IMPORTANT

All CON-related documents (**CON Applications, CON Determinations, CON Modifications and CON Completeness Letter Responses)** ***must be filed electronically*** through OHCA's single point of access, its OHCA Web Portal.

First time Portal users must register prior to submitting any documents. To register, click here: http://dphconwebportal.ct.gov .

To access the portal, click on the link above or www.ct.gov/ohca and go to the Certificate of Need page (on left side of page) and then click on the CON Portal.

If you have any questions, please email OHCA@ct.gov or call (860) 418-7001.

State of Connecticut
Office of Health Care Access
CON Determination Form
Relocation of a Health Care Facility

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed relocation of a health care facility must complete this form. The completed form ***must be filed electronically*** through the Office of Health Care Access' single point of access, its OHCA Web Portal.

To access the portal, click on the link above or www.ct.gov/ohca and go to the Certificate of Need page (on left side of page) and then click on the CON Portal.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name		
Doing Business As		
Name of Parent Corporation		
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail		

What is the Petitioner's Status: P for profit and NP for Nonprofit		
Contact Person at Facility, including Title/Position: This Individual at the facility will be the Petitioner's Designee to receive all correspondence in this matter.		
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail		
Contact Person's Telephone Number		
Contact Person's Fax Number		
Contact Person's e-mail Address		

SECTION II. INFORMATION ON PROPOSED RELOCATION

Please provide a description of the proposed relocation, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable.

Name of the Health Care Facility:

Current Location:

Proposed Location:

Current Population Served:

Proposed Population Served:

Current Payor Mix:

Proposed Payor Mix:

Any other information that the Petitioner deems relevant:

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____being duly sworn, depose and state that the
(Organization Name)

information provided in this CON Determination form is true and accurate to the best of my knowledge.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____
Notary Public/Commissioner of Superior Court

My commission expires: _____