APA-1

**TRANSMITTAL SHEET FOR**
**NOTICE OF INTENDED ACTION**

Control 410 Department or Agency State Health Planning and Development Agency
Rule No. 410-2-5-.05
Rule Title: Application for State Health Plan Adjustment
____ New _X_ Amend ____ Repeal ____ Adopt by Reference

| | |
|---|---|
| Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? | NO |
| Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? | YES |
| Is there another, less restrictive method of regulation available that could adequately protect the public? | NO |
| Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree? | NO |
| Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule? | N/A |
| Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? | YES |

**********

| | |
|---|---|
| Does the proposed rule have an economic impact? | NO |

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

**********

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Service Agency.

Signature of certifying officer Alva M. Lambert

Date October 10, 2017

(DATE FILED)
(STAMP)

# NOTICE OF INTENDED ACTION

AGENCY NAME: STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
(Statewide Health Coordinating Council)

RULE NO. & TITLE: 410-2-5-.05 Application for State Health Plan Adjustment
(Organizational Outline to be Used)

INTENDED ACTION:
The State Health Planning and Development Agency (Statewide Health Coordinating Council) proposes to amend the above styled section of the *Alabama State Health Plan.*

SUBSTANCE OF PROPOSED ACTION:
This proposed amendment clarifies the criteria that should be submitted when filing an Application for State Health Plan Adjustment.

TIME, PLACE, MANNER OF PRESENTING VIEWS:
In response to this Proposed Rule, all interested persons are invited to submit data, views, comments and/or arguments, orally or in writing. Any and all such data, comments, arguments and/or requests to orally address the SHCC shall be made in writing on or before December 6, 2017, and shall be made to:

Karen McGuire, Executive Secretary
State Health Planning and Development Agency
P. O. Box 303025
Montgomery, Alabama 36130-3025

On January 11, 2018, at 10:30 a.m., the SHCC shall conduct a public hearing in Room 200, 11 South Union Street, Montgomery, Alabama, at which time it shall consider the Proposed Rule, along with all written and oral submissions with respect to the Proposed Rule. Only those interested persons who have made timely written requests will be afforded the opportunity to speak.

Copies of the proposed changes are available for review at 100 North Union Street, RSA Union Building, Suite 870, Montgomery, Alabama. Phone (334) 242-4103 or visit the office Monday through Friday from 8:00 a.m. to 5:00 p.m., excluding State holidays.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
December 6, 2017

CONTACT PERSON AT AGENCY:
Karen McGuire, Executive Secretary
100 North Union Street
RSA Union, STE 870
Montgomery, AL 36104
(334) 242-4103

Alva M. Lambert

Alva M. Lambert, Executive Director

410-2-5-.05 **Application for State Health Plan Adjustment** ~~(Organizational Outline to be Used)~~

1. Requirements

(1) Applicant Identification. ~~Name of applicant, address, telephone number, contact person, fee and proof of publication of a notice of the proposed adjustment and the SHCC hearing or meeting scheduled to consider the adjustment in a newspaper having general circulation in the county in which the proposed adjustment is requested as well as any other county in the service area for which the adjustment is proposed.~~ An application for a Plan Adjustment must be filed in accordance with SHPDA Rule 410-1-3-.09, and accompanied by the administrative fee specified in Rule 410-2-5-.04(c)(5). The application must include the name of the applicant, physical address, telephone number, the contact person and their mailing address, telephone number, and e-mail address.

(2) Project Description. Provide a narrative statement explaining the nature of the request, with details of the plan adjustment desired. (If the request is for additional beds, indicate the number and type, i.e., Psychiatric, Rehabilitation, Pediatric, Nursing Home, etc.) The narrative should address availability, accessibility, cost, ~~and~~ quality of the health care in question, and state with specificity the proposed language of the adjustment.

(3) Service Area. Describe the geographical area to be served. (Provide a 8½" x 11" map of the service area. The map should indicate the location of other similar ~~like~~ health care facilities in the area.)

(4) Population Projections. Provide population projections for the service area. In the case of beds for a specific age group, such as pediatric beds or nursing home beds, be sure to document the existence of the affected population. An example for nursing home beds would be the number of persons 65 and older. The applicant must include the source of all information provided.

(5) ~~Present a summary of industry currently existing that anticipates major expansion and new industries projected for the area. Include names of industries and estimated number of people projected to be employed.~~ Need for the Adjustment. Address the current need methodology. If the application is to increase beds or services in a planning area, give evidence that those beds or services have not been available and/or accessible to the population of the area.

(6) Current and Projected Utilization. Provide current and projected utilization of similar facilities or services within the proposed service area. ~~If the application is to increase beds or services in a planning area, give evidence that those beds or services have not been available and/or accessible to the population of the area. Provide names of individuals denied services.~~

~~(7) Give the names and specialties of all physicians committed to practice in the area, their location, and if possible, their opinion of the proposed adjustment.~~

(7~~8~~) If additional staffing will be required to support the additional need, indicate the availability of such staffing.

(8~~9~~) Effect on Existing Facilities or Services. Address the impact this plan adjustment will have on other facilities in the area both in occupancy and manpower. ~~areas.~~

(9~~10~~) Community Reaction. Give evidence of project support demonstrated by local community, civic and other organizations. (Testimony and/or comments regarding plan adjustment provided by community leaders, health care professionals, and other interested citizens.)

(10~~1~~) Provide any other information or data available ~~you so desire~~ in justification of the ~~your~~ plan adjustment request.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: §§ 22-21-260(~~1~~)(13), (15), Code of Alabama, 1975.
History: Effective November 22, 2004. Amended: Filed _____; effective: _____.