



**State of Connecticut
Department of Public Health
Office of Health Care Access**

**Certificate of Need Application
Main Form**
Required for all CON applications

Contents:

- Checklist
- List of Supplemental Forms
- Proposal Information
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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 a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.
 - (*New*). A completed supplemental application specific to the proposal type can be found on OHCA's website at "[OHCA Forms.](#)" A list of supplemental forms can be found on page 2.
 - 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.
 - 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 completed Financial Attachment
 - Submission includes one (1) original hardcopy in a 3-ring binder and a USB flash drive containing:
 1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
 2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

For OHCA Use Only:

Docket No.: _____ Check No.: _____
OHCA Verified by: _____ Date: _____

Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** listed below. Check the box of the **Supplemental Form** to be submitted with the application, below. If unsure which form to select, please call the OHCA main number (860-418-7001) for assistance. All CON forms can be found on OHCA's website at [OHCA Forms](#).

Check form included	Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
<input type="checkbox"/>	(1)	Establishment of a new health care facility (mental health and/or substance abuse) - see note below*
<input type="checkbox"/>	(2)	Transfer of ownership of a health care facility (excludes transfer of ownership/sale of hospital – see “Other” below)
<input type="checkbox"/>	(3)	Transfer of ownership of a group practice
<input type="checkbox"/>	(4)	Establishment of a freestanding emergency department
<input type="checkbox"/>	(5) (7) (8) (15)	Termination of a service: <ul style="list-style-type: none"> - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
<input type="checkbox"/>	(6)	Establishment of an outpatient surgical facility
<input type="checkbox"/>	(9)	Establishment of cardiac services
<input type="checkbox"/>	(10) (11)	Acquisition of equipment: <ul style="list-style-type: none"> - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - acquisition of nonhospital based linear accelerators
<input type="checkbox"/>	(12)	Increase in licensed bed capacity of a health care facility
<input type="checkbox"/>	(13)	Acquisition of equipment utilizing [new] technology that has not previously been used in the state
<input type="checkbox"/>	(14)	Increase of two or more operating rooms within any three-year period by an outpatient surgical facility or short-term acute care general hospital
<input type="checkbox"/>	Other	Transfer of Ownership / Sale of Hospital

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other “health care facilities,” as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

**If termination is due to insufficient patient volume, or it is a subspecialty being terminated, a CON is not required.

Proposal Information

Select the appropriate proposal type from the dropdown below. If unsure which item to select, please call the OHCA main number (860-418-7001) for assistance.

Proposal Type <small>(select from dropdown)</small>	Choose an item.
Brief Description	
Proposal Address	
Capital Expenditure	\$ Click here to enter text.
Is this Application the result of a Determination indicating a CON application must be filed? <input type="checkbox"/> No <input type="checkbox"/> Yes, Docket Number: Click here to enter text.	

Applicant(s) Information

	Applicant One	Applicant Two* <small>(if applicable)</small>
Applicant Name & Address		
Parent Corporation Name & Address <small>(if applicable)</small>		
Contact Person Name		
Title		
Email Address		
Phone		
Fax Number		
Tax Status <small>(check one box)</small>	<input type="checkbox"/> For Profit <input type="checkbox"/> Not-for-Profit	<input type="checkbox"/> For Profit <input type="checkbox"/> Not-for-Profit

**For more than two Applicants, attach a separate sheet with the above information*

FOR OFFICE USE ONLY	
Docket #:	Staff Assigned :
Date Received:	

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 the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

Date

Subscribed and sworn to before me on _____

Notary Public/Commissioner of Superior Court

My commission expires: _____

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a “§” indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.
2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).
3. Provide the following information:
 - a. utilizing [OHCA Table 1](#), list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;
 - b. identify in [OHCA Table 2](#) the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);
4. List the health care facility license(s) that will be needed to implement the proposal;
5. Submit the following information as attachments to the application:
 - a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);
 - b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;
 - c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;
 - d. letters of support for the proposal;
 - e. the protocols or 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 the protocols or guidelines.
 - f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Public Need and Access to Care

§ “Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;” (Conn.Gen.Stat. § 19a-639(a)(1))

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

§ “The relationship of the proposed project to the statewide health care facilities and services plan;” (Conn.Gen.Stat. § 19a-639(a)(2))

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on [OHCA's website](#).

§ “Whether there is a clear public need for the health care facility or services proposed by the applicant;” (Conn.Gen.Stat. § 19a-639(a)(3))

8. With respect to the proposal, provide evidence and documentation to support clear public need:
 - a. identify the target patient population to be served;
 - b. discuss how the target patient population is currently being served;
 - c. document the need for the equipment and/or service in the community;
 - d. explain why the location of the facility or service was chosen;
 - e. provide incidence, prevalence or other demographic data that demonstrates community need;
 - f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;
 - g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;
 - h. explain how access to care will be affected; and
 - i. discuss any alternative proposals that were considered.

