Supplemental CON Application Form

Establishment of Cardiac Services

Conn. Gen. Stat. § 19a-338(a)(9)

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 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: _____

1. Clear Public Need

a. The record in this docket will include, in addition to other materials, the most recent American College of Cardiology/American Heart Association (ACC/AHA) practice guidelines. The Applicants may submit any comments in response to this evidence, which they deem appropriate.

b. If applicable to the proposal (e.g., establishment of catheterization lab without a cardiac surgical program), provide a copy of a signed agreement between the Applicant and a tertiary care facility. Identify patient selection guidelines, the process and protocols involved in the transfer of a patient requiring cardiac surgery, and joint quality assurance reviews and joint training.

c. Has the Applicant held any discussions with the local emergency medical service ("EMS") regarding the proposed service? Describe.

2. Projected Volume

a. In table format, provide historical volumes (three full years and the current year-to-date) for each Applicant by service as applicable to the proposal.

TABLE A
CARDIAC HISTORICAL UTILIZATION BY ZIP CODE

Town	Zip Code	PSA or SSA	Actual Volume (Last 3 Completed FYs)			CFY Volume*
			FY**	FY**	FY**	FY**
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 six months, report actual volume and identify the period covered.

** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

TABLE B
CARDIAC HISTORICAL UTILIZATION BY INPATIENT/OUTPATIENT

Category	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY***	FY***	FY***	FY***
Inpatient Outpatient				
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 six months, report actual volume and identify the period covered.
** Identify each service type and add lines as necessary. Provide the number of visits or discharges as appropriate for each service listed.
*** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

TABLE C
CARDIAC HISTORICAL UTILIZATION BY UNIQUE PHYSICIAN IDENTIFIER

Unique Physician Identifier	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY***	FY***	FY***	FY***
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 six months, report actual volume and identify the period covered.
** Identify each service type and add lines as necessary. Provide the number of visits or discharges as appropriate for each service listed.
*** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

b. If applicable, for the most recently completed fiscal year, identify the number of:

   i. Patients with a diagnosis of ST-segment elevation acute myocardial infarction (AMI) that presented at the Hospital's emergency room.

   ii. Doses of thrombolytic medication, issued through its pharmacy, to patients with a diagnosis of AMI.

TABLE D
CARDIAC PROJECTED UTILIZATION BY INPATIENT/OUTPATIENT

Category	Projected Volume		
	FY*	FY*	FY*
Inpatient Outpatient			
Total			

* Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

TABLE E
CARDIAC PROJECTED UTILIZATION BY UNIQUE PHYSICIAN IDENTIFIER

Unique Physician Identifier	Projected Volume		
	FY*	FY*	FY*
Total			

* Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

c. Please identify the number of physicians that will be providing coverage for the proposed program. Explain whether the physicians will be full time with the proposed program or also providing coverage at other hospitals.