



---

Supplemental CON Application Form  
**Termination of a Service**  
Conn. Gen. Stat. § 19a-638(a)(5),(7),(8),(15)

---

**Applicant:**

**Project Name:**



**1. Project Description: Service Termination**

- a. Please provide
  - i. a description of the history of the services proposed for termination, including when they commenced ,
  - ii. whether CON authorization was received and,
  - iii. if CON authorization was required, the docket number for that approval.
- b. 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.
- c. 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.

**2. Termination's Impact on Patients and Provider Community**

- a. For each provider to which the Applicant proposes transferring or referring clients, provide the below information for the last completed fiscal year and current fiscal year.

**TABLE A**  
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.

- a. 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.

- b. 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.
- c. Describe how clients will be notified about the termination and transfer to other providers.
- d. For DMHAS-funded programs only, attach 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.