Supplemental CON Application Form

Acquisition of Equipment

Conn. Gen. Stat. § 19a-638(a)(10),(11), 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. Project Description: Acquisition of Equipment

a. Provide the name of the legal entity that will acquire/own the equipment.

b. Provide the name of the legal entity that will bill for imaging services performed on the new equipment.

c. Will the acquired equipment be new or refurbished? Provide the age (if refurbished), manufacturer, model and number of slices/tesla strength of the proposed equipment.

d. Will the acquired equipment be leased or purchased? Please describe the terms of the lease/purchase agreement.

e. List each of the applicant's service sites and the imaging modalities currently offered by location.

2. Clear Public Need

a. For new equipment, where are the patients in the proposed service area currently being served?

b. Describe the benefits (e.g., clinical uses, technological advancements, etc.) of the equipment you are acquiring compared to your existing machines.

c. Provide scholarly articles to validate the advantages of the proposed equipment.

d. Complete **Table A** for each piece of equipment of the type proposed and currently operated at each of the applicant's service sites. Provide the name/address, equipment strength (e.g. slices, tesla strength) and state whether the unit is open or closed (for MRI), the days of the week the unit is operational, the start and end time for each day and the number of scans/exams performed on each unit for the most recently **completed** fiscal year. Identify the fiscal year months and type of volume (e.g., scans) being reported.

TABLE A

EXISTING EQUIPMENT OPERATED BY THE APPLICANT

Provider Name/Address	Equipment Description	Days/Hours of Operation	Utilization FY____

e. Provide the rationale for locating the proposed equipment at the service location.

3. Actual and Projected Volume

a. Complete the following tables 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 proposed pieces of **equipment** (of the type proposed, at the proposed location only). In **Table B**, report the units of service by piece of equipment, and in **Table C**, report the units of service by **type of service** (e.g., orthopedic).

In completing these tables, please adhere to the following:

i) Identify each scanner or service and add lines as necessary. Break out inpatient/outpatient/ED volumes if applicable and **label** what the **volumes represent** (e.g., MRI scans) and the **fiscal year** reflected in the table.

ii) For CFY periods greater than 6 months, report annualized volume and identify the months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the months.

iii) If the first year of the proposal is only a partial year, provide the partial year and indicate the months included and then provide projections for the first three complete FYs - add columns as necessary.

iv) Table B and C totals should match.

TABLE B

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY **EQUIPMENT UNIT**

	Actual ***[Indicate Volume Type]*** **(Last 3 Completed FYs)**			**CFY Volume**	**Projected** ***[Indicate Volume Type]*** **(First 3 Full Operational FYs)**		
Equipment	FY ____	FY ____	FY ____	FY ____*	FY ____	FY ____	FY ____
Total							

***Months include** _____

TABLE C

HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY **TYPE OF SERVICE**

	Actual ***[Indicate Volume Type]*** **(Last 3 Completed FYs)**			**CFY Volume**	**Projected** ***[Indicate Volume Type]*** **(First 3 Full Operational FYs)**		
Service	FY ____	FY ____	FY ____	FY ____*	FY ____	FY ____	FY ____
Total							

***Months include** _____

b. 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 OHS Tables B and C.

c. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volumes by equipment and service type.

d. For the equipment's proposed location, use Table D to provide total facility volume by town (i.e., use **ONLY** official town names) for the **most recently completed FY**.

In completing Table D, please adhere to the following:

i) Identify the FY and volume type (e.g., scans)

ii) FY total should match corresponding FY total in Tables B and C.

TABLE D
UTILIZATION BY TOWN

Official Connecticut Town	**FY____ Volume: (indicate type)**
Total	

4. Cost Effectiveness

a. How will the equipment acquisition improve the cost effectiveness of health care delivery in the region?

b. How will patient costs for imaging services at the proposed service location be affected by the acquisition of the new equipment?