FORM C – RELOCATION OF AN EXISTING CERTIFICATE OF APPROVAL OR RELOCATION WITH A PHYSICAL EXPANSION/ EXPANSION OF SERVICES/SIGNIFICANT CHANGE IN CAPACITY

This application is solely for those seeking approval to relocate a modality or service listed on a facility's existing *Certificate of Approval*.

For all other applications, please review information available at: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/diagnostic-services/acdf-application-forms

IMPORTANT APPLICANT INFORMATION

Any publicly or privately-owned Diagnostic Facility in British Columbia intending to bill the British Columbia Medical Services Plan (MSP) for outpatient diagnostic services must obtain a *Certificate of Approval*, granted by the Advisory Committee on Diagnostic Facilities (ACDF) or the Medical Services Commission (MSC).

All *Certificates of Approval* are **site- and owner-specific and cannot be transferred or assigned**. If a facility is sold, the new owner must apply for a new *Certificate of Approval* in order to bill MSP for the provision of outpatient services.

Approval from the ACDF/MSC is required in order to bill MSP for the following outpatient services:

- Diagnostic Radiology
- Diagnostic Ultrasound
- Nuclear Medicine
- Polysomnography
- Pulmonary Function
- Electromyography (EMG)
- Electroencephalography (EEG)

Once an application is approved, the applicant must ensure all required facility accreditation and practitioner credentialing is in place prior to billing MSP for outpatient services.

HOW TO COMPLETE AND SUBMIT THIS APPLICATION

Applicants should complete the entire application, including the Conflict of Interest Declaration and Disclosure, in as much detail as possible. Additional pages should be added and uploaded along with an application, where additional space is required to provide complete information (please clearly indicate which questions/information you are providing additional information on). **When complete and authorized, the application must be submitted through the Ministry of Health's secure upload tool located at**: https://www2.gov.bc.ca/submitacdf

It is the responsibility of the applicant to demonstrate the need for the diagnostic facility or service(s) that are the subject of this application.

For detailed information on the ACDF and each part of this application, see the *ACDF User Guide to Applications for New, Expansion or Relocation of Public Outpatient Services*, at: http://www.gov.bc.ca/diagnosticfacilitiescommittee

For more information on the application and assessment process and the policies that govern it, it is recommended that all applicants review the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities*, at: http://www.gov.bc.ca/diagnosticfacilitiespolicies

PUBLIC DIAGNOSTIC OUTPATIENT SERVICES FACILITY APPLICATION

FORM C – PART 1

Application Date (YYYY / MM / DD)

TYPE OF APPLICATION

- ◯ Relocation of an existing Certificate of Approval
- ◯ Relocation with a physical expansion/expansion of services/significant change in capacity
- ◯ Relocation with significant physical expansion

  Applications involving relocation with significant physical expansion of a diagnostic facility are subject to ACDF Policy 2.4.2 *Assessment Criteria: Accessibility* (found at http://www.gov.bc.ca/diagnosticfacilitiespolicies) and may require additional actions from applicant. If checked, complete this application and contact Diagnostic Facilities Administration at DFAdmin@gov.bc.ca.

TYPE OF SERVICE

(A) Services Requiring Approval

Please specify the service(s) requiring approval by checking the applicable boxes below. ***Please note that due to the dinstinct criteria used to assess each type of application, please reference only ONE modality per application.***

◯ Electromyography (EMG)	◯ Radiology	◯ Ultrasound
◯ Electroencephalography (EEG)	☐ Bone Densitometry	☐ Doppler Studies
◯ Nuclear Medicine	☐ CT Colonography	☐ Nuchal Translucency
◯ Polysomnography	☐ Cardiac CT/CT Coronary Angiography	☐ Transthoracic Echocardiography
◯ Pulmonary Function	☐ Digital Breast Tomosynthesis	☐ Transesophageal Echocardiography

(B) Category(s) of Tests or Fee Item(s) Requiring Approval [1]

Category(s) of Tests	Fee Item(s) (if applicable)

FACILITY ACCREDITATION

Has the diagnostic facility received appropriate facility accreditation from the Diagnostic Accreditation Program (DAP) to provide the service(s) referenced in this application?

◯ Yes ◯ No ◯ Pending DAP approval

DIAGNOSTIC FACILITY INFORMATION

Diagnostic Facility Name	Diagnostic Facility Number	Diagnostic Facility Payment Number

Diagnostic Facility Current Location (street address, city, postal code)

Diagnostic Facility Proposed New Location (street address, city, postal code)

Diagnostic Facility Mailing Address (if different from above)

Please provide detailed reason(s) for relocation request

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
What are the current hours of operation?							

