



REGULATORY LICENSING UNIT, ARCHITECTURAL REVIEW GROUP
APPLICATION FOR PLAN REVIEW

www.dshs.state.tx.us/hfp/

Tel: (512) 834-6649 Fax: (512) 834-6620

Application #: _____
 Budget: ZZ122
 Fund: 152
 Remittance #: _____

1. Please indicate the type of facility, the estimated cost of the project, and the amount of plan review fee enclosed.							
√	FACILITY TYPE	PLAN REVIEW FEE REQUIREMENTS	COST OF PROJECT	PLAN REVIEW FEE			
	General Hospital	Plan review fee is based on cost of project. To determine project cost and plan review fee see items 1-7 on page 2 of application.	\$	\$			
	Special Hospital		\$	\$			
	Psychiatric Hospital and Crisis Stabilization Unit		\$	\$			
	Special Care Facility		\$	\$			
	Ambulatory Surgery Center		\$				
	End Stage Renal Disease Center		No plan review fee required with this application.	\$			
	Freestanding Emergency Center		\$				
2. Facility Name:				Lic. No.			
Address:							
		Phone No.:	Fax No.:				
Name, Title & Address of Owner/Administrator:							
		Phone No.:	Fax No.:				
3. Architectural Firm:							
Address:							
		Phone No.:	Fax No.:				
4. Name, Title & Firm of Project Contact Person:							
		Phone No.:	Fax No.:				
5. Name of Project:							
6. Project Description (List new, expanded or renovated services, beds, etc., indicating size of area and number of phases in project):							
Number of Phases:		Remodeled sq. ft.	Added sq. ft.	Deleted sq. ft.			
7. Estimated Start Date:			Estimated Completion Date:				
8. Hospitals Only: Bed changes involved in project? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If Yes, please indicate changes in the designed bed capacity below for this project ONLY</small>				9. ESRD's Only: Treatment Stations involved in project.			
Type of Beds	Beds Before Construction	No. Beds + or - Added/Deleted	Beds After Construction	Stations	Before Construction	Stations + or - Added/Deleted	Stations after construction
Medical/Surgical (Includes OB/Gyn)	_____	_____	_____	Treatment stations			
(Includes Pedi beds if less than 15)	_____	_____	_____	Isolation rm/stat			
Pediatric (Only if 15 or more)	_____	_____	_____	Hemo training			
Adolescent	_____	_____	_____	Peritoneal training			
Universal Care	_____	_____	_____	When plan review fee is required, please submit a separate check or money order for the exact amount of the plan review fee with each application. Fees paid to the department are not refundable. Fees are payable to: Texas Department of State Health Services Mail Plans (with copy of Application for Plan Review & copy of check) to: (See page 2 for express mail address) Texas Department of State Health Services Architectural Review Group Delivery Code 2835/MC-2003 P. O. Box 149347 Austin, Texas 78714-9347			
Intermediate Care	_____	_____	_____				
CCU/CCCU/PCCU	_____	_____	_____				
Neonatal CCU	_____	_____	_____				
Continuing Care Nursery	_____	_____	_____				
LDRP	_____	_____	_____				
Post Partum	_____	_____	_____				
Ante Partum	_____	_____	_____				
Comprehensive Medical Rehabilitation	_____	_____	_____				
Skilled Nursing	_____	_____	_____				
Psychiatric	_____	_____	_____				
Chemical dependency	_____	_____	_____				
Total Designed Type Bed Capacity Before Construction for this project only:				Mail Application for Plan Review and check to: ZZ122 - 152 Texas Department of State Health Services Architectural Review Group Delivery Code 2835/MC-2003 P. O. Box 149347 Austin, Texas 78714-9347			
Total Number of Designed Type Beds Added or Deleted for this project only:							
Total Designed Bed Capacity After Construction for this project only:							
Signature:				Title:			
Print Name:				Date:			

Construction documents (plans) for general or special hospitals, psychiatric hospitals, crisis stabilization units, and special care facilities will not be reviewed or approved until the required fee and an Application for Plan Review are received by the Department.

Construction documents (plans) for ambulatory surgical centers, (ASC), end stage renal disease facilities (ESRD), and freestanding emergency medical care facilities (FEC) will not be reviewed or approved until the Application for Plan Review is received by the Department.

Only one set of the plans is required for each submittal.

Plan review fees for general, special and psychiatric hospitals and special care facilities are based upon the estimated construction project costs which are the total expenditures required for a proposed project from initiation to completion, including at least the following:

- (1) expenditures for physical assets such as:
 - (A) site acquisition,
 - (B) soil tests and site preparation,
 - (C) construction and improvements required as a result of the project,
 - (D) building, structure, or office space acquisition,
 - (E) renovation,
 - (F) fixed equipment,
 - (G) energy provisions and alternatives;
- (2) expenditures for professional services including:
 - (A) planning consultants,
 - (B) architectural fees,
 - (C) fees for cost estimation,
 - (D) legal fees,
 - (E) managerial fees,
 - (F) feasibility study;
- (3) expenditures or costs associated with financing, excluding long-term interest, but including:
 - (A) financial advisor,
 - (B) fund-raising expenses,
 - (C) lender's or investment banker's fee,
 - (D) interest on interim financing; and
- (4) expenditure allowances for contingencies including:
 - (A) inflation,
 - (B) inaccurate estimates,
 - (C) unforeseen fluctuations in the money market, or
 - (D) other unforeseen expenditures;
- (5) Regarding purchases, donations, gifts, transfers, and other comparable arrangements whereby the acquisition is to be made for no consideration or at less than the fair market value, the project cost shall be determined by the fair market value of the item to be acquired as a result of the purchase, donation, gift, transfer, or other comparable arrangement.
- (6) The plan review fee schedule below is based on the cost of construction. If cost of project increases at completion, additional plan review fee may be required.

HOSPITALS (General, Special, Psychiatric and Crisis Stabilization Units)		SPECIAL CARE FACILITIES	
Estimated construction costs	Plan review fee	Estimated construction costs	Plan review fee
\$100,000 or less	\$ 300	\$150,000 or less	\$ 200
\$100,001 - \$ 600,000	\$ 850	\$150,001 - \$600.00	\$ 500
\$600,001 - \$2,000,000	\$ 2,000	\$600,001 - \$2,000,000	\$ 850
\$2,000,001 - \$5,000,000	\$ 3,000	\$2,000,001 - \$5,000,000	\$ 1,500
\$5,000,001 - \$10,000,000	\$ 4,000	\$5,000,001 - \$10,000,000	\$ 2,000
\$10,000,001 and over	\$ 5,000	\$10,000,001 and over	\$ 3,000

- (7) If an estimated construction cost cannot be established, the estimated cost shall be based on \$225.00 per square foot for general and special hospitals, and \$105.00 per square foot for psychiatric hospitals and special care facilities. No construction project shall be increased in size, scope or cost unless the appropriate fees are submitted with the proposed changes.

Express Mail - Plans (with copy of Application for Plan Review and copy of check) may be sent by **express mail** to: Texas Department of State Health Services, Architectural Review Group, Delivery Code 2835, 8407 Wall Street, Room S-241, Austin, TX 78754.

