

Supplemental CON Application Form
Establishment of a Freestanding Emergency Department
Conn. Gen. Stat. § 19a-638(a)(4), as amended by Public Act 18-91

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 the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486, as amended by Public Act 18-91 and/or 4-181 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. Clear Public Need

- a. If you are an existing provider, identify the number of days that the applicant diverted ED patients to another facility during the most recently completed fiscal year (“FY”). Provide the dates and number of hours that the facility was on diversion for each occurrence.
- b. Provide a detailed discussion as to other options the applicant considered prior to choosing to move forward with the proposed satellite ED (including, but not limited to, expanding the main campus ED, establishing a satellite ED in another town, etc.).
- c. Will urgent care be provided at the proposed freestanding ED? If yes,
 - i. Describe how the applicant will comply with Public Act No. 18-149, that requires prominent signage indicating the level of care provided:
 - ii. Will patients incur an additional facility fee or copay as a result of receiving urgent care services?

2. Projected Volume

- a. Complete the following tables for the last three completed FYs, current FY (“CFY”) and first three full operational FYs of the proposed service. In completing these tables, please adhere to the following:
 - i. Provide the number of visits for each trauma level/category and **label** the **fiscal year** reflected in the table.
 - ii. For CFY periods 6 months or greater, report annualized volume, **identify the months covered** and the method of annualizing. For periods less than 6 months, report actual volume and **identify the months covered**.
 - iii. If the first year of the proposal is only a partial year, provide the partial year utilization and **indicate the months included** in a footnote. In addition, provide projections for the first three complete FYs.

TABLE A
ACTUAL & PROJECTED VISITS BY TRAUMA LEVEL–MAIN ED

Trauma Level	Actual Volume (Last 3 Completed FYs)			CFY Volume	Projected Volume			
	FY _____	FY _____	FY _____	CFY _____*	Partial FY _____**	FY _____	FY _____	FY _____
Level 1								
Level 2								
Level 3								
Level 4								
Level 5								
Total								

*CFY Months include _____
 **Partial FY Months include _____

TABLE B
PROJECTED VISITS BY TRAUMA LEVEL–SATELLITE ED

Trauma Level	Projected Volume			
	Partial FY ____*	FY**	FY**	FY**
Level 1				
Level 2				
Level 3				
Level 4				
Level 5				
Total				

*Partial FY Months include _____

TABLE C
PROJECTED VISITS BY CATEGORY–MAIN ED

Category	Actual Volume (Last 3 Completed FYs)			CFY Volume	Projected Volume			
	FY ____	FY ____	FY ____	CFY ____*	Partial FY ____**	FY ____	FY ____	FY ____
Emergent								
Urgent								
Non-Emergent								
Total								

*CFY Months include _____

**Partial FY Months include _____

TABLE D
PROJECTED VOLUME BY CATEGORY–SATELLITE ED

Category	Projected Volume			
	Partial FY ____*	FY ____	FY ____	FY ____
Emergent				
Urgent				
Non-Emergent				
Total				

*Partial FY Months include _____

- b. Provide a detailed description of all assumptions used in the derivation/ calculation of the projected volumes.
- c. Identify the number of patients that would shift from the Hospital to the proposed ED for the first three full years of operation (by year) by the trauma levels and categories used in Tables A and C. What impact would the proposed shift have on the Hospital’s main campus ED utilization?

3. Financial Information

- a. Provide a detailed discussion on charges for the services at the proposed Satellite ED. Specifically discuss how they will differ from the charges for services at the Hospital’s Emergency Department on the main campus.

4. Quality Measures

- a. Describe how the proposed Satellite ED physicians/staff will determine whether the level of care available for a presenting patient is appropriate and describe the steps that would be taken to transfer a patient to a higher level of care setting (E.G., Trauma Level I), if needed.

- a. Provide a detailed discussion on charges for the services at the proposed Satellite ED. Specifically discuss how they will differ from the charges for services at the Hospital's Emergency Department on the main campus.