevant CN call.

4. LICENSING

Licensing manuals for hospital-based services may be obtained from the New Jersey Department of Health, Office of Certificate of Need and Healthcare Facility Licensure (609-292-8773) or online at the Department website at www.nj.gov/health.

5. FINANCIAL

Applicants should contact the New Jersey Department of Health, Health Care Financing Systems (609-984-6298) to obtain information with regard to financial requirements.

6. CONSTRUCTION

Applicants should contact the New Jersey Department of Community Affairs, Health Plans Review Program (609-633-8153) to obtain information regarding construction requirements.

New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
PO Box 358
Trenton, NJ 08625-0358

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY

INSTRUCTIONS:

All applicants must complete SECTION I, which begins on Page 1 and continues through Page 6, and SECTION VI, which begins on Page 15. Applicants for the following designations must ALSO complete the appropriate Section indicated:

Community Perinatal Center-Intermediate..... SECTION II, Page 7
Community Perinatal Center-Intensive ..... SECTION III, Page 8
Regional Perinatal Center ..... SECTION IV, Page 10
Neonatal Services as a Part of a
Specialty Acute Care Children's Hospital..... SECTION V, Page 13

SECTION I

Name of Facility	Date of Application

Location Address	Mailing Address, If Different

Name of Contact Person

Telephone Number	Fax Number	Email Address

Name of Consortium of Which Facility is a Member	Source of Data ☐ 3-Year Trend ☐ 1-Year

Previously Approved Designation

Designation Requested

☐ Community Perinatal Center-Birthing
☐ Community Perinatal Center-Basic
☐ Community Perinatal Center-Intermediate
☐ Community Perinatal Center-Intensive
☐ Regional Perinatal Center
☐ Specialty Acute Care Children's Hospital

Number of Licensed Beds (Entire Facility)	Type of Hospital ☐ Public ☐ Private
____	

Description of the Service Area (include a copy of a map showing the service area):

Services Provided

☐ Medical/Surgical ☐ Pediatrics ☐ Critical Care (Adult) ☐ Critical Care (Neonatal)
☐ Obstetrics/Gynecology ☐ Psychiatric ☐ Critical Care (Pediatric)

Name of Facility	Date of Application

Population Served for Perinatal/Obstetric Service:

Race Breakdown:

- White: _____
- Black: _____
- Asian: _____
- Native American: _____
- Other: _____

Ethnicity Breakdown:

- Hispanic: _____
- Non-Hispanic: _____

Percent of Payer Mix:

- Private Insurance: _____
- Managed Care Program (e.g., HMO/PPO): _____
- Medicaid: _____
- Self-Pay: _____
- Charity Care: _____

Age by Percent:

- Less than 5 Years: _____
- 5 - 18 Years: _____
- 19 - 44 Years: _____
- 45 - 65 Years: _____
- 65+ Years _____

Sex by Percent:

- Male: _____
- Female: _____

Describe any other unique population characteristics in your regional area:

OUTPATIENT DATA

Healthstart Participation:

	PEDIATRIC	**PRENATAL**
a. Is Hospital a Healthstart Provider?	☐ Yes ☐ No	☐ Yes ☐ No
b. If Yes, Provider Number:	_____	_____
c. If No, is Application Pending?	☐ Yes ☐ No	☐ Yes ☐ No
d. If Yes, Date of Application *	_____	_____

(* Provide copy of Healthstart Application with CN Application)

Name of Facility	Date of Application

AMBULATORY SERVICES

Prenatal and Postpartum Services:

Days of Operation: _____

Hours of Operation: _____

Staffing (Number of FTE's):

RN's: _____

LPN's: _____

Social Service Personnel: _____

Nutritionists: _____

Nurse Practitioners: _____

Certified Nurse Midwives: _____

Family Practice Physicians: _____

Obstetricians: _____

Location: ☐ On-Site ☐ Satellite

Location, If Off Site: _____

Number of Unduplicated Patients Served: _____

% of Referrals: _____

To Home Follow-Up: _____

To WIC: _____

To High-Risk OB: _____

To Family Planning: _____

% Returning for Postpartum Services: _____

Number of Visits: _____

Percent of Payer Mix:

