PROJECT COST ESTIMATE WORKSHEET
ARKANSAS DEPARTMENT OF HEALTH (ADH)
Health Facilities Section
Plan Review Office

FACILITY/ PROJECT NAME:________________________________________________________

PROJECT ADDRESS:________________________________________________________________

FACILITY TYPE:______________________________________ COUNTY:____________________

EXISTING FACILITY: YES[ ] / NO[ ] NEW LICENSE: YES[ ] / NO[ ]

ADMINISTRATOR NAME:________________________________________________________

FACILITY CONTACT:
TEL ___________________ FAX: ___________________ E-MAIL: ___________________

ARCHITECT/ENGINEER OF RECORD:_____________________________________________

ADDRESS: ___________________________________________________________________

ARCHITECT/ENGINEER CONTACT PERSON: _______________________________________

TEL ___________________ FAX: ___________________ E-MAIL: ___________________

Does this project have a plumbing component? YES[ ] / NO[ ] Plumbing Plans Enclosed? YES[ ] / NO[ ]

PLAN SUBMISSION FEE

The Plan Submission Fee is a one-time payment covering both Health Facilities Section Plan Review and Protective Health Codes Plumbing Division Plan Review.

The plan submission fee shall be $500 for projects exceeding $50,000 in total cost and shall be 1% of total cost for all projects costing less than or equal to $50,000. For projects consisting of multiple phases, Complex Renovation phases (Section 47:D) will require an additional submission fee for each phase. Phases which are Simple Renovations, repairs, or additions (Section 47:D) will not require additional fees.

Fee check must be made payable to “Division of Health”. Place the check in an envelope marked CHECK and attach to the cover page of the preliminary plan documents.

ESTIMATED PROJECT COST: $ ___________________ DATE SUBMITTED: ________________

CHECK AMOUNT (Not To Exceed $500): $___________ CHECK NUMBER: _______________

Submit all plans, documents, letters or related correspondence to:

For U. S. Postal Service or FedEx/UPS/DHL:
Health Facility Services
Freeway Medical Building
5800 West 10th St., Suite 400
Little Rock, AR  72204

Plan Review Office use only

Project ID #:___________________ Prepared By ___________________ Date:______________
**Functional Program Narrative**

Please provide a summary of the scope of the project and the intended use of the facility. If multiple project phases are involved, please briefly describe the scope of each phase.

Note: Any changes to a facility's number of licensed beds must be formally approved through the licensure process.