



## CONSTRUCTION PLANS AND DOCUMENTS SUBMITTAL FORM

*Please complete this form with information regarding the facility subject to plan review  
and submit it as part of the plan review package.*

Date: \_\_\_\_\_

1. **Licensure Category.** This submittal pertains to the following licensure category:

Select facility type:

2. **Facility Information.** Respond to Questions 2.a. - 2.c.

a. Is the facility currently licensed?

If yes, respond to the following:

Facility name	
Facility Address (Street/City/State/Zip)	
Facility Licensure Number	
Facility Certification Number	

b. Is the facility currently licensed and seeking a change of location?

If yes, respond to the following:

New Facility Address (Street/City/State/Zip )	
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c. Is the facility seeking initial licensure?

If yes, respond to the following:

Proposed facility name <sup>1</sup>	
Proposed Facility Address (Street/City/State/Zip)	

<sup>1</sup> Facility names must be approved by the Department prior to registration with the Secretary of State's Office. Facility name *changes* are also subject to Department approval.

d. Is the facility wholly government owned and operated?

If yes, respond to the following:

Voluntary plan review requested – fee included

Plan Review not requested – facility shall notify plan review intake in writing at least ten business days prior to providing department regulated services to the general public.

**3. Ownership Information.**

Owner Name	
Is the facility wholly owned?	

**4. Reason for Construction.** Check all that apply.

<input type="checkbox"/>	Initial licensure	<input type="checkbox"/>	Remodel: essential electrical system	<input type="checkbox"/>	Remodel: egress components
<input type="checkbox"/>	Initial certification <sup>2</sup>	<input type="checkbox"/>	Remodel: increase in -- stations (dialysis treatment clinics only); operating/procedure rooms (ASCs only); birthing rooms (birth centers only); or beds (other applicable facility types)	<input type="checkbox"/>	Remodel: 50% or more of smoke compartment being reconfigured
<input type="checkbox"/>	Change of licensure type	<input type="checkbox"/>	Remodel: addition of square footage	<input type="checkbox"/>	Other. Explain below:
<input type="checkbox"/>	Change of certification type	<input type="checkbox"/>	Remodel: sprinkler		
<input type="checkbox"/>	Change of location	<input type="checkbox"/>	Remodel: fire alarm		
<input type="checkbox"/>	Add/change secured unit	<input type="checkbox"/>	Remodel: medical gas		
<input type="checkbox"/>	Remodel: alteration to sleeping areas	<input type="checkbox"/>	Remodel: kitchen exhaust/suppression system		

**5. Project Information.**

Project square footage	
Plan review fee	
Estimated project completion date	
Estimated opening date	

<sup>2</sup> Certification is the federal process that verifies a health care entity is able to meet the standards of care required for Medicare/Medicaid reimbursement. For a complete list of health care entity types please refer to: <http://www.healthfacilities.info>

**6. Licensed Capacity.**

- a. Is the facility currently licensed and adding to its licensed capacity?

If yes, provide the following information, as applicable.

Number of:	Current	Additional Proposed
Stations <i>(dialysis treatment clinics only)</i>		
Operating /procedure rooms <i>(ambulatory surgical centers only)</i>		
Secured beds <i>(secured unit beds in assisted living and nursing home; locked psych unit in hospital)</i>		
Inpatient beds <i>(beds other than secured beds)</i>		

- 7. Official Point of Contact for the Project.** Provide information regarding the person who will be the official liaison between the Department and the construction project. *(It will be this person's responsibility to relay relevant communications from the Department to other project contacts, designers, contractors or facility personnel.)*

Contact name	
Organization	
Contact phone number	
Contact address <i>(Street/City/State/Zip)</i>	
Contact e-mail	

- 8. Local Fire Department Point of Contact for the Project.** Provide information regarding the person who will be reviewing the project for compliance with the locally adopted fire codes.

Contact name	
Organization	
Contact phone number	
Contact address <i>(Street/City/State/Zip)</i>	
Contact e-mail	

9. **Local Building Department Point of Contact for the Project.** Provide information regarding the person who will be reviewing the project for compliance with the locally adopted building codes.

Contact name	
Organization	
Contact phone number	
Contact address <i>(Street/City/State/Zip)</i>	
Contact e-mail	

10. **Facility Design Questions.** List questions that the applicant would like addressed by the plan review inspector prior to issuance of the preliminary review findings. *(Optional.)*

11. **Patient/Resident Services Description.** Describe the type and size of patient/resident services to be provided in the area subject to plan review. *(If you need more space for this description, you may attach additional pages; however, the narrative should be no more than 1-2 typed pages.)*

12. **Plan Review Packet Enclosures.** I understand that the following should be included in the plan review package submittal:

- the completed Construction Plans and Documents Submittal Form.
- a check in the amount of the plan review fee stapled to the front of the Construction Plans and Documents Submittal Form.
- the construction documents, including specifications and scale drawings with Life Safety Sheets for each floor of the project. For information about the submittal of construction documents, please refer to <http://www.cdphe.state.co.us/hf/LSCrequirements/planreviewsubmittalinstructions.pdf>