Family Services Working to Strengthen our Communities

475 Clinton Avenue
Bridgeport, CT 06605
203.368.4291
Fax: 203.368.1239
TTY: 203.368.5653
www.fswinc.org

January 24, 2007

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

Dear Commissioner Vogel,

Enclosed is the Form 2010, Application for Exemption From CON Process. I am submitting this application as FSW is closing one of its service sites located at 500 Purdy Hill Road, Monroe, CT 06468. This site is currently licensed as an Adult Outpatient Mental Health Clinic. With the closing, we will no longer deliver service from this location and will relinquish our DPH license for that site. We will maintain our main location in Bridgeport. Clients from the Monroe area can still be served in Bridgeport.

Should you need additional information, please contact me.

Sincerely,

William J. Hass, Ph.D.
Executive Vice President

Enclosure

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS
APPLICATION FOR EXEMPTION FROM CON PROCESS
Form 2010

All persons who are requesting an exemption from the Certificate of Need process under the requirements of Connecticut General Statutes, Sections 19a-639(d), 19a-639(e), 19a-639b and 17a-678 must complete this form. Please submit the completed forms 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 this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

	Applicant One	Applicant Two
Full Legal Name	FSW, Inc. CT	
Doing Business As		
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	475 Clinton Avenue Bridgeport, CT 06605	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	William J. Hass, Ph.D. Executive Vice President	
Contact Person's mailing address, if PO Box, include a street mailing address for Certified Mail	Same as above	

Contact Person's Telephone Number	203-368-5552	
Contact Person's Fax Number	203-332-7637	
Contact Person's e-mail Address	whass @fswinc.org	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title (i.e. use applicable state licensure categories):
Adult Outpatient Mental Health Clinic

b. Location of proposal, identifying Street address, Town, and Zip Code:
500 Purdy Hill Road, Monroe, CT 06468

c. List each town that this project is intended to serve:

Monroe, Trumbull, Shelton, Newtown

d. Estimated starting date for the project: Program will CLOSE 1/29/07

e. Provide a brief description of the proposal in the box below. Use an additional sheet if necessary.

FSW has operated a licensed Adult Outpatient Mental Health Clinic at the 500 Purdy Hill Road site. FSW is selling the office and ending services at this site effective 1/29/07.

Former clients can be served at FSW's Bridgeport location. All client records will be transferred to FSW's main office at 475 Clinton Avenue, Bridgeport, Ct 06605.

FSW's Bridgeport's site is also licensed as an Adult Outpatient Mental Health Clinic and will remain in operation under its current license.

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

Estimated Total Project Cost: $75,000

SECTION IV. EXEMPTION INFORMATION

I may be eligible for an exemption from the Certificate of Need process because of the following: (Please check the boxes that apply.)

Section 19a-639(d), C.G.S.

☐ This is a Community Health Center which:
- ☐ is proposing a capital expenditure which does not exceed three million dollars
- ☐ provides only primary care or dental services and either
- ☐ 1/3rd or more of the cost is financed by the State of Connecticut (supporting documentation attached);
- ☐ is receiving funds from the Department of Public Health (supporting documentation attached); or
- ☐ provides services in a medically underserved area or in a health professional shortage area with proof attached.

☐ This is a Federally Qualified Health Center Satellite which:
- ☐ is part of a federally qualified health center **(Supporting Documents Attached)**
- ☐ provides only primary care or dental services
- ☐ provides services in a medically underserved area or a health professional shortage area with proof attached.

Section 19a-639(e), C.G.S.

☐ This is a school-based clinic, which is:
- ☐ licensed or will be licensed by the Department of Public Health (DPH)
- ☐ approved by the DPH as meeting a standard model for a comprehensive school-based health clinic
- ☐ proposing a capital expenditure not exceeding three million dollars
- ☐ located entirely on the property of an existing school site.

Section 19a-639b, C.G.S.

☐ This proposal is intended for a non-profit facility, institution or provider that is currently under contract with a state agency or department where:
- ☐ the activity meets a specific service need;
- ☐ the activity is the relocation of services;

X the activity is a termination of service/function;

☐ has a capital expenditure that does not exceed three million dollars, **and**

☐ has received an endorsement from the Commissioner, executive director, chairman or chief court administrator of the state agency or department confirming the service need. **(Supporting Documents Attached)**

Section 17a-678, C.G.S.

