

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.

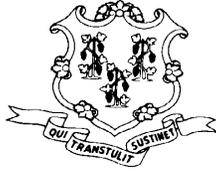
Signature

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:

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:**

1. 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) of the closest existing provider;
- 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.

3. Projected Service Volume

- a. Complete the following tables for the first three projected fiscal years (“FYs”) of the proposal. In Table 1, report the units of service by service or procedure type, and in Table 2, report the units of service by each existing and proposed operating room/station. Add lines as necessary.

Table 1: Projected Service Volume, by Service or Procedure Type

	Projected Volume (First 3 Full Operational FYs)*		
	FY ***	FY ***	FY ***
Service or procedure type**			
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.

** Identify each service/procedure type and add lines 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 2: Projected Service Volume, by Operating Room/Station

	Projected Volume (First 3 Full Operational FYs)*		
	FY ***	FY ***	FY ***
Operating Room/Station**			
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.

** Identify each equipment room/station by location and any other identifier, and add lines 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, 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. Explain how the proposal contributes to the quality of health care delivery in the region.
- b. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.
- 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. 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 3: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	\$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure (TCE)	\$
Medical Equipment Lease (Fair Market Value) ***	\$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	

Fair Market Value of Space ***	
Total Capital Cost (TCC)	\$
Total Project Cost (TCE + TCC)	\$
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	\$

* 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 affect the financial strength of the state's health care system.

6. Projected Patient Population Mix:

- a. Provide the projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

Table 4: Projected Patient Population Mix

	Year 1 FY **	Year 2 FY **	Year 3 FY **
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.

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

7. Financial Attachments I & II

- 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 a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.
- c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).
- d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).
- e. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.
- f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.
- g. Describe how this proposal is cost effective.