

Supplemental CON Application Form

**Establishment of Cardiac Services**

Conn. Gen. Stat. § 19a-338(a)(9)

**Applicant:**

**Project Name**:

# Affidavit

Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Position – CEO or CFO)

of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Subscribed and sworn to before me on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public/Commissioner of Superior Court

My commission expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Clear Public Need**
   1. The record in this docket will include, in addition to other materials, the most recent American College of Cardiology/American Heart Association (ACC/AHA) practice guidelines. The Applicants may submit any comments in response to this evidence, which they deem appropriate.
   2. If applicable to the proposal (e.g., establishment of catheterization lab without a cardiac surgical program), provide a copy of a signed agreement between the Applicant and a tertiary care facility. Identify patient selection guidelines, the process and protocols involved in the transfer of a patient requiring cardiac surgery, and joint quality assurance reviews and joint training.
   3. Has the Applicant held any discussions with the local emergency medical service (“EMS”) regarding the proposed service? Describe.
2. **Projected Volume**
   1. In table format, provide historical volumes (three full years and the current year-to-date) for each Applicant by service as applicable to the proposal.

**Table a**

Cardiac Historical Utilization by Zip Code

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Town** | **Zip Code** | **PSA or SSA** | **Actual Volume**  **(Last 3 Completed FYs)** | | | **CFY Volume\*** |
| **FY\*\*** | **FY\*\*** | **FY\*\*** | **FY\*\*** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |

\* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered

and the method of annualizing. For periods less than six months, report actual volume and identify the period

covered.

\*\* Fill in years. In a footnote, identify the period covered by the Applicant’s FY (e.g., July 1-June 30, calendar

year, etc.).

**Table B**

Cardiac Historical Utilization by Inpatient/Outpatient

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Category** | **Actual Volume**  **(Last 3 Completed FYs)** | | | **CFY Volume\*** |
| **FY\*\*\*** | **FY\*\*\*** | **FY\*\*\*** | **FY\*\*\*** |
| Inpatient |  |  |  |  |
| Outpatient |  |  |  |  |
| **Total** |  |  |  |  |

\* For periods greater than 6 months, report annualized volume, identifying the number of actual months

covered and the method of annualizing. For periods less than six months, report actual volume and

identify the period covered.

\*\* Identify each service type and add lines as necessary. Provide the number of visits or discharges as

appropriate for each service listed.

\*\*\* Fill in years. In a footnote, identify the period covered by the Applicant’s FY (e.g., July 1-June 30,

calendar year, etc.).

**Table c**

Cardiac Historical Utilization by Unique Physician Identifier

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Unique Physician Identifier** | **Actual Volume**  **(Last 3 Completed FYs)** | | | **CFY Volume\*** |
| **FY\*\*\*** | **FY\*\*\*** | **FY\*\*\*** | **FY\*\*\*** |
|  |  |  |  |  |
|  |  |  |  |  |
| **Total** |  |  |  |  |

\* For periods greater than 6 months, report annualized volume, identifying the number of actual months

covered and the method of annualizing. For periods less than six months, report actual volume and

identify the period covered.

\*\* Identify each service type and add lines as necessary. Provide the number of visits or discharges as

appropriate for each service listed.

\*\*\* Fill in years. In a footnote, identify the period covered by the Applicant’s FY (e.g., July 1-June 30,

calendar year, etc.).

* 1. If applicable, for the most recently completed fiscal year, identify the number of:
     1. Patients with a diagnosis of ST-segment elevation acute myocardial infarction (AMI) that presented at the Hospital’s emergency room.
     2. Doses of thrombolytic medication, issued through its pharmacy, to patients with a diagnosis of AMI.

**Table d**

Cardiac Projected Utilization by Inpatient/Outpatient

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Projected Volume** | | |
| **FY\*** | **FY\*** | **FY\*** |
| Inpatient |  |  |  |
| Outpatient |  |  |  |
| **Total** |  |  |  |

\* Fill in years. In a footnote, identify the period covered by the Applicant’s

FY (e.g., July 1-June 30, calendar year, etc.).

**Table e**

Cardiac Projected Utilization by Unique Physician Identifier

|  |  |  |  |
| --- | --- | --- | --- |
| **Unique Physician Identifier** | **Projected Volume** | | |
| **FY\*** | **FY\*** | **FY\*** |
|  |  |  |  |
|  |  |  |  |
| **Total** |  |  |  |

\* Fill in years. In a footnote, identify the period covered by the Applicant’s

FY (e.g., July 1-June 30, calendar year, etc.).

* 1. Please identify the number of physicians that will be providing coverage for the proposed program. Explain whether the physicians will be full time with the proposed program or also providing coverage at other hospitals.