



Massachusetts Department of Public Health Determination of Need Application Form

Version: 11-8-17

Application Type: Application Date: 04/05/2019 10:15 am

Applicant Name:

Mailing Address:

City: State: Zip Code:

Contact Person: Title:

Mailing Address:

City: State: Zip Code:

Phone: Ext: E-mail:

Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name:

Facility Address:

City: State: Zip Code:

Facility type: CMS Number:

1. About the Applicant

1.1 Type of organization (of the Applicant):

1.2 Applicant's Business Type: Corporation Limited Partnership Partnership Trust LLC Other

1.3 What is the acronym used by the Applicant's Organization?

1.4 Is Applicant a registered provider organization as the term is used in the HPC/CHIA RPO program? Yes No

1.5 Is Applicant or any affiliated entity an HPC-certified ACO? Yes No

1.6 Is Applicant or any affiliate thereof subject to M.G.L. c. 6D, § 13 and 958 CMR 7.00 (filing of Notice of Material Change to the Health Policy Commission)? Yes No

1.7 Does the Proposed Project also require the filing of a MCN with the HPC? Yes No

1.8 Has the Applicant or any subsidiary thereof been notified pursuant to M.G.L. c. 12C, § 16 that it is exceeding the health care cost growth benchmark established under M.G.L. c. 6D, § 9 and is thus, pursuant to M.G.L. c. 6D, §10 required to file a performance improvement plan with CHIA? Yes No

1.9 Complete the Affiliated Parties Form

2. Project Description

2.1 Provide a brief description of the scope of the project.

Please see attached letter.

2.2 and 2.3 Complete the Change in Service Form

3. Delegated Review

3.1 Do you assert that this Application is eligible for Delegated Review? Yes No

3.1.a If yes, under what section?

4. Conservation Project

4.1 Are you submitting this Application as a Conservation Project? Yes No

5. DoN-Required Services and DoN-Required Equipment

5.1 Is this an application filed pursuant to 105 CMR 100.725: DoN-Required Equipment and DoN-Required Service? Yes No

6. Transfer of Ownership

6.1 Is this an application filed pursuant to 105 CMR 100.735? Yes No

7. Ambulatory Surgery

7.1 Is this an application filed pursuant to 105 CMR 100.740(A) for Ambulatory Surgery? Yes No

8. Transfer of Site

8.1 Is this an application filed pursuant to 105 CMR 100.745? Yes No

8.2 Current location of Site

Facility Name:

Physical Address:

City: State: Zip Code:

Facility type:

8.3 Location of Proposed Site

Facility Name: Regis Dental Center

Physical Address: 1432 Main Street

City: Waltham State: Massachusetts Zip Code: 02451

Facility type: Dental Facility

8.4 Compare the scope of the project for each element below:		
	Current Site	Proposed Site
Gross Square Feet	11,000 sf	10,493 sf
Primary Service Area Towns served	Please see attached letter	Please see attached letter
Patient Population (Demographics)	Please see attached letter	Please see attached letter
Patient Access	Please see attached letter	Please see attached letter
Impact on Price	Please see attached letter	Please see attached letter
Total Medical Expenditure	Please see attached letter	Please see attached letter
Provider Costs	Please see attached letter	Please see attached letter
Description	Please see attached letter	Please see attached letter

8.5 Detail all Anticipated Capital Expenditures to be incurred as a result of the proposed Transfer of Site.		
Add Del Row	Anticipated Capital Expenditure	Cost
<input type="checkbox"/> <input type="checkbox"/>	Build out of new location	\$1,000,000.00
<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/> <input type="checkbox"/>		
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	Total Cost	\$1,000,000.00

9. Research Exemption

9.1 Is this an application for a Research Exemption? Yes No

10. Amendment

10.1 Is this an application for a Amendment? Yes No

11. Emergency Application

11.1 Is this an application filed pursuant to 105 CMR 100.740(B)? Yes No

12. Total Value and Filing Fee

Enter all currency in numbers only. No dollar signs or commas. Grayed fields will auto calculate depending upon answers above.

Your project application is for: Transfer of Site/Change in Designated Location

12.1 Total Value of this project:	\$1,000,000.00
12.2 Total CHI commitment expressed in dollars: (calculated)	\$0.00
12.3 Filing Fee: (calculated)	\$0.00
12.4 Maximum Incremental Operating Expense resulting from the Proposed Project:	\$125,000.00
12.5 Total proposed Construction costs, specifically related to the Proposed Project, If any, which will be contracted out to local or minority, women, or veteran-owned businesses expressed in estimated total dollars.	\$500,000.00

13. Factors

Required Information and supporting documentation consistent with 105 CMR 100.210

Some Factors will not appear depending upon the type of license you are applying for.

Text fields will expand to fit your response.

Documentation Check List

The Check List below will assist you in keeping track of additional documentation needed for your application. Once you have completed this Application Form the additional documents needed for your application will be on this list. E-mail the documents as an attachment to: DPH.DON@state.ma.us

- Affidavit of Truthfulness Form
- Articles of Organization / Trust Agreement

Document Ready for Filing

When document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form.

To make changes to the document un-check the "document is ready to file" box. Edit document then lock file and submit

Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the "E-mail submission to Determination of Need" button.

This document is ready to file:



Date/time Stamp: 04/05/2019 10:15 am

E-mail submission to
Determination of Need

Application Number: -19032112-TS

Use this number on all communications regarding this application.

Community Engagement-Self Assessment form