Private Insurance: _____

Managed Care Programs (e.g., HMO/PPO): _____

Medicaid: _____

% Healthstart: _____

Self-Pay: _____

Charity Care: _____

High-Risk Consultation/Services Available (describe where located, name of provider, and hours available for consultation):

_____

Name of Facility	Date of Application

AMBULATORY SERVICES, CONTINUED

Pediatric Services:

Days of Operation: _____

Hours of Operation: _____

Staffing (Number of FTE's):

RN's: _____

LPN's: _____

Social Service Personnel: _____

Nutritionists: _____

Nurse Practitioners: _____

Pediatricians: _____

Family Practice Physicians: _____

Location: ☐ On-Site ☐ Satellite

Location, If Off Site: _____

Number of Unduplicated Patients Served: _____

% of Referrals: _____

To Home Visit: _____

To WIC: _____

To Early Intervention: _____

Number of Visits: _____

Percent of Payer Mix:

Private Insurance: _____

Managed Care Programs (e.g., HMO/PPO): _____

Medicaid: _____

% Healthstart: _____

Self-Pay: _____

Charity Care: _____

High-Risk Consultation/Services Available (describe where located, name of provider, and hours available for consultation):

_____

CONSULTANT SERVICES

Consultant Services Available:

	On-Site		By Phone		24-Hour	
Registered Dietician/Nutritionist	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Geneticists/Genetic Counselors	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Social Workers	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Public Health Nurses	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Physician Specialists	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Lactation Consultants	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Name of Facility	Date of Application

INPATIENT DATA * (Report Previous Two (2) Years Separately)

Number of Deliveries Per Year:	Number of Pediatric Admissions:
_____	_____

Unit	Number of Licensed/ Approved Beds/ Bassinets	Patient Days	Occupancy Rate	Average Daily Census	Transfer In	Transfer Out	Total Number of Beds/ Bassinets Requested	Number of Increase/ Decrease In Unit Size
Labor								
Delivery								
Recovery								
LDR								
Postpartum								
LDRP								
Newborn								
Intermediate								
Intensive Unit								

* If Certificate of Need is for relocation of beds in a Health System, provide above data for each site separately.

Have any construction Certificates of Need been approved for your facility for the above services?

☐ Yes ☐ No If Yes, include copies of blueprints.

a. Is construction underway or to commence shortly?

☐ Yes ☐ No

b. Specify:

_____

Are any construction Certificates of Need pending approval for your facility for the above services?

☐ Yes ☐ No

a. Specify:

_____

Will the designation requested in this application require any new construction which will require a Certificate of Need?

☐ Yes ☐ No

Does the facility currently meet all construction standards for the designation being requested?

☐ Yes ☐ No

Will the requested bassinets be accommodated in existing space without physical plant/space waivers?

☐ Yes ☐ No ☐ N/A – No bassinets requested

Name of Facility	Date of Application

RESIDENCY PROGRAMS

Does your facility have residency programs in the following areas:

Obstetrics:	☐ Yes	☐ No	If Yes, Number of Current Residents: _____
Pediatrics:	☐ Yes	☐ No	If Yes, Number of Current Residents: _____
Family Practice:	☐ Yes	☐ No	If Yes, Number of Current Residents: _____

Description of Physical Plant for the Above-Mentioned Units and Surgical Suite for C-Sections.

Are all staffing requirements met for the type of designation for which you are applying?

