

**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
25 South Stockton Street, 2nd 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.

**INSTRUCTIONS FOR
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(Continued)**

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 <input type="checkbox"/> 3-Year Trend <input type="checkbox"/> 1-Year	
Previously Approved Designation			
Designation Requested <input type="checkbox"/> Community Perinatal Center-Birthing <input type="checkbox"/> Community Perinatal Center-Intensive <input type="checkbox"/> Community Perinatal Center-Basic <input type="checkbox"/> Regional Perinatal Center <input type="checkbox"/> Community Perinatal Center-Intermediate <input type="checkbox"/> Specialty Acute Care Children's Hospital			
Number of Licensed Beds (Entire Facility) _____		Type of Hospital <input type="checkbox"/> Public <input type="checkbox"/> Private	
Description of the Service Area (include a copy of a map showing the service area): 			
Services Provided <input type="checkbox"/> Medical/Surgical <input type="checkbox"/> Pediatrics <input type="checkbox"/> Critical Care (Adult) <input type="checkbox"/> Critical Care (Neonatal) <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Psychiatric <input type="checkbox"/> Critical Care (Pediatric)			

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

Name of Facility	Date of Application
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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:

	<u>PEDIATRIC</u>	<u>PRENATAL</u>
a. Is Hospital a Healthstart Provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If Yes, Provider Number:	_____	_____
c. If No, is Application Pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. If Yes, Date of Application *	_____	_____

(* Provide copy of Healthstart Application with CN Application)

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

Name of Facility	Date of Application
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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):

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

Name of Facility	Date of Application
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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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Geneticists/Genetic Counselors	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Social Workers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Public Health Nurses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician Specialists	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lactation Consultants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

Name of Facility	Date of Application
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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

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

Name of Facility	Date of Application
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RESIDENCY PROGRAMS

Does your facility have residency programs in the following areas:

Obstetrics:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Number of Current Residents:	<hr/>
Pediatrics:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Number of Current Residents:	<hr/>
Family Practice:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Number of Current Residents:	<hr/>

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:

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pediatrician with Training and Experience in Neonatal Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anesthesiologist/Nurse Anesthetist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Registered Nurse (clinical responsibility)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Registered Nurse Staff Ratio:	
Newborn (Includes Licensed Nurses) 1:8	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intermediate 1:4	<input type="checkbox"/> Yes <input type="checkbox"/> No
Attach copies of the following documentation:	
<ol style="list-style-type: none"> 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:	

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

Name of Facility		Date of Application																								
<p>SECTION III TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A COMMUNITY PERINATAL CENTER -INTENSIVE</p>																										
Number of Maternal-Fetal Transports Made: _____	Number of Neonatal Transports Made: _____	Number of Neonatal Transports Accepted: _____																								
<p>Staff Requirements</p> <p>Available on a 24-hour basis and able to arrive within 30 minutes or in hospital):</p> <table style="width:100%; border:none;"> <tr> <td style="width:55%;">Obstetrician</td> <td style="width:20%;"><input type="checkbox"/> Yes</td> <td style="width:25%;"><input type="checkbox"/> No</td> </tr> <tr> <td>Neonatologist</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Anesthesiologist with Special Training in Care of Neonates</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Registered Nurse (clinical responsibility)</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table> <p>Available on a 24-hour basis and able to arrive within 30 minutes or in hospital):</p> <table style="width:100%; border:none;"> <tr> <td style="width:55%;">Neonatologist, Neonatal Fellow or Pediatrician with Training in Neonatal Medicine</td> <td style="width:20%;"><input type="checkbox"/> Yes</td> <td style="width:25%;"><input type="checkbox"/> No</td> </tr> </table> <p>Registered Nurse Staff Ratio:</p> <table style="width:100%; border:none;"> <tr> <td style="width:55%;">Newborn (Includes Licensed Nurses) 1:8</td> <td style="width:20%;"><input type="checkbox"/> Yes</td> <td style="width:25%;"><input type="checkbox"/> No</td> </tr> <tr> <td>Intermediate 1:4</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Intensive 1:2</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table>			Obstetrician	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neonatologist	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anesthesiologist with Special Training in Care of Neonates	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Registered Nurse (clinical responsibility)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neonatologist, Neonatal Fellow or Pediatrician with Training in Neonatal Medicine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Newborn (Includes Licensed Nurses) 1:8	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Intermediate 1:4	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Intensive 1:2	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Obstetrician	<input type="checkbox"/> Yes	<input type="checkbox"/> No																								
Neonatologist	<input type="checkbox"/> Yes	<input type="checkbox"/> No																								
Anesthesiologist with Special Training in Care of Neonates	<input type="checkbox"/> Yes	<input type="checkbox"/> No																								
Registered Nurse (clinical responsibility)	<input type="checkbox"/> Yes	<input type="checkbox"/> No																								
Neonatologist, Neonatal Fellow or Pediatrician with Training in Neonatal Medicine	<input type="checkbox"/> Yes	<input type="checkbox"/> No																								
Newborn (Includes Licensed Nurses) 1:8	<input type="checkbox"/> Yes	<input type="checkbox"/> No																								
Intermediate 1:4	<input type="checkbox"/> Yes	<input type="checkbox"/> No																								
Intensive 1:2	<input type="checkbox"/> Yes	<input type="checkbox"/> No																								
<p>Does your facility have a Neonatal Transport Team?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, describe team members and vehicles:</p> 																										
<p>Attach copies of the following documentation:</p> <ol style="list-style-type: none"> 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 																										

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

Name of Facility	Date of Application
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**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:

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

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: _____
<p>Attach copies of the following documentation:</p> <ol style="list-style-type: none"> 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 	
<p>Describe outreach and educational activities to professionals within the region (attach additional documentation if needed):</p>	
<p>Describe follow-up home care services for high-risk women and infants:</p>	

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

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? <div style="text-align: right; margin-right: 50px;">_____ Years</div> <div style="text-align: right; margin-right: 50px;">_____ Months</div>	
Does your facility have 24-hour consultation capabilities with subspecialists? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your facility have antenatal testing capability? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, give location:	
Does your facility have a maternal-fetal transport team? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, describe team members and vehicle used: b. Describe reasons for any neonatal transports out of your facility:	

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

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.):	

**APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)**

Name of Facility	Date of Application
SECTION VI TO BE COMPLETED BY ALL APPLICANTS	
CERTIFICATION BY APPLICANT	
<p style="text-align: center;"><i>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></p> <p style="text-align: center;"><i>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.</i></p>	
Name of Individual Completing Form	Title
Signature	Date