INSTRUCTIONS

Close Instructions | Print Instructions

Filling in Form: This form should be completed and submitted on line using Adobe Acrobat Reader Version 9 or higher. Go to Adobe.com if you do not have the latest version.

Save completed form for your reference (Use the "Save" option only, "Save as" will remove your ability to enter data.)
Reset button will clear all data from the form. **Print button** will print a hard copy of the form.

General Rules for Filling in Forms

Radio Button	**Radio Button:** Select only one answer from the group.
Check Box	**Check Box:** Select all the answers that apply from the group.
+ - Button	**Button:** Clicking on a button will perform the task listed on the label. Plus and minus buttons will add or delete a row in a table.
Date/Time Field	**Date Field:** Click on calendar for arrow to appear, select date. If you type in the date be sure to use this format: MM/DD/YYYY.
Drop-down List	**Drop Down List:** Click on the arrow and select a response from the items supplied. Some drop down lists will allow you to type in custom information.
Text Field	**Text Field:** Type response in the area provided. Answers that require large amounts of text will grow as you type. You can cut and paste text from MS Products or another PDF form.
Numeric Field	**Numeric Field:** Enter numbers only. No $ signs, % signs or commas. If you enter anything other than a number the field will appear blank.
Required	**Required Entry:** Fields with red boxes are required to have a response before form is submitted.
Signature Field	**Signature Fields:** Click on field to sign and date stamp the form with your electronic signature. Signing the form usually locks data entered on the form to prevent change. To change the data on the form delete the signature.

Application Instructions

1. Be sure that you are using the most current version of this Application. www.mass.gov/dph/don\ Additional forms for Affidavit of Truthfulness, Affiliated Parties, Change in Service and Factor 6 can also be found on this site.
2. You can only select a single Application Type. The Application Type selected will determine what documents are needed to complete. Choose the type that best describes the Proposed Project.
3. If you have questions please contact the Determination of Need program at 617- 624- 5690 or via e-mail at dph.don@state.ma.us

Massachusetts Department of Public Health
Determination of Need
Application Form

Version: 11-8-17

Application Type: Transfer of Site/Change in Designated Location

Application Date: 04/02/2025 11:27 am

Applicant Name: VHS Acquisition Subsidiary Number 9, Inc., d/b/a MetroWest Medical Center

Mailing Address: 115 Lincoln Street

City: Framingham State: Massachusetts Zip Code: 01702

Contact Person: Neil Wallis Title: MetroWest Medical Center Associate Administrator

Mailing Address: 115 Lincoln Street

City: Framingham State: Massachusetts Zip Code: 01702

Phone: 5182609999 Ext: E-mail: Neil1.Wallis@mwmc.com

Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name: MetroWest Health & Wellness Center

Facility Address: 761 Worcester Rd #2

City: Framingham State: Massachusetts Zip Code: 01701

Facility type: Hospital CMS Number: 220175

Add additional Facility Delete this Facility

2 Facility Name: MetroWest Medical Center Outpatient Primary Care

Facility Address: 61 Lincoln Street

City: Framingham State: Massachusetts Zip Code: 01702

Facility type: Hospital CMS Number: 220175

Add additional Facility Delete this Facility

3 Facility Name: Framingham Union Hospital

Facility Address: 115 Lincoln Street

City: Framingham State: Massachusetts Zip Code: 01702

Facility type: Hospital CMS Number: 220175

Add additional Facility Delete this Facility

1. About the Applicant

1.1 Type of organization (of the Applicant): for profit

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? MWMC

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

1.5.a If yes, what is the legal name of that entity? Boston Medical Center Health Plan, Inc., d/b/a WellSense Health Plan

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.

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? Transfer of Site or change of a designated Location

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: MetroWest Health & Wellness Center

Physical Address: 761 Worcester Rd #2

City: Framingham State: Massachusetts Zip Code: 01701

Facility type: Hospital

8.3 Location of Proposed Site

Facility Name: Please see attached.

Physical Address:

City: *Type first letter then scroll* State: Massachusetts Zip Code:

Facility type: *Select from dropdown list or enter type if not on list*

8.4 Compare the scope of the project for each element below:

	Current Site	Proposed Site
Gross Square Feet	Please see attached.	Please see attached.
Primary Service Area Towns served	Please see attached.	Please see attached.
Patient Population (Demographics)	Please see attached.	Please see attached.
Patient Access	Please see attached.	Please see attached.
Impact on Price	Please see attached.	Please see attached.
Total Medical Expenditure	Please see attached.	Please see attached.
Provider Costs	Please see attached.	Please see attached.
Description	Please see attached.	Please see attached.

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
+ -	Please see attached.	
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
	Total Cost	

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:	$0.00
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:	$137,600.00
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.	$0.00

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: 04/02/2025 11:27 am

E-mail submission to Determination of Need

Application Number: MWMC-25040109-TS

Use this number on all communications regarding this application.

☐ Community Engagement-Self Assessment form