PRE-CONSTRUCTION PROJECT INFORMATION FORM

FACILTY NAME: ____

FACILITY LICENSE TYPE:

General Acute Hospital ____ Critical Access Hospital (CAH) ____ Specialty Hospital (specify) ____
CDD ____ Assisted Living ____ Nursing Home ____ ICF/IID ____ Childrens Day Health ____
Adult Day ____ Mental Health/Substance Abuse Trmt ____ Hospice ____ Health Clinic/ESRD ____
Health Clinic/ASC ____ Health Clinic ____ Other____

FACILITY ADDRESS: (City, Street, County)

____

PROJECT NAME (**Note:** the project name **must** match on all documents submitted)

PROJECT SCOPE: Please provide a **brief** description of the construction project.

Will construction affect current patients/residents/clients? Yes ___ No ___ Not Applicable ___
If YES, *please describe the plan to accommodate their needs and ensure licensure regulations will continue to be met during construction*:

Is the project a single phase or a multi-phase project? Single phase ______ Multi-phase ______
*If multi-phase, please provide the name of each phase (ie ER West, Patient Tower 3E, etc). Keep in mind these names **must** match all through out the process.*

PROJECT TYPE: New Facility ____ Replacment Facility ____ Addition ____ Remodeling ____

FACILITY PROJECT CONTACT PERSON

Printed Name: ____

Phone Number: ____________________________ Email address: ________________________________

Signature of facility staff submitting this documentation: ____________________________________

Printed Name: ____ Date: ______________________

____ I have submitted plans to DHHS Facility Construction and reviewed the State Fire Marshal website.