Supplemental CON Application Form

Termination of a Service

Conn. Gen. Stat. § 19a-638(a)(5),(7),(8),(15), 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: Service Termination

a. Please provide:

   i. a description of the history of the services proposed for termination, including when they commenced;

   ii. a statement explaining whether CON approval was required for the establishment of the service that would be terminated; and

   iii. if CON approval was required, the docket number for that approval.

b. Explain in detail the applicant's rationale for this termination of service and the process undertaken in making the decision to terminate.

c. Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide a copy of the meeting minutes that are relevant (i.e., remove unrelated material) to the proposal.

2. Termination's Impact on Patients and Provider Community

a. Provide an assessment/study that evaluates the availability of post termination services for the patient population currently being served (including all payer types). Include a detailed discussion that includes: names of providers, services offered, service locations and accessibility (e.g., distance from current location, availability of public transportation and parking, etc.)

b. In Table A (below), provide the names of all providers to whom the applicant proposes to transfer clients and their total/available capacity. In addition, provide the applicant's volume of the terminating service for the most recently **completed** fiscal year ("FY") and current fiscal year ("CFY").

   In completing the table, please adhere to the following:

   i. Fill in year and identify the period covered by the applicant's FY (e.g., July 1-June 30, calendar year, etc.). Label and provide the patient volume (e.g., visits, discharges, etc.) as appropriate.

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 months included.

TABLE A
PROVIDERS ACCEPTING TRANSFERS/REFERRALS

Accepting Transfers/Referrals Provider(s)				**Terminating Service**	
Provider Name	**Provider Address**	**Total Capacity**	**Available Capacity**	*[Indicate Volume type]* **FY ____**	*[Indicate Volume type]* **CFY____***
Total					

***Months include _____**

c. Provide evidence (e.g., written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients and that they will accept all payer types currently being served.

d. Identify any special populations that utilize the service(s) and explain how these populations will maintain access to the service following termination at the specific location; also, specifically address how the termination of this service will affect access to care for all payer types, including Medicaid recipients and indigent persons.

e. Describe how clients will be notified about the termination and transfer to other providers.

f. Describe the nature of patient medical records that have been maintained relative to the terminated service. How will these records be made available to new providers as a function of the transition of care?

g. For DMHAS-funded programs only, attach a report that provides the following information for the last three full FYs and the current FY to-date:
   i. Average daily census;
   ii. Number of clients on the last day of the month;
   iii. Number of clients admitted during the month; and
   iv. Number of clients discharged during the month.

3. Cost Effectiveness

a. How will the proposed service termination affect the cost effectiveness of health care delivery in the region? Provide evidence to support your response.

b. Will there be any additional cost to patients (e.g., facility fees) that will result from receiving the terminated service at any of the alternative providers listed in Table A, above?

4. **Transfer to Affiliate** (this question to be completed by a hospital proposing to terminate a service, but the service will continue to be provided by a related affiliate)

a. Provide the historical and projected utilization by individual service location(s) for the terminated hospital service. Include a description of the specific assumptions used to determine the projected volume and provide specific evidence or data to support the projections anticipated in Table C, below.

TABLE B
HISTORICAL UTILIZATION BY [indicate location]

Service	Actual Volume [indicate type] (Last 3 Completed FYs)			CFY Volume*
	FY ____	FY ____	FY ____	FY ____
Total				

*Months include _____

TABLE C
PROJECTED UTILIZATION BY [indicate location]

Service	Projected Volume (indicate type)			
	Partial FY ____*	FY ____	FY ____	FY ____
Total				

*Months include _____

b. Provide the historical and projected payer mix **by individual service location(s**) for the terminated hospital service. Include a description of the specific assumptions used to determine the projected payer mix and provide specific evidence or data to support the projections anticipated in Table D, below.

Note: payer mix should be calculated from patient volumes, not patient revenues.

TABLE D
APPLICANT'S CURRENT & PROJECTED PAYER MIX BY [indicate location]

Payer	Most Recently Completed FY ____		Projected					
			FY ____		FY ____		FY ____	
		%		%		%		%
Medicare								
Medicaid								
TRICARE								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

c. Complete Financial Worksheet A (non-profit entity) or B (for-profit entity), available at OHS Forms, for the related **hospital affiliate** that will continue to provide the hospital's terminated service.

d. If applicable, complete Financial Worksheet A (non-profit entity) or B (for-profit entity), available at OHS Forms, for the **parent company** of the related hospital affiliate that will continue to provide the hospital's terminated service.