Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☐ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: _____ Check No.: _____
OHCA Verified by:_____ Date: _____

☐ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

☐ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

☐ **Attached are completed Financial Attachments I and II.**

☐ **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to ohca@ct.gov.

Important: For CON applications(less than 50 pages) filed electronically through email, the signed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

☐ **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

AFFIDAVIT

Applicant: _____

Project Title: _____

_____

I, _____, _____
(Individual's Name) (Position Title – CEO or CFO)

of _____ being duly sworn, depose and state that
(Hospital or Facility Name)

_____'s information submitted in this Certificate of
(Hospital or Facility Name)

Need Application is accurate and correct to the best of my knowledge.

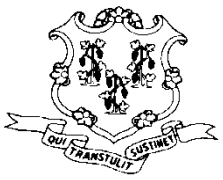
_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____



State of Connecticut
Office of Health Care Access
Certificate of Need Application

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:

Applicant:

Applicant's Facility ID*:

Contact Person:

Contact Person's Title:

Contact Person's Address:

Contact Person's Phone Number:

Contact Person's Fax Number:

Contact Person's Email Address:

Project Town:

Project Name:

Statute Reference: Section 19a-638, C.G.S.

Estimated Total Capital Expenditure:

*Please provide either the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier.

Project Description: Equipment Utilizing New Technology

a. Please provide a narrative detailing the proposal.

b. Submit equipment information by providing vendor marketing materials and/or a vendor proposal/quotation received by the Applicant. The documentation should include, but is not limited to, the manufacturer's name, make and model; unit strength of the proposed equipment; other notable equipment specifications; and equipment enhancements or add-ons.

c. Discuss the process employed by Applicant in selecting the proposed equipment. Identify the criteria used in the selection process and discuss why the proposed equipment was selected over the others evaluated.

d. Identify out-of-state providers that currently utilize the proposed equipment. Relate the health benefits that have been derived by the providers' patients that have received diagnoses or have been treated using the proposed equipment.

e. List each of the Applicant's services currently offered by location that will be affected by the proposed equipment.

f. Provide letters of support that have been received from the following:

    1. Medical practitioners that will use the proposed equipment to diagnosis or treat their patients; and

    2. Medical practitioners that intended to refer their patients for service(s) that will be provided through the use of the proposed equipment.

2. Clear Public Need

a. Explain why there is a clear public need for the proposed equipment. Provide evidence that demonstrates this need.

b. Discuss the efficacy of the proposed equipment in the diagnosis or treatment of a known medical condition. Provide documentation that supports the efficacy of utilizing the proposed equipment.

c. Provide the following regarding the proposal's location:

    i. The rationale for locating the proposed equipment at the proposed site;

    ii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

iii. How and where the proposed patient population is currently being served;

iv. Identify the name and location (i.e. address, town and state), facility ID and hours of operation (as available) of the closest existing provider;

TABLE 1
EXISTING SERVICE PROVIDERS

Facility Name	Facility ID*	Facility Address	Service	Days/Hours of Operation

*Please provide either the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

v. The effect of the proposal on existing providers; and

vi. If the proposal involves a new site of service, identify the service area towns and the basis for their selection.

TABLE 2
APPLICANT'S SERVICE AREA

Town	Reason for Inclusion

Note: Provide basis for the selected towns.

3. Projected Service Volume

a. Complete the following tables for the first three projected fiscal years ("FYs") of the proposal. In Table 3a, report the units of service by service or procedure type, and in Table 3b, report the units of service by each existing and proposed operating room/station. Add lines as necessary.

TABLE 3A
PROJECTED UTILIZATION BY SERVICE OR PROCEDURE TYPE

Service or Procedure Type*	Projected Volume		
	FY**	FY**	FY**
Total			

*Identify each service/procedure type and add lines as necessary. Provide the number of visits/ discharges as appropriate for each service listed.
**If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. In a footnote, identify the period covered by the Applicant's fiscal year FY (e.g. July 1-June 30, calendar year, etc.).

TABLE 3B
PROJECTED UTILIZATION BY OPERATING ROOM/STATION

Operating Room/Station*	Projected Volume		
	FY**	FY**	FY**
Total			

*Identify each equipment room/station by location and any other identifier, and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
**If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. In a footnote, identify the period covered by the Applicant's fiscal year FY (e.g. July 1-June 30, calendar year, etc.).

b. Provide a detailed description of all assumptions used in the derivation/calculation of the projected volumes, in light of the throughput characteristics and anticipated annual capacity of the proposed equipment.

c. Describe existing referral patterns in the area to be served by the proposal.

d. Explain how the existing referral patterns will be affected by the proposal.

e. Explain any increases and/or decreases in volume seen in the tables above.

f. Provide a copy of any articles, studies, or reports that support the need to acquire the proposed equipment, along with an explanation regarding the relevance of the selected articles.

4. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

b. Explain how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to, (1) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (2) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program.

c. What specialized training will each type of medical/clinical practitioner have to complete prior to their involvement with the proposed equipment utilizing new technology?

d. Describe the Applicant's efforts in attracting board certified medical practitioners and qualified clinical technicians with appropriate training in the use of the proposed equipment.

e. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

f. Identify each oversight entity, whether governmental or professional in nature, whose approval/accreditation needs to be obtained by the Applicant prior to the operation of the proposed equipment and/or after the initiation of the service related to the proposed equipment. For each required approval/accreditation, describe the progress the Applicant has made in securing such approval/ accreditation.

g. Provide the written protocols that have been established in conjunction with the operation of the proposed equipment.

h. Provide a description of any transfer agreement that has been or will be established as a result of this proposal.

5. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Does the Applicant have non-profit status?

☐ Yes (Provide documentation) ☐ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

d. Financial Statements

i. <u>If the Applicant is a Connecticut hospital:</u> Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii. <u>If the Applicant is not a Connecticut hospital (other health care facilities):</u> Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books).

e. Submit a final version of all capital expenditures/costs as follows:

TABLE 4
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	Cost
Equipment (Medical, Non-medical Imaging) Land/Building Purchase* Construction/Renovation** Land/Building Purchase* Other (specify)	
Total Capital Expenditure (TCE)	
Lease (Medical, Non-medical Imaging)***	
Total Capital Cost (TCO)	
Total Project Cost (TCE+TCO)	

*If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.
**If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/

renovation; completion date of the construction/renovation; and commencement of operations date.
***If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

f. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

g. Demonstrate how this proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant.

6. Projected Patient Population Mix:

a. Provide the projected volume (and corresponding percentages) by patient population mix; including, but not limited to, access to services by Medicaid recipients and indigent persons for the proposed program.

TABLE 5
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Projected					
	FY**		FY**		FY**	
	Volume	%	Volume	%	Volume	%
Medicare*						
Medicaid*						
CHAMPUS & TriCare						
Total Government						
Commercial Insurers						
Uninsured						
Workers Compensation						
Total Non-Government						
Total Payer Mix						

*Includes managed care activity.
**Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.
Note: The patient population mix should be based on patient volumes, not patient revenues.

b. Provide the basis for/assumptions used to project the patient population mix.

c. For the Medicaid population only, provide the assumptions and actual calculation used to determine the projected patient volume.

d. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation for good cause for doing so. *Note: good cause shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.*

7. Financial Attachment I

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

b. Provide the assumptions utilized in developing **Financial Attachment I** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

c. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

d. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

e. Describe how this proposal is cost effective.