Supplemental CON Application Form

**Acquisition of Equipment Utilizing New Technology**

Conn. Gen. Stat. §19a-638(a)(13)

**Applicant:**

**Project Name:**

# Affidavit

Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

(Name) (Position – CEO or CFO)

of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 of the Connecticut General Statutes, and that all facts contained in this Certificate of Need application are true 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Project Description: Equipment Utilizing New Technology**
   1. Provide vendor marketing materials and/or a vendor proposal/quotation received by the Applicant for the proposed equipment. The documentation should include, but not be 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.
   2. Discuss the process used by the Applicant to select the proposed equipment/ vendor. Specifically, identify the criteria used in the selection process and discuss why the proposed equipment/vendor was selected over the others evaluated.
   3. To the extent known, identify out-of-state providers that currently utilize the proposed equipment.
   4. Describe what outcomes have been achieved by patients that have received diagnoses or have been treated using the proposed equipment.
   5. List each of the Applicant’s current services (by location) that will utilize the proposed equipment. If applicable, provide the number of patients that will shift from an existing service (by location) to utilize the proposed equipment.
   6. Provide letters of support that have been received from the following:
2. Medical practitioners that will use the proposed equipment to diagnose or treat their patients; and
3. Medical practitioners that intend to refer their patients for service(s) that will be provided through the use of the proposed equipment.
4. **Clear Public Need**
   1. Discuss the efficacy of the proposed equipment in the diagnosis or treatment of a known medical condition(s) and provide documentation that supports the proposed equipment’s use for these diagnoses (including peer reviewed literature).
5. **Quality Measures**
   1. What specialized training will each type of medical/clinical practitioner have to complete prior to their involvement with the proposed equipment utilizing new technology?
   2. 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.
   3. 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 for the operation of the equipment for diagnoses/treatment.
6. **Projected Volume**
   1. Utilizing Table A, below, provide the unduplicated client volume, related percentage and associated number of discharges/visits by payer type. Ensure that client volumes are unduplicated. In addition, discharge/visit volume should match totals provided in the “Inpatient Discharges” or “Outpatient Visits” row in the Financial Worksheet. If the first operational year is a partial year, provide the anticipated volume and indicate the months that were included.

**TABLE A**

**CURRENT AND PROJECTED PAYER MIX BY NUMBER OF CLIENTS AND VISITS**

| **Payer** | **Projected** | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Partial FY \_\_\_\_\*** | | | **FY \_\_\_\_** | | | **FY \_\_\_\_** | | | **FY \_\_\_\_** | | |
| **Clients** | **%** | **Dis./**  **Visit**  **Vol.** | **Clients** | **%** | **Dis./**  **Visit**  **Vol.** | **Clients** | **%** | **Dis./**  **Visit**  **Vol.** | **Clients** | **%** | **Dis./**  **Visit**  **Vol.** |
| Medicare |  |  |  |  |  |  |  |  |  |  |  |  |
| Medicaid |  |  |  |  |  |  |  |  |  |  |  |  |
| TRICARE |  |  |  |  |  |  |  |  |  |  |  |  |
| **Total Government** |  |  |  |  |  |  |  |  |  |  |  |  |
| Commercial Insurers:  In Network |  |  |  |  |  |  |  |  |  |  |  |  |
| Commercial Insurers:  Out of Network |  |  |  |  |  |  |  |  |  |  |  |  |
| Uninsured |  |  |  |  |  |  |  |  |  |  |  |  |
| Workers Compensation |  |  |  |  |  |  |  |  |  |  |  |  |
| **Total Non-Government** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Total Payer Mix** |  | **100** |  |  | **100** |  |  | **100** |  |  | **100** |  |

**\*Months included \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* 1. If commercial payments are anticipated, have you established any commercial carrier provider agreements? If yes, describe these agreements (name of carrier, duration, etc.). If no, describe any progress made to date.