☐ Yes ☐ No

a. If No, explain:

Name of Facility	Date of Application

SECTION II
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A COMMUNITY PERINATAL CENTER -INTERMEDIATE

Number of Maternal-Fetal Transports Made:	Number of Neonatal Transports Made:
_____	_____

Staff Requirements (available on a 24-hour basis and able to arrive within 30 minutes or in hospital):

Obstetrician or Obstetric Resident with Three (3) Years of Training	☐ Yes	☐ No
Pediatrician with Training and Experience in Neonatal Medicine	☐ Yes	☐ No
Anesthesiologist/Nurse Anesthetist	☐ Yes	☐ No
Registered Nurse (clinical responsibility)	☐ Yes	☐ No

Registered Nurse Staff Ratio:

Newborn (Includes Licensed Nurses) 1:8	☐ Yes	☐ No
Intermediate 1:4	☐ Yes	☐ No

Attach copies of the following documentation:

1. Copy of Perinatal Record Utilized by Providers
2. Copy of Criteria for Transfer
3. Copy of Letters of Agreement with Maternal-Fetal and Neonatal Transports
4. Copy of Contracts with All Required Staff, Including Written Policy for Arrival Time

Describe home follow-up services for women and infants:

Describe family planning services:

Name of Facility	Date of Application

SECTION III
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A COMMUNITY PERINATAL CENTER -INTENSIVE

Number of Maternal-Fetal Transports Made:	Number of Neonatal Transports Made:	Number of Neonatal Transports Accepted:
____	____	____

Staff Requirements

Available on a 24-hour basis and able to arrive within 30 minutes or in hospital):

Obstetrician	☐ Yes	☐ No
Neonatologist	☐ Yes	☐ No
Anesthesiologist with Special Training in Care of Neonates	☐ Yes	☐ No
Registered Nurse (clinical responsibility)	☐ Yes	☐ No

Available on a 24-hour basis and able to arrive within 30 minutes or in hospital):

Neonatologist, Neonatal Fellow or Pediatrician with Training in Neonatal Medicine	☐ Yes	☐ No

Registered Nurse Staff Ratio:

Newborn (Includes Licensed Nurses) 1:8	☐ Yes	☐ No
Intermediate 1:4	☐ Yes	☐ No
Intensive 1:2	☐ Yes	☐ No

Does your facility have a Neonatal Transport Team?

☐ Yes ☐ No

If Yes, describe team members and vehicles:

Attach copies of the following documentation:

1. Copy of Perinatal Record Utilized by Providers
2. Copy of Criteria for Transfer
3. Copy of Letters of Agreement with Maternal-Fetal and Neonatal Transports Made Out of Facility
4. Copy of Contracts with All Required Staff, Including Written Policy for Arrival Time
5. Copy of Letters of Agreement for Neonatal Transports Accepted

Name of Facility	Date of Application

SECTION III, CONTINUED
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A
COMMUNITY PERINATAL CENTER
-INTENSIVE

Describe home follow-up services for women and infants:

Describe family planning services:

Describe provision or arrangements for high-risk infant screening and tracking program:

Name of Facility	Date of Application

SECTION IV
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A REGIONAL PERINATAL CENTER

Number of Maternal-Referrals (include co-managed or delivered at the RPC even if delivered by referring Obstetrician): _____	Number of Neonatal Transports Accepted: _____
Number of Low Birthweight Infants (<2500 grams) Managed in Preceeding 2 Years: _____	Number of Very Low Birthweight Infants (<1500 grams) Managed in Preceeding 2 Years: _____
Number of Neonatal Transports Accepted: _____	Percentage of Transports for the Region: _____

Attach copies of the following documentation:

1. Copy of Perinatal Record Utilized by Providers
2. Copy of Letters of Agreement with Maternal-Fetal and Neonatal Transports Accepted and Back Transports of Infants
3. Copy of Contracts with All Required Staff, Including Written Policy for Arrival Time
4. Copy of Contracts with Subspecialists, Including Written Policy for Arrival Time

Describe outreach and educational activities to professionals within the region (attach additional documentation if needed):

Describe follow-up home care services for high-risk women and infants:

Name of Facility	Date of Application

SECTION IV, CONTINUED
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A REGIONAL PERINATAL CENTER

Describe family planning services:

Describe high risk infant screening and tracking program:

