**Schedule 1**

**All CON Applications**

**Contents:**

* **Acknowledgement and Attestation**
* **General Information**
* **Contacts**
* **Affiliated Facilities/Agencies**

**Acknowledgement and Attestation**

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant:

I further certify that the information contained in this application and its accompanying schedules and attachments are accurate, true and complete in all material respects. I acknowledge and agree that this application will be processed in accordance with the provisions of articles 28, 36 and 40 of the public health law and implementing regulations, as applicable.

|  |  |
| --- | --- |
| SIGNATURE: | DATE |
|  |  |
| PRINT OR TYPE NAME | TITLE |
|  |  |

**General Information**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | | Title of Attachment: |
| Is the applicant an existing facility? If yes, attach a photocopy of the resolution or consent of partners, corporate directors, or LLC managers authorizing the project. | | YES  NO |  |
| Is the applicant part of an "established PHL Article 28\* network" as defined in section 401.1(j) of 10 NYCRR? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart. | | YES  NO |  |

**Contacts**

The Primary and Alternate contacts are the only two contacts who will receive email notifications of correspondence in NYSE-CON. ***At least one of these two contacts should be a member of the applicant.*** The other may be the applicant’s representative (e.g., consultant, attorney, etc.). What is entered here for the Primary and Alternate contacts should be the same as what is entered onto the General Tab in NYSE-CON.

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Contact** | NAME AND TITLE OF CONTACT PERSON | CONTACT PERSON'S COMPANY | |
|  |  | |
| BUSINESS STREET ADDRESS | | |
|  | | |
| CITY | STATE | ZIP |
|  |  |  |
| TELEPHONE | E-MAIL ADDRESS | |
|  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Alternate Contact** | NAME AND TITLE OF CONTACT PERSON | CONTACT PERSON'S COMPANY | |
|  |  | |
| BUSINESS STREET ADDRESS | | |
|  | | |
| CITY | STATE | ZIP |
|  |  |  |
| TELEPHONE | E-MAIL ADDRESS | |
|  |  | |

The applicant must identify the operator's chief executive officer, or equivalent official.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CHIEF EXECUTIVE** | NAME AND TITLE | | | |
|  | | | |
| BUSINESS STREET ADDRESS | | | |
|  | | | |
| CITY | | STATE | ZIP |
|  |  | |  |
| TELEPHONE | E-MAIL ADDRESS | | |
|  |  | | |

The applicant's lead attorney should be identified:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ATTORNEY** | NAME | FIRM | | BUSINESS STREET ADDRESS |
|  |  | |  |
| CITY, STATE, ZIP | | TELEPHONE | E-MAIL ADDRESS |
|  | |  |  |

If a consultant prepared the application, the consultant should be identified:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CONSUTANT** | NAME | FIRM | | BUSINESS STREET ADDRESS |
|  |  | |  |
| CITY, STATE, ZIP | | TELEPHONE | E-MAIL ADDRESS |
|  | |  |  |

The applicant's lead accountant should be identified:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ACCOUNTANT** | NAME | FIRM | | BUSINESS STREET ADDRESS |
|  |  | |  |
| CITY, STATE, ZIP | | TELEPHONE | E-MAIL ADDRESS |
|  | |  |  |

Please list all Architects and Engineer contacts:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ARCHITECT and/or ENGINEER** | NAME | FIRM | | BUSINESS STREET ADDRESS |
|  |  | |  |
| CITY, STATE, ZIP | | TELEPHONE | E-MAIL ADDRESS |
|  | |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ARCHITECT and/or ENGINEER** | NAME | FIRM | | BUSINESS STREET ADDRESS |
|  |  | |  |
| CITY, STATE, ZIP | | TELEPHONE | E-MAIL ADDRESS |
|  | |  |  |

**Other Facilities Owned or Controlled by the Applicant**

*Establishment (with or without Construction) Applications only*

**NYS Affiliated Facilities/Agencies**

Does the applicant legal entity or any related entity (parent, member or subsidiary corporation) operate or control any of the following in New York State?

|  |  |  |
| --- | --- | --- |
| **FACILITY TYPE - NEW YORK STATE** | **FACILITY TYPE** |  |
| Hospital | HOSP | **Yes  No** |
| Nursing Home | NH | **Yes  No** |
| Diagnostic and Treatment Center | DTC | **Yes  No** |
| Midwifery Birth Center | MBC | **Yes  No** |
| Licensed Home Care Services Agency | LHCSA | **Yes  No** |
| Certified Home Health Agency | CHHA | **Yes  No** |
| Hospice | HSP | **Yes  No** |
| Adult Home | ADH | **Yes  No** |
| Assisted Living Program | ALP | **Yes  No** |
| Long Term Home Health Care Program | LTHHCP | **Yes  No** |
| Enriched Housing Program | EHP | **Yes  No** |
| Health Maintenance Organization | HMO | **Yes  No** |
| Other Health Care Entity | OTH | **Yes  No** |

Upload as an attachment to Schedule 1, the list of facilities/agencies referenced above, in the format depicted below:

| **Facility Type** | **Facility Name** | **Operating Certificate**  **or License Number** | **Facility ID (PFI)** |
| --- | --- | --- | --- |

**Out-of-State Affiliated Facilities/Agencies**

In addition to in-state facilities, please upload, as an attachment to Schedule 1, a list of all health care, adult care, behavioral, or mental health facilities, programs or agencies located outside New York State that are affiliated with the applicant legal entity, as well as with parent, member and subsidiary corporations, in the format depicted below.

| **Facility Type** | **Name** | **Address** | **State/Country** | **Services Provided** |
| --- | --- | --- | --- | --- |

In conjunction with this list, you will need to provide documentation from the regulatory agency in the state(s) where affiliations are noted, reflecting that the facilities/programs/agencies have operated in substantial compliance with applicable codes, rules and regulations for the past ten (10) years (or for the period of the affiliation, whichever is shorter). More information regarding this requirement can be found in Schedule 2D.