Does the facility relocation include an increase in operating hours? If yes, indicate below the intended new operating hours. ◯ Yes ◯ No

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
What are the intended new operating hours?							

What is the current square footage of the area devoted to outpatient clinical use i.e. the area directly providing the outpatient service(s) to be relocated? (Do not include waiting rooms, staff room, reception or other non-clinical space).

[1] For further detail on applicable Modalities, Categories and Fees see "Billings & Fees" at: http://www.gov.bc.ca/diagnosticfacilitiesfeeitems
To view the Medical Services Commission Payment Schedule, see: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians

DIAGNOSTIC FACILITY INFORMATION continued

What is the proposed square footage of the area devoted to outpatient clinical use, i.e., the area directly providing the outpatient service(s) to be relocated? (Do not include waiting rooms, staff room, reception or other non-clinical space).

Proposed Square Footage

☐ No change

Does the facility's relocation include a significant change in capacity? (i.e., +/– 20% or more in volume, in a 12 month period compared with approved baseline, or +/– 30% or more in volume in a 36 month period.) If yes, please provide details.

◯ Yes ◯ No

If there is to be a change in the delivery of the diagnostic services being relocated, please explain the change(s) in detail. *(Examples could be different equipment, different staffing levels, etc.)*

EQUIPMENT

1. Provide details of existing equipment.

Name/Brand of Equipment	Year/Make/Model	Year Installed	Daily Exam/Test Limit	Detail (as relevant)

2. If applicable, provide details of new or additional equipment to be utilized if this application is approved.

Name/Brand of Equipment	Year/Make/Model	Daily Exam/Test Limit	Detail (as relevant)

State the combined/total number of pieces of equipment

Are there leasing or building ownership deadlines impacting this application? If yes, provide date and details of the deadline and impact.

◯ Yes ◯ No

If this application is approved, what is your estimated implementation date?

Month: Year:

Has an application been submitted for this service/facility in the last 18 months? If yes, please provide submission date:	Submission Date (YYYY / MM / DD)
◯ Yes ◯ No	

PUBLIC DIAGNOSTIC OUTPATIENT SERVICES FACILITY APPLICATION

FORM C – PART 2

APPLICANT INFORMATION

Health Authority / Corporate Name
Health Authority / Corporate Mailing Address

PRIMARY CONTACT INFORMATION	ALTERNATE CONTACT INFORMATION
Name	Name
Title	Title
Email	Email
Phone Number	Phone Number

CONFLICT OF INTEREST

Appendix A (Conflict of Interest Declaration) and Appendix B (Conflict of Interest Disclosure) must be completed and submitted with the application in order for this application to be considered. For the relevant policies, see Policy 2.4.4 of the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities* and the *Diagnostic Facility Conflict of Interest Policy* at http://www.gov.bc.ca/diagnosticfacilitiespolicies

Are Appendix A and Appendix B included with this application? ◯ Yes ◯ No

LOCATION OF LIKE DIAGNOSTIC FACILITIES (providing same service as applicant facility)

Provide the name, location, distance in kilometres and approximate driving time from applicant diagnostic facility to closest public and privately-owned diagnostic facility providing the same service(s) as applicant facility. For a current list of approved diagnostic facilities see "Approved Diagnostic Services Facilities in B.C." at http://www.gov.bc.ca/diagnosticfacilitiescommittee

Closest publicly-owned, ACDF-approved diagnostic facility (e.g. hospital) providing the same service(s) as applicant facility

Public Diagnostic Facility Name		Diagnostic Facility Street Address
Distance to applicant facility (km)	Approx. driving time to applicant facility	

Closest privately-owned, ACDF-approved diagnostic facility providing the same service(s) as applicant facility

Private Diagnostic Facility Name		Diagnostic Facility Street Address
Distance to applicant facility (km)	Approx. driving time to applicant facility	

RATIONALE FOR APPLICATION

◯ Medical Need
◯ Health & Safety
◯ Other (please specify)

Please provide detailed rationale for application. Specify any gaps in current availability of this diagnostic service for the geographic area applicant diagnostic facility is expected to serve (as applicable). Append additional information as required.

IMPACT

How would this application impact other services within this or other Health Authorities?

Have any such implications or impacts been discussed with the affected Health Authority? Please provide details below.

If applicable, describe how relocation will improve the delivery and management of inpatient services at the applicant facility.

