Application for Additional Community Capacity in Technology

I. General Information

A. Facility/practice name and address:

B. Operator name (if different from above):

C. Site/location (if different from above):

D. Contact person/representative:

Name:
Title:
Address:

Phone:
Email:

E. Name of person completing application (if different from contact person/ representative):

Name:
Title:
Address:

Phone:
Email:

II. Overview of Technology

A. Describe the proposed technology.

B. Describe the technology's intended use:

Clinical Indications for which the Proposed Technology is Generally Accepted	Procedures Likely to be Supplanted or Replaced by Proposed Technology

C. Does the proposed technology enhance currently available technology?

Yes [ ] or No [ ]. If yes, describe how.

III. Community Need

A. Describe your estimate of community need for this technology in this region. Illustrate the basis of your estimate.

B. Does this additional capacity serve an unmet community need?

Yes [ ] or No [ ]. If yes, how is this need being addressed presently?

C. Volume of Services and Need for Services:

1. Define a unit of service for this technology and estimate the number of units your facility will perform in the first and third full years of operation:

Type of Unit of Service	Current Year	First Year	Third Year

2. What is your estimate of the number of units of service per hour, per day, and per year that can be produced if the technology operates efficiently? Illustrate the basis of your estimate.

3. If the proposed technology replaces an existing unit, describe disposition of the current unit.

IV. Financial

A. Total Project Cost

Item	Cost
Land and/or building acquisition	
Site development	
Fixed equipment	
Estimated cost for refurbishing unit to status for "new machine" warranty	
Moveable equipment	
Financing Costs	
Consultant costs (e.g., architect)	
Total Project Cost	

B. Project Financing

Please describe the plan for financing this project.

C. Incremental Annual Operating Cost

Type of Expense	Current Year	Incremental Cost	
		First Year	Third Year
Salaries and Wages			
Employee Benefits			
Professional Fees			
Supplies, medical & surgical			
Supplies, other			
Utilities			
Purchased services			
Other direct expenses (i.e. lease)			
Interest			
Depreciation			
Rent			
Total Operating Cost			

D. Incremental Annual Revenue Schedule

Source of Revenue	Current Year	Incremental Revenue	
		First Year	Third Year
Commercial Fee for Service			
Commercial Managed Care			
Medicare Fee for Service			
Medicare Managed Care			
Medicaid Fee for Service			
Medicaid Managed Care			
Private			
OASAS			
OMH			
Charity Care			
Bad Debt			
All Other			
Total Revenue			

Does the percentage of Medicaid and private pay patients using this technology differ from the percentage of Medicaid and private patients using other technology at your facility?

Yes [ ] or No [ ]. If yes, how?

E. Incremental Staffing

Category of Staffing	Current Year	Incremental Staffing	
		First Year	Third Year
Management & supervision			
Physician			
Nursing			
Technicians			
Support			
Other			
Total Staffing			

V. Access

A. What region/locale do you propose to serve with this additional capacity?

B. Hours of Operation - Please provide the hours of operation (i.e., from x time to y time).

Day of Week	Current Year	First Year	Third Year
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

C. If CTAAB approves your project, how long will it be from the approval date until the new capacity is operational?

VI. Quality

A. Is the technology presently approved for marketing by the FDA?

Yes [ ] or No [ ]. If no, describe the current status of FDA review.

B. If this additional capacity is for diagnostic purposes, how does its sensitivity and specificity compare to existing technology already available in the region?

C. If the technology is for treatment purposes, what evidence of improved health outcomes is demonstrated in peer-reviewed literature?

D. Provide copies of peer-reviewed medical literature that demonstrates improved health outcomes. (If no documentation is provided, CTAAB will assume the merits of this technology are not proven.)

E. Describe any investigational trials applicable to the proposed technology and their current status. Provide documentation of these trials.

F. Identify the primary users/practitioners of this technology at your facility and describe their training.

G. Describe any professional society and/or state guidelines governing any specialized training requirements for using this technology.

H. Describe the training protocols for practitioners using this technology.

VI. Additional Information

A. Is the technology described in CPT-4 terms?

B. Are the CPT-4 codes used unique to this technology, or can they be used for other services as well?

Return completed application to:

Community Technology Assessment Advisory Board
c/o Finger Lakes Health System Agency
1150 University Avenue, Building 5
Rochester, New York 14607