

## IMPORTANT

***All Office of Health Strategy (OHS) Certificate Of Need (CON)-related documents (Determinations, Applications, Completeness Letter Responses and Modifications) **must be filed electronically** through OHS's single point of access, its CON Web Portal.***

***First time Portal users must register prior to submitting any documents.*** To register, click here: [Certificate of Need Web Portal](#)

To access the portal, click on the link above or and click <https://portal.ct.gov/OHS> on the "Certificate of Need Program" link and then click on the "https://dphconwebportal.ct.gov" link.

***OHS may, at its discretion, utilize data from Hospital Reporting System (HRS) and the Connecticut All Payer Claims Database (APCD) to supplement the administrative record and the hearing record associated with an application. OHS may also reference and cite HRS and APCD data in its agreed settlements and final decisions.***

For any questions, please email [HSP@ct.gov](mailto:HSP@ct.gov) or call (860) 418-7001.

**CON Application - Main Form**  
*Required for all CON applications*

---

**Contents:**

- OHS Waiver
- Checklist
- List of Supplemental Forms
- Proposal Information
- Affidavit
- Executive Summary
- Project Description
- Public Need and Access to Health Care
- Financial Information
- Utilization

## OHS Waiver

Please be advised that the Office of Health Strategy (OHS) is in the process of revising its regulations (19a-639a-3(b)) to enable it to accept new CON filings **via OHS's website**.

While proceeding through this legal process, **OHS waives the requirement for applicant(s) to file paper copies pursuant to Sec.19a-639a-3 of the regulations**. All new CON applications filed electronically with OHS should be submitted via OHS's website ([Certificate of Need Web Portal](#)) and include the following:

1. A scanned copy of each submission in its entirety\*, including all attachments, properly executed and notarized where necessary, in Adobe (.pdf) format.
2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

**\*All application components (e.g., Main Form, Supplemental Form, Financial Worksheet and Exhibits) should be compiled and paginated.**

Note: Should anyone not have the ability to file electronically, the present paper submission process may still be used.

If you have any questions regarding a CON filing with OHS, please contact us by email at [HSP@ct.gov](mailto:HSP@ct.gov) or call us directly at (860) 418-7001.

# Checklist

**Instructions:** Review each item below and check box when completed. [**Checklist *must* be submitted as the first page of the CON application.**]

- ☐ A completed CON Main Form, including an affidavit for each applicant, signed and notarized by the appropriate individuals. CON forms can be found at [OHS Forms](#).
- ☐ A completed Supplemental Form specific to the proposal type (see next page to determine which Supplemental Form to include in the application).
- ☐ A filing fee using Master Card or Visa submitted electronically via OHS's website ([Certificate of Need Web Portal](#)) in the amount of **\$500.00**.

**Note:** Should anyone not have the ability to pay electronically using Master Card or Visa, contact us at (860) 418-7001 for further instructions.

- ☐ Attached is evidence demonstrating that public notice has been published for 3 consecutive days in a newspaper that covers the location of the proposal. Use the following link to help determine the appropriate publication: [Connecticut newspapers](#). **The application must be submitted no sooner than 20 days, but no later than 90 days from the last day of the newspaper notice.**

The following information **must** be included in the public notice:

- A statement that the applicant is applying for a certificate of need pursuant to section § 19a-638 of the Connecticut General Statutes;
- A description of the scope and nature of the project;
- The street address where the project is to be located; and
- The total capital expenditure for the project.

(Please fax (860-418-7054) or email ([HSP@ct.gov](mailto:HSP@ct.gov)) a courtesy copy of the newspaper order confirmation to OHS at the time of publication.)

- ☐ A completed Financial Worksheet specific to the application type.
- ☐ All confidential or personally identifiable information (e.g., Social Security number) has been redacted.
- ☐ All material should be submitted via OHS's website ([OHS Web Portal](#)) and include:
  1. A scanned copy of each submission in its entirety\*, including all attachments in Adobe (.pdf) format.
  2. An electronic copy of the applicant's responses in MS Word (the application) and MS Excel (the Financial Worksheet).

**\*All application components (e.g., Main Form, Supplemental Form, Financial Worksheet and Exhibits) should be compiled and paginated.**

**Note: OHS hereby waives requirement to file any paper copies.**

## Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** listed below. Check the box of the **Supplemental Form** to be submitted with the application, below. If unsure which form to select, please call the OHS main number (860-418-7001) for assistance. All CON forms can be found on OHS's website at [CON Forms and Submission](#).

