



Certificate of Need Program

**INFORMATION REQUEST FORM**

Name <i>(please type or print)</i>	Title
	Telephone Number
Organization	Fax Number
	E-mail address
Address <i>(Street / City / State / Zip Code)</i>	

**I request the following and agree to pay charges as billed by the Certificate of Need Program:**

<u>Check Item Needed</u>	<u>Quantity</u>	<u>Cost/Item</u>	<u>Total</u>
<input type="checkbox"/> Certificate of Need Rulebook	_____	_____	_____
<input type="checkbox"/> Hosp & NH ICF/SNF Occup. and Bed Need Summary by County	_____	_____	_____
<input type="checkbox"/> Six-Qtr Occupancy of Hosp & NH Lic. & Available ICF/SNF Beds	_____	_____	_____
<input type="checkbox"/> Six-Qtr Occupancy of ICF/SNF Licensed Beds	_____	_____	_____
<input type="checkbox"/> RCF/ALF Occupancy and Bed Need Summary By County	_____	_____	_____
<input type="checkbox"/> Six-Qtr Occupancy of RCF/ALF Licensed and Available Beds	_____	_____	_____
<input type="checkbox"/> Six-Qtr Occupancy of RCF/ALF Licensed Beds	_____	_____	_____
<input type="checkbox"/> Inventory of Hospital Beds in Missouri	_____	_____	_____
<input type="checkbox"/> Special Computer and File Searches <i>(1 hour minimum charge)</i>	_____	_____	_____
<input type="checkbox"/> Certificate of Need educational and performance handouts	_____	_____	_____
<input type="checkbox"/> Copies of Other Materials <i>(Please specify in the blanks below)</i>	_____	_____	_____
_____			
_____			
_____			
_____			
		<b>Subtotal = \$</b>	_____
		Shipping and Handling Fee**	_____

\* Charge will be assessed **after** search and added to final bill. **Total due: \$** \_\_\_\_\_ **\*\*\***

\*\* If delivered by regular mail (**waived** if items picked up at CONP Office), or billed at actual cost if shipped by courier or other method of delivery.

\*\*\* A check made payable to "**Missouri Health Facilities Review Committee**" **must** accompany all out-of-state requests.

Signature <i>(signature is required to process request)</i>	Date
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Mail (with prepayment if required), e-mail or fax request form to:

**Certificate of Need Program**  
**P.O. Box 570**  
**Jefferson City, MO 65102**

Phone: 573-751-6403 Fax: 573-751-7894 E-mail: tom.piper@dhss.mo.gov  
For electronic versions for some of the above, go to CON web site at: **www.dhss.mo.gov/con**