

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 the following email addresses:
steven.lazarus@ct.gov and leslie.greer@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.

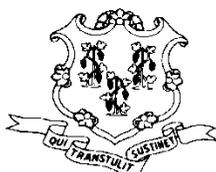
Signature

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: Service Termination

- a. For each of the Applicant’s programs, identify the location, population served, hours of operation, and whether the program is proposed for termination.
- b. Describe the history of the services proposed for termination, including when they were begun and whether CON authorization was received.
- c. Explain in detail the Applicant’s rationale for this termination of services, and the process undertaken by the Applicant in making the decision to terminate.
- d. Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide copy of the minutes (excerpted for other unrelated material) for the meeting(s) the proposed termination was discussed and voted on.
- e. Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need.

2. Termination’s Impact on Patients and Provider Community

- a. 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 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.

- b. For each provider to whom the Applicant proposes to transfer or refer clients, provide the facility ID, total capacity, current available capacity, as well as the utilization for the last completed year and for the current year.

TABLE 2
PROVIDERS ACCEPTING TRANSFERS/REFERRALS

Facility Name	Facility ID*	Facility Address	Total Capacity	Available Capacity	Utilization FY XX**	Utilization Current CFY***

*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.

**Fill in year and identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.). Label and provide the number of visits or discharges as appropriate.

***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.

- c. Identify any special populations that utilize the service(s) and explain how these populations will maintain access to the service following termination at the specific location; also, specifically address how the termination of this service will affect access to care for Medicaid recipients and indigent persons.
- d. What impact will the proposal have upon the cost effectiveness of providing access to services provided under the Medicaid program? If not applicable to the proposal, explain why it is not applicable.
- e. Provide evidence (e.g. written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients.
- f. Describe how clients will be notified about the termination and transfer to other providers.

3. Actual and Projected Volume

- a. Provide volumes for the most recently completed FY by town.

TABLE 3
UTILIZATION BY TOWN

Town	Utilization FY XX*

*Fill in year and identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.). Label and provide the number of visits or discharges as appropriate.

- b. Complete the following table for the past three fiscal years ("FY") and current fiscal year ("CFY"), for the number of visits/discharges, as appropriate, by service.

TABLE 4
HISTORICAL AND CURRENT VISITS/DISCHARGES

Service**	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/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.).

- c. Explain any increases and/or decreases in volume seen in the table(s) above.

- d. For DMHAS-funded programs only, provide a report that provides the following information for the last three full FYs and the current FY to-date:
 - i. Average daily census;
 - ii. Number of clients on the last day of the month;
 - iii. Number of clients admitted during the month; and
 - iv. Number of clients discharged during the month.

4. Projected Patient Population Mix:

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

5. 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 when the Applicants' funding and/or licensing agencies (e.g. DPH, DMHAS) were notified of the proposed termination, and when the Applicants' licenses will be returned.

6. 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. 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).

- d. Submit a final version of all capital expenditures/costs.

TABLE 6
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.

- e. 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.
- f. 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.

7. Financial Attachments 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. Was the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?
- d. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.
- e. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.
- f. Describe how this proposal is cost effective.