Check form included	Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
<input type="checkbox"/>	(1)	<b>Establishment of a new health care facility</b> (mental health and/or substance abuse) - see note below*
<input type="checkbox"/>	(2)	<b>Transfer of ownership of a health care facility</b> (excludes transfer of ownership/sale of hospital – see “Other” below)
<input type="checkbox"/>	(3)	<b>Transfer of ownership of a group practice</b>
<input type="checkbox"/>	(4)	<b>Establishment of a freestanding emergency department</b>
<input type="checkbox"/>	(5) (7) (8) (15)	<b>Termination of a service:</b> - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
<input type="checkbox"/>	(6)	<b>Establishment of an outpatient surgical facility</b>
<input type="checkbox"/>	(9)	<b>Establishment of cardiac services</b>
<input type="checkbox"/>	(10) (11)	<b>Acquisition of equipment:</b> - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - acquisition of nonhospital based linear accelerators
<input type="checkbox"/>	(12)	<b>Increase in licensed bed capacity</b> of a health care facility
<input type="checkbox"/>	(13)	<b>Acquisition of equipment utilizing [new] technology</b> that has not previously been used in the state
<input type="checkbox"/>	(14)	<b>Increase of two or more operating rooms</b> within any three-year period by an outpatient surgical facility or short-term acute care general hospital
<input type="checkbox"/>	Other	<b>Transfer of Ownership / Sale of Hospital</b>

\*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other “health care facilities,” as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

\*\*If termination is due to insufficient patient volume or a subspecialty is being terminated, a CON is not required.

## Proposal Information

Select the appropriate proposal type from the dropdown below. If unsure which item to select, please call the OHS main number (860-418-7001) for assistance.

<b>Proposal Type</b> (select from dropdown)	Choose an item.
<b>Brief Description</b>	
<b>Proposal Address</b>	
<b>Capital Expenditure</b>	\$ Click here to enter text.
<p><b>Is this Application the result of a Determination indicating a CON application must be filed?</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, Docket Number: Click here to enter text.</p>	

## Applicant(s) Information

	Applicant One	Applicant Two (if applicable)
<b>Applicant's Full Legal Name* &amp; Address:</b>		
<b>Applicant Tax Status:</b> (check one box)	<input type="checkbox"/> For Profit <input type="checkbox"/> Not-for-Profit	<input type="checkbox"/> For Profit <input type="checkbox"/> Not-for-Profit
<b>Parent Corporation Full Legal Name &amp; Address:</b> (if applicable)		
<b>New Company:</b> (if applicable)		
<b>Contact Person:</b> (provide only one contact person per application)		
Name:		
Title:		
Address:		
Email:		
Phone number:		

\*For more than two applicants, attach a separate sheet providing the following information: applicant's full legal name, address, tax status and, if applicable, the parent company's name and address.

## 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 Sections 19a-630, 19a-637, 19a-638, 19a-639 of the Connecticut General Statutes, and that all facts contained in the submitted Certificate of Need application are true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature Date

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

\_\_\_\_\_  
Notary Public/Commissioner of Superior Court

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

## **Executive Summary**

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.



*Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Strategy is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a “§” indicates it is actual text from the statute and may be helpful when responding to prompts.*

## Project Description

1. Provide a detailed narrative describing the proposal. Explain how the applicant(s) determined the necessity for the proposal and discuss the benefits to the public and for each applicant, separately. Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline, anticipated start date, and why the proposal is needed in the community.
2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between applicant(s)? What have the applicant(s) accomplished so far?).
3. Provide the following information:
  - a. utilizing **OHS Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

**OHS TABLE 1  
APPLICANT'S SERVICES AND SERVICE LOCATIONS**

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination

- b. utilizing **OHS Table 2**, identify the service area towns (i.e., use **ONLY** [official town names](#)) and explain the reason for their inclusion (e.g., market share).

**Please note: use of village or area names instead of an official town name (Connecticut has 169 official towns) will not be accepted and will require revision/resubmission of the table.**

**OHS TABLE 2  
SERVICE AREA TOWNS**

Official Town Name	Reason for Inclusion

4. List all health care facility license(s) that will be needed to implement the proposal (i.e., include Department of Public Health, Department of Children and Families licenses, etc.);
5. Submit the following information as attachments to the application:
  - a. a copy of all Connecticut Department of Public Health, Department of Children and Families license(s) currently held by the applicant(s);
  - b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;
  - c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the articles;
  - d. letters of support for the proposal;
  - e. the “state, federal, national or industry-approved” protocols or Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of all relevant sections and briefly describe how the applicant proposes to meet the protocols or guidelines; and
  - f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

## Public Need and Access to Care

§ “Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Office of Health Strategy;” Conn.Gen.Stat. § 19a-639(a)(1).

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Office of Health Strategy (OHS).

§ “The relationship of the proposed project to the statewide health care facilities and services plan;” Conn.Gen.Stat. § 19a-639(a)(2).

