

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. For Construction Projects, please complete Subset for New Construction Attachment
9. Provide any available estimates of the cost to renovate the facility to current codes and the cost associated with new construction.
10. Describe the changes that have or will be made to each department or functional area as part of this project including, as applicable, square footage in new construction, square footage to be renovated and the nature of the changes to be made.
11. Describe the condition of each area and system including the condition of the finishes prior to this project. If part or all of an existing department or functional area has been or will be converted to another use as part of this project, clearly describe such changes.
12. Describe any changes that have or will be made to electrical and mechanical systems including changes in fire alarm systems, nurse call systems, air conditioning, lighting, furnishings and wall, floor and ceiling finishes.
13. Provide evidence of the financial feasibility of the proposed changes including securing necessary financing at reasonable costs to meet capital costs and operating expenses. Provide some assurance that funds will be available to complete the project.
14. Specifically address current compliance with codes governing handicapped accessibility including ADA and improvements that will be made to comply with ADA requirements.

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15. Please describe the effect of this proposed change on the facility's current residents.
16. 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.
alternative less costly means of meeting the service needs of the population to be served.
17. Identify any other factor that the Department should consider in determining whether this request will be granted, modified or denied. Provide supporting documentation.
18. 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 demonstrating the project is financially feasible and there are funds available to sustain the facility, if necessary, during the project period.