Staff Requirements

Available on a 24-hour basis and able to arrive within 30 minutes:		
Perinatologist	☐ Yes	☐ No
Neonatologist	☐ Yes	☐ No
Anesthesiologist with Special Training in Care of Neonates	☐ Yes	☐ No
Perinatal Clinical Specialist (with Master's in MCH)	☐ Yes	☐ No
Available on a 24-hour basis, present in hospital:		
Obstetrician	☐ Yes	☐ No
Neonatologist, Neonatal Fellow or Pediatrician with Training in Neonatal Medicine	☐ Yes	☐ No
Registered Nurse Staff Ratio:		
Newborn (Includes Licensed Nurses) 1:8	☐ Yes	☐ No
Intermediate 1:4	☐ Yes	☐ No
Intensive 1:2	☐ Yes	☐ No

Name of Facility	Date of Application

SECTION IV, CONTINUED
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A REGIONAL PERINATAL CENTER

How long has the board certified perinatologist been on staff?

_____ Years _____ Months

Does your facility have 24-hour consultation capabilities with subspecialists?

☐ Yes ☐ No

Does your facility have antenatal testing capability?

☐ Yes ☐ No

a. If yes, describe all components and follow-up procedures:

Does your facility have a high-risk prenatal clinic under the direction of a board certified perinatologist?

☐ Yes ☐ No

a. If yes, give location:

Does your facility have a maternal-fetal transport team?

☐ Yes ☐ No

a. If yes, describe team members and vehicle used:

b. Describe reasons for any maternal-fetal transports out of your facility:

Does your facility have a neonatal transport team?

☐ Yes ☐ No

a. If yes, describe team members and vehicle used:

b. Describe reasons for any neonatal transports out of your facility:

Name of Facility	Date of Application

SECTION V

TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION OF NEONATAL SERVICES AS PART OF A SPECIALTY ACUTE CARE CHILDREN'S HOSPITAL

Number of Low Birthweight Infants (<2500 grams) Managed in Past 2 Years:	Number of Very Low Birthweight Infants (<1500 grams) Managed in Past 2 Years:	Number of Neonatal Transports Accepted:
_____	_____	_____

Attach copies of the following documentation:

1. Copy of Contracts with All Required Staff, Including Written Policy for Arrival Time
2. Copy of Letters of Agreement with Regional Perinatal Centers and All Acceptable Community Perinatal Centers Within the Region
3. Copy of Contracts with Subspecialists, Including Written Policy for Arrival Time

Staff Requirements

Board Certified Neonatologist (available ona 24-hour basis, present in the hospital)	☐ Yes	☐ No
Perinatal Clinical Nurse Specialist	☐ Yes	☐ No
Registered Nurse (clinical responsibility)	☐ Yes	☐ No

Registered Nurse Staff Ratio:

Intermediate 1:4	☐ Yes	☐ No
Intensive 1:2	☐ Yes	☐ No

Does your facility have a neonatal transport team?

☐ Yes ☐ No

a. If yes, describe team members and vehicle used:

Name of Facility	Date of Application

SECTION V, CONTINUED

TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION OF NEONATAL SERVICES AS PART OF A SPECIALTY ACUTE CARE CHILDREN'S HOSPITAL

Describe outreach and educational activities to professionals within the region (attach additional documentation if needed):

Describe high-risk infant screening and tracking program:

Describe subspecialty services available for neonates (e.g., ECMO, transplant surgery, etc.):

Name of Facility	Date of Application

SECTION VI

TO BE COMPLETED BY ALL APPLICANTS

CERTIFICATION BY APPLICANT

I certify that by applying for the perinatal designation specified above in this application, all of the information provided in this application is true and correct to the best of my knowledge and ability.

I further certify that I have read and understand all the requirements of this designation as specified in N.J.A.C. 8:33C and N.J.A.C. 8:43G and that this facility meets all of those requirements for service.

Name of Individual Completing Form	Title

Signature	Date