7. Describe how the proposed project aligns with the OHS Health Systems Planning’s Statewide Health Care Facilities and Services Plan, available at [HSP Publications Library](#).

§ “Whether there is a clear public need for the health care facility or services proposed by the applicant;” Conn.Gen.Stat. § 19a-639(a)(3).

8. With respect to the proposal, provide evidence and documentation to support clear public need:
  - a. identify the target patient population to be served;
  - b. discuss if and how the target patient population is currently being served;
  - c. document the need for the equipment and/or service in the community;
  - d. explain why the location of the facility or service was chosen;
  - e. provide incidence, prevalence or other demographic data that demonstrates community need;
  - f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;
  - g. list any changes to the clinical services offered by the applicant(s) and explain why the change was necessary;
  - h. explain how access to care will be affected; and
  - i. discuss any alternative proposals that were considered.

*§ “Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons;” Conn.Gen.Stat. § 19a-639(a)(5).*

9. Describe and provide specific details on how the proposal will improve:
  - a. the quality of health care in the region;
  - b. accessibility of health care in the region; and
  - c. the cost effectiveness of health care delivery in the region.
10. What specific steps will the applicant(s) take to ensure that future health care services provided will adhere to the National Standards on culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area? (More details can be found at [National CLAS Standards](#)).
11. Provide specific details describing how this proposal will help improve the coordination of patient care.
12. Describe how this proposal will improve access to care for Medicaid recipients and indigent persons and, in addition, answer the following:
  - a. Are you a current Medicaid provider?
  - b. How will you assure that you will abide by the Medicaid access standards?
13. Provide a copy of the applicant’s charity care policy and sliding fee scale applicable to the proposal.
14. If charity care policies will be changed as a result of the proposal, list all changes and describe how the new policies will affect patients.

*§ “Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;” Conn.Gen.Stat. § 19a-639(a)(10).*

15. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

§ *“Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care.” Conn.Gen.Stat. § 19a-639(a)(12).*

16. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.
17. Will the proposal result in increased costs to any State of Connecticut program (e.g., Medicaid)?
18. Are you currently participating in any accountable care organization (ACO) arrangements? If yes, please describe in detail.

## Financial Information

§ “Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;” Conn.Gen.Stat. § 19a-639(a)(4).

19. Provide the applicant’s fiscal year: start date (mm/dd) and end date (mm/dd).
20. Describe how this proposal will help ensure the stability of the state’s health care system or demonstrate that the proposal is financially feasible for the applicant(s).
21. Provide a detailed explanation for all capital expenditure/costs associated with the proposal and list the dollar amount in **OHS Table 3**.

**OHS TABLE 3  
TOTAL PROPOSAL CAPITAL EXPENDITURE**

Category	Cost
Equipment (specify the type)	
Land/Building	
Construction/Renovation	
Other (specify)	
<b>Total Capital Expenditure</b>	

22. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as: interest rate; term; letter of interest or approval from a lending institution.
23. Include as an attachment:
  - a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, statement of cash flow, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current; and
  - b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available at [OHS Forms](#), providing a summary of revenue, expense, and volume statistics, “without the CON project,” “incremental to the CON project,” and “with the CON project.” **Note: the actual results reported in the Financial Worksheet must match the audited financial statements previously submitted or referenced. In addition, please make sure that the fiscal years reported on the Financial Worksheet are the same fiscal years reported for the utilization and payer mix tables (OHS Tables 5 and 6).**

24. Fully identify the basis for the projections and explain all calculations reported in the Financial Worksheet. In providing these detailed assumptions, please include the following:
- a. Identify general assumptions for projected amounts that are estimated to be the same, both with or without this proposed project (i.e., project-neutral increases or decreases that occur between years). Explain significant variances (+/- 25% variances) that occur between years for the project neutral changes;
  - b. Identify specific assumptions for all projected amounts that are estimated to change as a result of implementation of the proposed project (i.e., project-specific increases or decreases). Address projected changes in revenue, payer mix, expense categories and FTEs. In addition, connect any service, volume (utilization) or payer mix change described elsewhere in the CON application narrative or tables with these financial assumptions; and
  - c. If the applicant does not project any specific increases or decreases with the project in the Financial Worksheet, explain why.
25. Describe any projected incremental losses from operations resulting from the implementation of the CON proposal. If losses will result, provide an estimate of the timeframe needed to achieve incremental operational gains.

## Utilization

§ “The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;”  
Conn.Gen.Stat. § 19a-639(a)(6).