ACCESS

Identify and provide details of any access/availability issues impacting provision of service that this application will address.

UTILIZATION

Appropriate utilization of diagnostic services is a key focus of the Medical Service Commission (MSC). The MSC's Guidelines and Protocols Committee (GPAC) is responsible for developing provincial guidelines and protocols to support appropriate utilization. The MSC approved guidelines and protocols are available at: http://www.bcguidelines.ca/

If this application is approved, how will utilization of the diagnostic service provided be managed? Please provide details below.

- ☐ BC Guidelines and Protocols
- ☐ Clinical guidelines and protocols (e.g. Canadian Clinical Practice Guidelines)
- ☐ Utilization Methods

VOLUME ESTIMATES / CAPACITY

If application is approved, information pertaining to volume of MSP billable services will assist with establishing a facility throughput baseline. Baselines are used in the measurement of diagnostic facility throughput increase/decrease, for the purpose of monitoring for Significant Change. Throughput is defined as the volume of approved services rendered in a given time period.

For more information on the policy of Significant Change, see *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities*, posted at: http://www.gov.bc.ca/diagnosticfacilitiespolicies

Please estimate ***both*** the projected monthly volume of MSP billable service(s) applied for as well as the potential maximum monthly volume of MSP billable service(s) applied for (i.e. the volume of tests expected if application is approved and the maximum volume of tests that could be done based on facility and equipment capacity detailed in this application).

Estimates should be based on the expanded facility/equipment or new location (not current facility/equipment/location).

Category of Test(s) and/or Fee Items	Projected Monthly Volume of MSP Billable Services	Potential Maximum Monthly Volume of MSP Billable Services

STAFFING

As human resources are a key component of any diagnostic facility, the Advisory Committee on Diagnostic Facilities requires details of current/projected clinical and technical staffing levels.

Medical Director responsible for onsite diagnostic service(s) referenced in application	Department
Email	Phone

What is the basis of the Medical Director's remuneration?

◯ Fee-for-service ◯ Contract ◯ Salary ◯ Other (specify):

Please list ALL medical practitioners who will perform and bill the Medical Services Plan for the services applied for. Include Fee-for-Service as well as those medical practitioners who will perform the services and be reimbursed through other methods, i.e., contract, salary. If more lines needed, please append additional listings to this application.

Name of Medical Practitioner	MSP Practitioner Number	Qualifications if No MSP Practitioner Number	Basis for Renumeration (fee-for-service, contract, salary, other)

STAFFING continued

Name of Medical Practitioner	MSP Practitioner Number	Qualifications if No MSP Practitioner Number	Basis for Renumeration (fee-for-service, contract, salary, other)

***NOTE:** As an MSP Practitioner Number is considered personal information, the applicant is responsible for informing the practitioners listed here that their MSP Practitioner Number is provided as part of this application. The applicant must retain a record of such notification.*

Many modalities under the ACDF require additional credentialing before physicians/practitioners can undertake and bill the Medical Services Plan for that work.
Have all required credentialing documents granted through the appropriate health authority or the College of Physicians and Surgeons of BC (for those practitioners working solely in privately-owned facilities) been obtained by all physicians/practitioners seeking to bill the Medical Services Plan for delivering the services currently provided or applied for here?

If yes, please submit all appropriate credentialing letters with this application.
If no, please indicate the number of physicians/practitioners that require additional credentialing and when this credentialing will be obtained.

◯ Yes ◯ No

STAFFING continued

Please provide the name (if available), title, qualifications, and basis of remuneration for the scientific, technical and supervisory staff involved in providing services applied for.
If the number of staff exceeds the available space, please append additional practitioner listings to this application.

Name of Scientific, Technical and Supervisory Staff	**Title**	**Qualifications**	**Remuneration** (e.g., fee-for service, contract, salary)	**Hours of Work** (e.g., M-F, 9am - 4pm)

Is there any additional clinical and/or technical expertise required to provide the diagnostics service(s) noted in this application?
If yes, please provide details on the number of experts required, how they will be obtained (e.g. staff recruitment, contracted resources, telemetry etc.) and when they will be available to provide service.

◯ Yes ◯ No

FUNDING

Has/will funding be requested to support this application?

◯ Yes ◯ No

If yes, what is the source of funding?

☐ Ministry of Health ☐ Foundation/Endowment/Grant ☐ Other (specify):

What is funding required for? Check all that apply.

☐ Training ☐ Equipment ☐ Other (specify):
☐ Staffing ☐ Construction/Renovations

How much funding is required?

Capital: $ Operating: $

Has funding been approved?	If yes, when will funding be received?	If no, when is the funding approval anticipated?
◯ Yes ◯ No		
Has the budget been approved?	If yes, when will the budget be received?	If no, when is the budget approval anticipated?
◯ Yes ◯ No		

Please provide additional details regarding the source of funding for the services(s) referenced in this application, and details about Ministry of Health funding (if applicable).

APPLICATION AUTHORIZATION

Diagnostic Facility Medical Director*	Regional Head of Diagnostic Service	CEO of Health Authority or Agency*
Name	Name	Name
Title	Title	Title
Date	Date	Date
Signature	Signature	Signature

* *Medical Director responsible for the onsite diagnostic service(s) referenced in this application*

* *or formally authorized designate*

When this application is complete and authorized it should be submitted through the Ministry of Health's secure upload tool located at:
https://www2.gov.bc.ca/submitacdf

Personal information on this form (MSP Practitioner Number) is collected under the authority of the *Medicare Protection Act* and the Medical and Health Care Services Regulation. The information will be used as part of the assessment of an application pertaining to a diagnostic services facility. If you have any questions about the collection of this information, please contact Diagnostic Facilities Administration at DFAdmin@gov.bc.ca. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may only be disclosed as allowed by that Act.

APPENDIX A: CONFLICT OF INTEREST DECLARATION

To: Secretariat and Chair, ACDF

I have read and understood the Diagnostic Facility Conflict of Interest Policy (the "Policy"), and I undertake to be bound by the obligations contained therein.

I understand that it is my responsibility to report to the ACDF the information described in the Policy, and I undertake to do so.

I understand that the information I disclose will be held by the ACDF and that the information may be shared with members of the Medical Services Commission, as necessary.

I agree to inform the ACDF of any change in circumstances that may give rise to a conflict of interest with respect to a diagnostic facility, as soon as it is practicable.

ATTENTION: The person completing/signing this Declaration Form (the "Declarant") must be duly authorized to make the declaration on behalf of the person/entity submitting an application.

Name of diagnostic facility to which this conflict of interest declaration is in respect of:

SIGNATURE **If Publicly Owned Facility: CEO of Health Authority or Agency*** **If Privately Owned Facility: Owner of Facility**
Name
Title
Date
Signature

** or formally authorized designate*

APPENDIX B: CONFLICT OF INTEREST DISCLOSURE

To: Secretariat and Chair, ACDF

Is there a (potential) conflict of interest to disclose in relation to the diagnostic facility? Check one:

◯ Yes, there is a (potential) conflict of interest to disclose in relation to the diagnostic facility. If yes, provide details of the (potential) conflict of interest in Parts I and II of Appendix B.

◯ I am unsure if the circumstances constitute, or may constitute, a (potential) conflict of interest. If unsure, provide details of the (potential) conflict of interest in Parts I and II of Appendix B.

◯ No, there is no conflict to interest to disclose in relation to the diagnostic facility.

If no conflict of interest is indicated, Appendix B must be completed by signing and completing the Appendix B signature block information.

ATTENTION: The person completing/signing this Disclosure Form (the "Declarant") must be duly authorized to make the declaration/ disclosure on behalf of the subject person/entity; that is the person who owns or intends to own the diagnostic facility (as applicable).

If applicable, provide full detail and circumstances that relate to potential conflicts of interest by completing Parts I and II.

APPENDIX B PART I

Append additional pages as necessary, to provide all relevant information.

Diagnostic Facility Name(s)	List the names of all relevant practitioners, family members, diagnostic facility owners (including the declarant) or business associates who hold or may hold a relevant financial or material interest	Any relevant affiliations or relationships with the owner or intended owner of the diagnostic facility and the details of any interest or benefit that may relate to a conflict of interest	Any other information, including dates, that is relevant to understanding and assessing the nature, scope and degree/extent of potential conflicts of interest

APPENDIX B PART II

In the space below, provide any additional information (not covered in Part I) that is relevant to understanding and assessing the nature, scope and degree/extent of potential conflicts of interest. Include any detail regarding proposed avoidance or mitigation measures relating to any actual or potential conflicts of interest. Append additional pages as necessary to provide all relevant information.

Name of diagnostic facility to which this conflict of interest disclosure is in respect of:

SIGNATURE **If Publicly Owned Facility: CEO of Health Authority or Agency*** **If Privately Owned Facility: Owner of Facility**
Name
Title
Date
Signature

** or formally authorized designate*

Save Print Clear Form