§ “Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons; (Conn.Gen.Stat. § 19a-639(a)(5))

9. Describe how the proposal will:
 - a. improve the quality of health care in the region;
 - b. improve accessibility of health care in the region; and
 - c. improve the cost effectiveness of health care delivery in the region.
10. How will the Applicant(s) ensure that future health care services provided will adhere to the National Standards on culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (More details on CLAS standards can be found at <http://minorityhealth.hhs.gov/>).
11. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?
12. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.
13. Provide a copy of the Applicant’s charity care policy and sliding fee scale applicable to the proposal.

§ “Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;” (Conn.Gen.Stat. § 19a-639(a)(10))

14. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

§ “Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care.” (Conn.Gen.Stat. § 19a-639(a)(12))

15. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

Financial Information

§ “Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;” (Conn.Gen.Stat. § 19a-639(a)(4))

16. Provide the Applicant’s fiscal year: start date (mm/dd) and end date (mm/dd).
17. Describe the impact of this proposal on the financial strength of the state’s health care system or demonstrate that the proposal is financially feasible for the applicant.
18. Provide a final version of all capital expenditure/costs for the proposal using [OHCA Table 3](#).
19. 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.
20. Include as an attachment:
 - a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;
 - b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available on OHCA’s website under [OHCA Forms](#), providing a summary of revenue, expense, and volume statistics, “without the CON project,” “incremental to the CON project,” and “with the CON project.” **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**
21. Complete [OHCA Table 4](#) utilizing the information reported in the attached Financial Worksheet.
22. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.
23. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.
24. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

Utilization

§ *“The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;”*
(Conn.Gen.Stat. § 19a-639(a)(6))

25. Complete [OHCA Table 5](#) and [OHCA Table 6](#) for the past three fiscal years (“FY”), current fiscal year (“CFY”) and first three projected FYs of the proposal, for each of the Applicant’s existing and/or proposed services. Report the units by service, service type or service level.
26. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.
27. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using [OHCA Table 7](#) and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

§ *“Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;”*
(Conn.Gen.Stat. § 19a-639(a)(7))

28. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.**
29. Using [OHCA Table 8](#), provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

§ *“The utilization of existing health care facilities and health care services in the service area of the applicant;”* (Conn.Gen.Stat. § 19a-639(a)(8))

30. Using [OHCA Table 9](#), identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.
31. Describe the effect of the proposal on these existing providers.

32. Describe the existing referral patterns in the area served by the proposal.

33. Explain how current referral patterns will be affected by the proposal.

§ “Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;” (Conn.Gen.Stat. § 19a-639(a)(9))

34. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

§ “Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;” (Conn.Gen.Stat. § 19a-639(a)(11))

35. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

Tables

**TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS**

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination

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**TABLE 2
SERVICE AREA TOWNS**

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion

* Village or place names are not acceptable.

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**TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE**

Purchase/Lease	Cost
Equipment (Medical, Non-medical, Imaging)	
Land/Building Purchase*	
Construction/Renovation**	
Other (specify)	
Total Capital Expenditure (TCE)	
Lease (Medical, Non-medical, Imaging)***	
Total Lease Cost (TLC)	
Total Project Cost (TCE+TLC)	

* 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.

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**TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES**

	FY 20__*	FY 20__*	FY 20__*
Revenue from Operations	\$	\$	\$
Total Operating Expenses			
Gain/Loss from Operations	\$	\$	\$

* Fill in years using those reported in the Financial Worksheet attached.

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**TABLE 5
HISTORICAL UTILIZATION BY SERVICE**

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 20__***	FY 20__***	FY 20__***	FY 20__***
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 6 months, report actual volume and identify the period covered.
- ** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.
- *** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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**TABLE 6
PROJECTED UTILIZATION BY SERVICE**

Service*	Projected Volume		
	FY 20__**	FY 20__**	FY 20__**
Total			

- * Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
- ** 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. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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**TABLE 7
 APPLICANT'S CURRENT & PROJECTED PAYER MIX**

Payer	Current		Projected					
	FY 20__**		FY 20__**		FY 20__**		FY 20__**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
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. New programs may leave the "current" column blank.

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**TABLE 8
UTILIZATION BY TOWN**

Town	Utilization FY 20__**

* List inpatient/outpatient/ED volumes separately, if applicable

** Fill in most recently completed fiscal year.

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**TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS**

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization

* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

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