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.

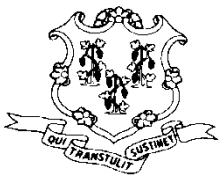
_____ _____
Signature Date

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.

1. Project Description: Freestanding Emergency Department

a. Please provide a narrative detailing the proposal.

b. Provide letters that have been received in support of the proposal.

2. Clear Public Need

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

b. Identify how often the Applicant has diverted ED patients to another facility during the most completed fiscal year ("FY"). Identify the number of hours the facility was on diversion for each date.

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

i. The rationale for choosing the proposed service location;

ii. The service area towns and the basis for their selection;

TABLE 1

APPLICANT'S SERVICE AREA

Town	Reason for Inclusion

Note: Provide basis for the selected towns.

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

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

v. Identify the name and location (i.e. address, town and state), facility ID and hours of operation (as available) of existing providers in the towns listed above and in nearby towns;

TABLE 2
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.

vi. Describe existing referral patterns in the area to be served by the proposal; and

vii. The effect of the proposal on existing providers, explaining how current referral patterns will be affected by the proposal.

d. Provide a detailed discussion as to other options the Applicant considered prior to choosing to move forward with the proposed satellite ED (including expanding the main campus ED, establishing a satellite ED in another town, etc.).

e. Explain why the proposal will not result in an unnecessary duplication of existing or approved health care services.

f. Attach a copy of any articles, studies, or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles.

3. Projected Volume

a. Complete the following tables for the last three completed fiscal years ("FYs"), current FY, first three FYs of the proposed service.

TABLE 3A
ACTUAL & PROJECTED VOLUME BY LEVEL–MAIN ED

Trauma Level	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY ***	FY ****	FY ***	FY ***	FY ***	FY ***	FY ***
Level 1							
Level 2							
Level 3							
Level 4							
Level 5							
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.
**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.
***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 3B
PROJECTED VOLUME BY LEVEL–SATELLITE ED

Trauma Level	Projected Volume (First 3 Full Operational FYs)*			
	FY**	FY**	FY**	FY**
Level 1				
Level 2				
Level 3				
Level 4				
Level 5				
Total				

*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.
**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 3C
PROJECTED VOLUME BY CATEGORY–MAIN ED

Category	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY ***	FY ***	FY ***	FY ***	FY ***	FY ***	FY ***
Emergent							
Urgent							
Non-Emergent							
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.
**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.
***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 3D
PROJECTED VOLUME BY CATEGORY–SATELLITE ED

Category	Projected Volume (First 3 Full Operational FYs)*			
	FY**	FY**	FY**	FY**
Emergent				
Urgent				
Non-Emergent				
Total				

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

c. Identify the number of patients that would shift from the Hospital to the proposed ED for the first three full years of operation (by year) by the levels and categories used in Tables 3A and 3C. What impact would the proposed shift have on the Hospital's main campus ED?

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. 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.

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. If the Applicant is a Connecticut hospital: 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. If the Applicant is not a Connecticut hospital (other health care facilities): 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. Patient Population Mix: Current and Projected

a. Provide the current and 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	Most Recently Completed FY**		Projected					
			FY**		FY**		FY**	
	Volume	%	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. Provide a detailed discussion on charges for the services at the proposed Satellite Emergency Department. Specifically discuss how they will differ from the ones charged for services at the Hospital's Emergency Department on the main campus.

f. Describe how this proposal is cost effective.