COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY
CERTIFICATE OF NEED

LETTER OF INTENT

(Valid for a period of one year from date of filing)

1. NAME & ADDRESS OF FACILITY, PROGRAM OR SERVICE:

_____

_____

_____

2. NAME & ADDRESS OF OWNER:
(Legally responsible person, corporation, or other entity who is or will be the license holder)

_____

_____

_____

3. CONTACT PERSON:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

4. CITY & COUNTY OF PROPOSED SERVICE OR FACILITY:

City: _____ County: _____

5. DESCRIPTION OF PROJECT: _____

_____

_____

6. DATE APPLICATION WILL BE FILED:

_____

7. FILED BY:

_____
(Authorized Signature) (Date)

_____
(Name - Print)

_____
(Title)

_____
(Address if different from question number 1 above)

COMPLETE AND RETURN TO:

OFFICE OF HEALTH POLICY
CERTIFICATE OF NEED
275 EAST MAIN STREET 4WE
FRANKFORT, KY 40621