NEW YORK STATE | Department of Health | Office of Health Insurance Programs

New Freestanding Clinic Form

New providers are required to submit the following:					
1	Cover letter providing the details of the request, signed by the provider's CEO/CFO and addressed to =>	**Monique Grimm** **Chief Health Care Fiscal Analyst** **Bureau of Hospital & Clinic Rate Setting** **One Commerce Plaza, Room 1432** **99 Washington Avenue** **Albany, New York 12210**			
2	Copy of the Certificate of Need (CON) approval letter issued by the Division of Health Facility Planning. For copies or questions email: cons@health.ny.gov				
3	Copy of the Operating Certificate.				
4	If the building is leased, a copy of the lease.				
5	Annual Visits / Procedures projected as part of the Certificate of Need (CON) process			**Total Annual Visits**	**Total Annual Medicaid Fee-for-Service Visits**
6	**Provider Type ==>**		*Refer to Grouping per NYCRR Part 86-4.13*		
7	Itemized details of the Total CON-approved capital costs. ***Note : Complete all applicable information. All items may NOT apply to your facility.***				
		CON Approved Capital Costs ($ Value)	**Useful Life of the Asset**	**Depreciation / Amortization per Year**	
a.	Rent (if the building is leased)				
b.	Building				
c.	Renovation & Demolition				
d.	Construction Contingency				
e.	Architect / Engineering Fees				
f.	Other Fees				
g.	Moveable Equipment				
h.	Financing Costs				
i.	Interim Interest Expense				
j.	CON Fees				
	Total Project Cost approved per the CON application	**$0**		**$0**	