**CON Notification Form**

**(Increase in Licensed Bed Capacity** **of a Mental Health Facility)**

All persons who are increasing the licensed bed capacity of a mental health facility pursuant to Section 31 of Public Act 22-42 (to be codified at C.G.S. § 19a-638(b)(23)), shall notify the Office of Health Strategy (“OHS”) by submitting this Notification Form. **There is no fee associated with submitting a Notification Form.**

The completed Notification Form ***must be uploaded to the*** [***Portal***](https://dphconwebportal.ct.gov/Account/Login?ReturnUrl=%2F)***.***

##### SECTION I. PETITIONER INFORMATION

|  |  |
| --- | --- |
|  | Petitioner |
| Petitioner’s Full Legal Name |  |
| Doing Business As (d/b/a), if applicable |  |
| Name of Petitioner’s Parent Organization,  if applicable |  |
| Petitioner’s Mailing Address,  including a street address for Certified Mail |  |
| Petitioner’s Tax Status:  Profit or Nonprofit |  |
| Petitioner’s Designated Contact (to receive all correspondence in this matter),  Name and Title |  |
| Petitioner’s Designated Contact’s Mailing Address including a street address for Certified Mail |  |
| Petitioner’s Designated Contact’s Office Phone Number and Cell Phone Number |  |
| Petitioner’s Designated Contact’s Email Address |  |

##### SECTION II. INFORMATION FOR NOTIFICATION

Please provide a description regarding the notification (the “Petitioner”), highlighting each of its important aspects, on at least one, but not more than two separate 8.5” X 11” sheets of paper. At a minimum, each of the following elements need to be addressed:

1. The number of beds the Petitioner is currently licensed to have;
2. The type of beds the Petitioner currently has;
3. A description of all services that are being or will be provided at the facility;
4. The number of beds the Petitioner will add pursuant to Section 31 of Public Act 22-42 (to be codified at C.G.S. § 19a-638(b)(23));
5. Whether the Petitioner will need a new license by the Department of Public Health (“DPH”) with the addition of beds and, if so, what type; and
6. The anticipated date of implementation for the increase of beds;
7. Whether the addition of beds is meant to be temporary or permanent; and
8. Evidence that the Petitioner accepts reimbursement for any covered benefit provided to a covered individual under:
9. An individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of C.G.S. § 38a-469;
10. a self-insured employee welfare benefit plan established pursuant to the federal Employee Retirement Income Security Act of 1974, as amended from time to time; and
11. HUSKY Health, as defined in C.G.S. § 17b-290.

Please note: If the mental health facility does not accept or stops accepting reimbursement for any covered benefit provided to a covered individual under a policy, plan or program described in clauses a, b, and c, above, a Certificate of Need for such increase in the licensed bed capacity shall be required.

**SECTION III. AFFIDAVIT**

##### (Each Petitioner must submit a completed Affidavit.)

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Position – CEO or CFO)

of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_being duly sworn, depose and state that the

(Organization Name)

information provided in this CON Notification Form is true and accurate to the best of my

knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

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

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Notary Public/Commissioner of Superior Court

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