PLEASE HELP CANCER PATIENTS IN WEST MAUI

Re: Certificate of Need Application #20-17 - Establishment of Radiation Therapy Services

Tri- Isle Subarea Health Planning Council review shall be held via Zoom meeting as follows:

Time: Nov 12, 2021 02:00 PM Hawaii Join Zoom Meeting
https://zoom.us/j/97118844372
Meeting ID: 971 1884 4372
Passcode: 195486

Dial by your
location
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 669 900 6833 US (San Jose)
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+1 929 205 6099 US (New York)
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Passcode:
195486
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At each meeting, you or your representative will be given approximately 10 minutes for a presentation. It is most important to directly address the 12 certificate of need criteria or the 6 categories of the criteria in your presentation. Any person from the public wishing to testify will be given approximately three (3) minutes each and will be requested to focus their comments on the criteria.

Certificate of Need applications are reviewed according to the following criteria: relation to the state health services and facilities plan, need and accessibility, quality, cost and finances, relation to the existing health care system, and availability of resources. A copy of the criteria sheet is enclosed for your convenience. We are in the process of obtaining quorums for the Statewide Health Coordinating Council and the Review Panel meetings and will contact you as soon as we are able to confirm we have quorum for these meetings.

(see next sheet for Chart of Criteria)

CRITERIA BY WHICH CERTIFICATE OF NEED APPLICATIONS MUST BE JUDGED

	CRITERIA	MET	NOT MET	COMMENTS
RELATIONSHIP TO THE STATE PLAN	1. Relationship of the proposal to the state health services and facilities plan.			
NEED AND ACCESSIBILITY	2. The need that the population served or to be served has for the services proposed to be offered or expanded, and the extent to which all residents of the area, and in particular the elderly, low income persons, racial and ethnic minorities, women, persons with disabilities, and other underserved groups are likely to have access to those services. 3. In the case of a reduction, elimination, or relocation of a facility or service: A. the need that the population presently served has for the service; B. the extent to which that need will be met adequately by the proposed relocation or by alternative arrangements; and C. the effect of the reduction, elimination, or relocation of the service on the ability of the elderly, low income persons, racial and ethnic minorities, women, persons with disabilities and other underserved groups to obtain needed health care.			
QUALITY OF SERVICE/CARE	4. The applicant's compliance with federal and state licensure and certification requirements. 5. The quality of the health care services proposed. 6. In the case of existing health services or facilities, the quality of care provided by those facilities in the past.			
COST AND FINANCES	7. The probable impact of the proposal on the overall costs of health services to the community. 8. The probable impact of the proposal on the costs of and charges for providing health services by the applicant. 9. The immediate and long-term financial feasibility of the proposal.			
RELATIONSHIP TO THE EXISTING HEALTHCARE SYSTEM	10. The relationship of the proposal to the existing health care system of the area. 11. The availability of less costly or more effective alternative methods of providing services.			
AVAILABILITY OF RESOURCES	12. The availability of resources (including health personnel, management personnel, and funds for capital and operating needs) for the provision of the services proposed to be provided and the need for alternative uses of these resources as identified by the state health services and facilities plan.			