26. Complete **OHS Table 4** and **OHS Table 5** for the past three fiscal years (“FY”), current fiscal year (“CFY”) and first three projected FYs of the proposal for each of the applicant’s existing and/or proposed services. In completing these tables, please adhere to the following:

- a) Identify each service type and add lines as necessary. Provide the number of visits or discharges as appropriate for each service type and **label** what the **volumes represent** (e.g., visits) and the **fiscal year** reflected in the table.
- b) For CFY periods 6 months or greater, report annualized volume, identify the months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the months covered.
- c) For OHS Table 5, if the first year of the proposal is only a partial year, provide the partial year utilization and indicate the months included in a footnote. In addition, provide projections for the first three complete FYs.

**Note: Please make sure that the fiscal years reported on OHS Table 5 match the fiscal years reported in the Financial Worksheet and payer mix (OHS Table 6) projections.**

**OHS TABLE 4  
HISTORICAL UTILIZATION BY SERVICE**

Service	Actual Volume <span style="color: blue;">[indicate type]</span> (Last 3 Completed FYs)			CFY Volume*
	FY ____	FY ____	FY ____	FY ____
<b>Total</b>				

\*Months include \_\_\_\_\_

**OHS TABLE 5  
PROJECTED UTILIZATION BY SERVICE**

Service	Projected Volume <span style="color: blue;">[indicate type]</span>			
	Partial FY ____*	FY ____	FY ____	FY ____
<b>Total</b>				

\*Months include \_\_\_\_\_



27. Provide a detailed explanation of all assumptions used in the derivation/calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHS Tables 4 and 5.
28. Provide the current and projected patient population mix **by individual service location(s)** for the proposal using **OHS Table 6**, provide the number and percentage of patients by payer, all assumptions and label what the volume represents (e.g., discharges).

**Note: payer mix should be calculated from patient volumes, not patient revenues. Also, current year should be the most recently completed fiscal year. Projected years should match OHS Table 5 and the Financial Worksheet.**

**OHS TABLE 6**  
**APPLICANT'S CURRENT & PROJECTED PAYER MIX [indicate location]**

Payer	Most Recently Completed FY ____		Projected					
			FY ____		FY ____		FY ____	
	Volume: (indicate type)	%	Volume: (indicate type)	%	Volume: (indicate type)	%	Volume: (indicate type)	%
Medicare								
Medicaid								
TRICARE								
<b>Total Government</b>								
Commercial Insurers								
Uninsured								
Self-pay								
Workers Compensation								
<b>Total Non-Government</b>								
<b>Total Payer Mix</b>								

§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;"  
Conn.Gen.Stat. § 19a-639(a)(7).

29. Describe the population (as identified in question 8(a)) by gender, race ethnicity (to the extent it is collected), age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health and Connecticut State Data Center) and document the source.**

30. Using **OHS Table 7**, provide a breakdown of utilization by town (i.e., use **ONLY official town names**) for the **most recently completed fiscal year**. Indicate the fiscal year and the type of volume being reported: number of persons, visits, scans or other appropriate unit.

**OHS TABLE 7  
UTILIZATION BY TOWN**

FY\_\_\_\_\_

Official Connecticut Town	Volume: (indicate type)

§ "The utilization of existing health care facilities and health care services in the service area of the applicant;" Conn.Gen.Stat. § 19a-639(a)(8).

31. Using **OHS Table 8**, identify all existing providers in the service area and, as available, list the services provided, population served, days/hours of operation and current utilization. Include providers in the towns served or proposed to be served by the applicant, as well as providers in towns contiguous to the service area.

**OHS TABLE 8  
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS**

Facility's Provider Name, Street Address and Town	Program or Service	Population Served	Days/Hours of Operation	Current Utilization

32. Will this proposal shift volume away from existing providers in the area? If not, explain in detail why the proposal will have no impact on existing provider volumes.
33. If applicable, describe what effect the proposal will have on existing physician referral patterns in the service area.
34. Will the proposal result in additional providers added to your staff? If yes, provide the number, location and provider types to be added.
35. If applicable, describe how the proposal will help advance the applicant's ability to participate in alternative payment arrangements for healthcare delivery and reimbursement (e.g., shared savings arrangements).
36. Considering the proposed transaction as a whole, describe any potential constraints or limitations that will impact the applicant's ability to participate in the State's Core Data Analytics Solution, through OHS, or its successor, the Connecticut Health Information

Exchange Entity (“HIEE”). The Health Information Exchange Use Case Final Recommendations Report can be found at: <https://portal.ct.gov/OHS/HIT-Work-Groups/Health-IT-Advisory-Council/Publications>.

*§ “Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;” Conn.Gen.Stat. § 19a-639(a)(9).*

37. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

*§ “Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;” Conn.Gen.Stat. § 19a-639(a)(11).*

38. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.