State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Catholic Charities of Fairfield County, Inc	
Doing Business As	Catholic Family Services -Shelton	
Name of Parent Corporation	Catholic Charities of Fairfield County, Inc	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	238 Jewett Ave Bridgeport,CT06606	
Applicant type (e.g., profit/non-profit)	Non-Profit	
Contact person, including title or position	William Hoey, Area Executive	
Contact person's street mailing address	238 Jewett Ave. Bridgeport, CT 06606	
Contact person's phone #, fax # and e-mail address	(203) 416-1318 (203) 373-0853 bhoey@ccfc-ct.org	

Catholic Charities
238 Jewett Avenue • Bridgeport, Connecticut 06606-2892 • Phone: 203-372-4301 • Fax: 203-373-0835 • www.bridgeportdiocese.com

AL BARBER
PRESIDENT
CHIEF OPERATING OFFICER
ABARBER@CCFC-CT.ORG

March 24, 2006

Commissioner
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

To Whom It May Concern;

Per statutory requirement, enclosed please find a *Letter of Intent* form concerning the anticipated closure of a Psychiatric Outpatient Clinic for Adults, located at 452 Howe Ave, Shelton, CT. 06484

Kindly contact me at your convenience, should you have any questions or concerns.

Sincerely,

William Hoey

William Hoey, LCSW
Area Executive

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

_Outpatient Psychiatric Clinic_____

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation X Service Termination

☐ Bed Addition` ☐ Bed Reduction ☐ Change in Ownership/Control

N/A ☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

N/A ☐ Project expenditure/cost cost greater than $ 1,000,000

N/A ☐ Equipment Acquisition greater than $ 400,000

☐ New ☐ Replacement ☐ Major Medical

☐ Imaging ☐ Linear Accelerator

N/A ☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address):
__Shelton, CT_____

d. List all the municipalities this project is intended to serve: __Shelton, CT_____

e. Estimated starting date for the project: ____N/A_____

f. Type of project: _____18_____ **(Fill in the appropriate number(s) from page 7 of this form)**

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $ N/A

b. Please provide the following breakdown as appropriate: N/A

Construction/Renovations	$
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
N/A				

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan

☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding

☐ Funded Depreciation ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT – N/A

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: _____

Project Title: _____

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

of _Catholic Charities of Fairfield County, Inc__ being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that _ _____

complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____
Notary Public/Commissioner of Superior Court

My commission expires: _____

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

Section VI – Project Description

1. Services Provided
Project provides a range of outpatient clinical and counseling services, including comprehensive assessment and psychiatric evaluations. (Please refer to attached Dept of Public Health License)

2. Services Proposed - N/A

3. Current Population
Project serves individuals, couples and families residing in the greater Shelton area.

4. Unmet Need
N/A – Project has been staff by 1 part time clinician. Current caseload of clients will be transferred to adjacent project site in Bridgeport and the mental health clinic of Catholic Charities, Hartford which is located in Ansonia.

5. Similar Existing Service Sites
Yes. Catholic Charities, Bridgeport and Catholic Charities Hartford both have clinics within 10 miles of this site, both provide identical services in this area

6. Effect on Health Care Delivery System
Effect is negligible – please refer to responses to questions #4 and #5

7. Responsible Party
The Catholic Charities licensed outpatient psychiatric clinic located at 238 Jewett Avenue, Bridgeport, CT will continue to provide service to Darien-based clientele

8. **Payors of Service**
Project services generate reimbursement directly from clients, or from public/private 3rd party payors, such as Medicaid, Medicare, Anthem BlueCross, Healthnet, United Behavioral Health and Oxford.

5

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. C-0125

Psychiatric Outpatient Clinic for Adults

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Catholic Charities of Fairfield County, Inc. of Bridgeport, CT, d/b/a Catholic Mental Health Clinic is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Catholic Mental Health Clinic is located at 452 Howe Ave, Shelton, CT 06484 with:
William E. Hoey, LCSW as Executive Director
William E. Hoey, LCSW as Director

This license expires **December 31, 2008** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2005. RENEWAL

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner