

# **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 10<sup>th</sup> St., Suite 400  
Little Rock, AR 72204

**Plan Review Office use only**

Project ID #: \_\_\_\_\_ Prepared By \_\_\_\_\_ Date: \_\_\_\_\_



