

**MASSACHUSETTS DETERMINATION OF NEED PROGRAM**

**RESEARCH PROJECT NOTICE OF ASSURANCE FORM**

To assure compliance with the requirements of Massachusetts General Laws, c.111, §.25C, (A) (1) (a), concerning the exemption of certain research projects from determination of need review, please answer questions 1-6 below. Please refer to Massachusetts General Laws, c.111, §.25B and the Massachusetts Determination of Need Regulations for applicable definitions in completing this form.

- 1. A brief description of the proposed project indicating if this project is related solely to research in the basic biomedical or health care delivery areas.

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- 2. a. Will the proposed project increase clinical bed capacity?

Yes \_\_\_\_\_ No \_\_\_\_\_

- b. Will the proposed project increase the outpatient load capacity of the health care facility?

Yes \_\_\_\_\_ No \_\_\_\_\_

- 3. a. Will the project increase the gross patient service revenue of the facility?

Yes \_\_\_\_\_ No \_\_\_\_\_

- b. Will the project increase non-patient service revenue of the facility?

Yes \_\_\_\_\_ No \_\_\_\_\_

Provide explanation if answer to either or both is Yes. \_\_\_\_\_

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**Research Project Notice of Assurance**

- 4. a. Will the project increase patient-related expenses of the facility?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- b. Will the project increase non-patient-related expenses of the facility?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Provide explanation if answer to either or both is Yes. \_\_\_\_\_  
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- 5. Please indicate source and percent of project funding. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 6. Is an application for determination of need pending for a reasonably similar capital expenditure or change in services?  
Yes \_\_\_\_\_ No \_\_\_\_\_

- 7. On behalf of \_\_\_\_\_ (Name of Facility)  
the undersigned assure that the project shall be related solely to the conduct of research in the basic biomedical or health care delivery areas and shall at no time result in any increase in the clinical bed capacity or outpatient load capacity of the facility and shall at no time cause an increase in the total patient care charges of the facility to the public for health care services, supplies and accommodations.

The undersigned also assure that the facility shall not file an application for determination of need for such capital expenditure or change in services until at least one year after commencing such research project. Each of the undersigned hereby certifies that he or she has read this document and that every statement contained herein is true to the best of his or her knowledge.

\_\_\_\_\_  
Signature of Chief Executive Officer

\_\_\_\_\_  
Signature of the Chairman of the Board of Trustees

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date