OHS CONNECTICUT Office of Health Strategy

Supplemental CON Application Form

Establishment of a New Health Care Facility (Mental Health and/or Substance Abuse Treatment)*

Conn. Gen. Stat. § 19a-638(1), as amended by Public Act 18-91

Applicant:

Project Name:

*****This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11), as amended by Public Act 18-91 - hospitals licensed by the Connecticut Department of Public Health under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

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: New Facility or Service (Mental Health and/or Substance Abuse)

a. Place a checkmark (✓) in the "Needed for Proposal" column for each license (and applicable treatment service(s)) that the applicant is seeking from the State's Department of Public Health (DPH) and Department of Children and Families (DCF) in relation to the proposal.

TABLE 1
DPH/DCF LICENSES NEEDED FOR THE PROPOSAL

DPH Private Freestanding:	**Needed for Proposal**
Mental Health Psychiatric Outpatient Clinic for Adults (includes both Intensive Outpatient (IOP) and Outpatient treatment (OP); less than four (4) hours of treatment/person/day)	☐
Mental Health Day Treatment (outpatient; one unit of service must be four (4) hours or more per person daily; aka, Partial Hospitalization)	☐
Mental Health Residential Living Center	☐
Mental Health Community Residence	☐
Facility for the Care or the Treatment of Substance Abusive or Dependent Persons: *Select at least one of the following if proposing substance abuse treatment services*: **Ambulatory Chemical Detox** (outpatient) ☐ **Day and Evening Treatment** (outpatient; one unit of service must be four (4) hours or more per person daily) ☐ **Chemical Maintenance** (outpatient; administers Methadone; DEA involved in approval) ☐ **Outpatient Treatment** (Includes both IOP and OP; less than four (4) hours of treatment/person/day) ☐ **Care and Rehab (residential)** ☐ **Intermediate and long term treatment and rehab** (residential) ☐ **Detoxification & Evaluation** (residential) ☐ **Intensive Treatment** (residential) ☐ **Medical Triage** (similar to an evaluation service) ☐	☐
DCF License:	
Outpatient Psychiatric Clinic for Children	☐
Extended Day Treatment	☐
Child Caring Facilities (residential)	☐

b. Explain the method used to derive your service area.

c. Describe any unique demographic characteristics of the service area or population (e.g., a health professional shortage or medically underserved population or area designation, a relatively higher rate of low-income population than the state, etc.).

d. Describe any unique services (i.e., services not currently or readily available in the service area) that may be included in the proposal.

e. Explain how the proposed program will operate, including the specific services to be provided, treatment approaches and structure.

f. Explain how the proposed program will help integrate behavioral health with primary care providers. Will new referral relationships be established?

g. How will the applicant track/measure the quality or success of the proposed program's outcomes?

h. If multiple levels or intensities of care will be offered at the facility as a result of the proposal, how will patients be screened to ensure they are directed to the appropriate level?

i. Explain in detail how the new program will align with state and/or federal initiatives (e.g., CT Alcohol and Drug Policy Council recommendations, CT Opioid REsponse Initiative, community benefits, etc.).

j. List the type and number of DPH-licensed health care professionals that will be required to initiate the proposal. Indicate whether these professionals are currently on staff. If not, explain how you plan to recruit employees to fill the vacant positions, when you anticipate those positions will be filled and how those positions will funded.

k. Describe your experience with any health code violations that have occurred at any of your existing facilities. Provide copies of any incidence or violation citations that occurred within the past three years and describe how they have been resolved.

2. Projected Volume

a. For each behavioral health disorder to be treated in the program, provide the prevalence rate(s) from the Substance Abuse and Mental Health Administration ("SAMSHA"), or a similar organization, demonstrating that the target population has a need for the proposed services. Indicate the source of the provided rates.

b. For each of the behavioral health disorders and specific population groups to be served, report the following (include the basis for determining the estimate and document all assumptions). **Complete a separate table for each population and behavioral health disorder served:**

(i) An estimate of the number of persons within the population group that need the proposed service based on the relevant prevalence rate indicated in (a) and proposed service area population, utilizing Table 2.

TABLE 2
ESTIMATE OF *[Indicate Behavioral Health Disorder]* INCIDENCE IN CONNECTICUT

	POPULATION (1)	**PREVALENCE RATE (2)**	**INCIDENCE (1) x (2)**
Applicant's Proposed Service Area			
All of CT			
Service Area as Percent of CT		N/A	

(ii) The number of persons in need of the service that will be served by the proposal (estimated patient/client volume) by service level utilizing Table 3.

TABLE 3
PROJECTED UTILIZATION BY SERVICE

Service Level (e.g., IOP)	**Projected Volume**		
	FY ____	**FY ____**	**FY ____**
Unduplicated Client Total			

Please note: for 2a and b, provide only publicly available and verifiable information and document the source.

c. How will the target population, including those that have never been a patient or client, access the proposed program (e.g., referrals, word of mouth, etc.)? Where are potential clients currently receiving services? What services are they receiving?

d. Provide a needs assessment or business plan that separates projected volume by your anticipated payer mix.

e. Utilizing Table 4, below, provide the unduplicated client volume, related percentage and associated number of discharges/visits. Ensure that client volumes are unduplicated and consistent with the totals projected in Table 3. In addition, discharge/visit volume should match totals provided in the "Inpatient Discharges" or "Outpatient Visits" row in the Financial Worksheet. If the first operational year is a partial year, provide the anticipated volume and indicate the months that were included.

TABLE 4
CURRENT AND PROJECTED PAYER MIX BY NUMBER OF CLIENTS AND VISITS

Payer	Projected											
	Partial FY ____*			FY ____			FY ____			FY ____		
	Clients	%	Dis./ Visit Vol.	Clients	%	Dis./ Visit Vol.	Clients	%	Dis./ Visit Vol.	Clients	%	Dis./ Visit Vol.
Medicare												
Medicaid												
TRICARE												
Total Government												
Commercial Insurers: In Network												
Commercial Insurers: Out of Network												
Uninsured												
Self-pay												
Workers Compensation												
Total Non-Government												
Total Payer Mix		**100**			**100**			**100**			**100**	

***Months included** _____

f. If commercial payments are anticipated, have you established any commercial carrier provider agreements? If yes, describe these agreements (name of carrier, duration, etc.). If no, describe any progress made to date.

3. Other Providers

a. Provide any transfer agreements with other area health care facilities pertaining to the proposal (e.g., if proposing a residential substance abuse facility, any agreements with area acute care hospitals).

b. Describe any expected or established agreements or relationships with other area providers to ensure patients will have a complete continuum of care available to them.