

Certificate of Need Application

Department of Social Services - Certificate of Need Application

1. Please include a copy of your Letter of Intent for a Certificate of Need.
2. Please complete Attachment I.
3. Provide a narrative summary of the project including the reason for undertaking the project.
4. Describe any relationship between this request and the facility's historical, current and future utilization statistics. Describe the current and projected payer mix of patients (% private, % Medicaid, % Medicare, etc.) at the facility. Identify facility bed configuration by floor pre and post project including the number of rooms and type of room (private, semi-private, etc.).
5. Quantify the current financial condition of the facility including the impact, if any, of this request on the Facility's rates (please provide support).
6. Explain how this proposal will impact the quality, cost effectiveness, and accessibility of health care delivery in the area. Document the public need or lack of need for this request.
7. Provide a synopsis, including dates, of major facility building renovations, new construction and physical plant/capital improvements.
8. Provide any available estimates of the cost to renovate the facility to current codes.
9. Describe the changes required to each department or functional area to comply with current health and safety requirements including the condition of electrical and mechanical systems including changes in fire alarm systems, nurse call systems, air conditioning, lighting, furnishings and wall, floor and ceiling finishes.
10. Provide evidence of the cost the required changes including securing necessary financing at reasonable costs to meet capital costs and operating expenses.
11. Specifically address current compliance with codes governing handicapped accessibility including ADA and improvements that will be made to comply with ADA requirements.
12. Please describe the effect of this proposed change on the facility's current residents.
13. Is there a clear public need for this request? Provide the following information:
 - a. the areas to be served (preferably by town),
 - b. the incidence and prevalence of the medical conditions to be treated within the areas to be served,
 - c. the number of individuals within the service areas that need the service(s) proposed and the length of time that they will need such services,
 - d. all other providers within the service areas providing the type of services being proposed and statistics on the utilization of such services compared to the capacity of such services.

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alternative less costly means of meeting the service needs of the population to be served.

14. Identify any other factor that the Department should consider in determining whether this request will be granted, modified or denied. Provide supporting documentation.
15. Please provide copies of audited financial statements or other financial documents that may be available including but not limited to financial statements presented to the board of directors or other information which may be available to demonstrate the financial condition of the facility.