☐ This is a proposal to close a service delivery system gap in the statewide substance abuse service delivery plan which:

- ☐ is a community agency operating a program in a state institution or facility
- ☐ is a nonprofit community agency operating a program in a state institution or facility and is receiving funds from the Department of Mental Health and Addiction Services (DMHAS)
- ☐ is a nonprofit substance abuse facility and is receiving funds from DMHAS
- ☐ is submitting a letter from the Commissioner of DMHAS **(Supporting Documents Attached)** with proof of DMHAS funding and confirming the above

SECTION V. EXEMPTION AFFIDAVIT

To be completed by each Applicant

Applicant: FSW, Inc. CT

Project Title: Mental Health Clinic 500 Purdy Hill Road, Monroe, CT 06468

I, Brian J. Langdon, President & CEO

of FSW, Inc. CT, being duly sworn, depose and

state that said facility complies with all of the criteria: (*Check One Only)*

☐ Stated in 19a-639(d) of the Connecticut General Statutes (FQHC/CHC)

☐ Stated in 19a-639(e) of the Connecticut General Statutes (School-based clinic)

X Stated in 19a-639b of the Connecticut General Statutes (Non-Profit)

X Stated in 17a-678 of the Connecticut General Statutes (DMHAS)

☐ Stated in 19a-639c of the Connecticut General Statutes (Replacement equipment Waiver)

Brian J Langdon
Signature

1/23/07
Date

Subscribed and sworn to before me on 1/23/07

Gladys Nunez
Notary Public/Commissioner of Superior Court

My commission expires: 3/31/2010

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A Healthcare Service Agency

M. JODI RELL
GOVERNOR

THOMAS A. KIRK, JR., PH.D.
COMMISSIONER

February 2, 2007

Mr. William J. Hass, Ph.D.
Executive Vice President
FSW, Inc. CT
475 Clinton Avenue
Bridgeport, Connecticut 06605

Dear Mr. Hass:

I am responding to your telephone inquiry of January 15, 2007 to Department of Mental Health and Addiction Services (DMHAS) staff person, Donna C. Stimpson. It is my understanding that FSW, Inc. CT is seeking a DMHAS Certificate of Need (CON) Exemption recommendation to terminate outpatient psychiatric services for adults at 500 Purdy Hill Road in Monroe, Connecticut.

Under Connecticut General Statutes (C.G.S.) Section 19a-639b, as amended by Public Act (P.A.) 06-64, DMHAS may only consider a CON exemption request by applicants that are currently under contract with DMHAS. We have determined that the clinic (Monroe) requested for termination under FSW's CON exemption application is not currently under contract with DMHAS. Accordingly, FSW, Inc. CT is not eligible for consideration for a DMHAS CON exemption.

We are sending a copy of this letter to the Office of Health Care Access (OHCA). You may wish to contact OHCA to explore other CON options.

Sincerely,

Peter B. Rockholz, M.S.S.W.
Deputy Commissioner

PBR:dcs
cc: Alfred Bidorini, Donna C. Stimpson, DMHAS CON Review Committee
Paolo Fiducia, Office of Health Care Access
2007 DMHAS CON File

T:/Planning/Certificate of Need/No Contract Letter/2007/FSW aka Family Svs of Woodfield Let 2/02/07.doc

(AC 860) 418-7000
410 Capitol Avenue, P.O. Box 341431 • Hartford, Connecticut 06134
www.dmhas.state.ct.us

410 State St., Bpt., CT 06604 - Fax #203-384-1158

Connecticut Post

Fax

To: Paulo Fiducia From: Donna L. Robinson

Fax: (860) 418-7053 Phone: 203-330-6292

Date: 3-1-2007 E-Mail: drobinson@ctpost.com

Re: Legal Notice Pages: 3

☐ Urgent ☑ For Review ☐ Please Comment ☑ Please Reply ☐ Please Recycle

• Comments:

RECEIVED
2007 MAR -2 AM 8:18
COMMISSIONER
HEALTH CARE ACCESS

Order Confirmation

Ad Order Number	Customer	Customer Account	Ordered By	PO Number
0001002878	CONN, STATE OF/OFFICE HEALTH C	106794	PAOLO FIDUCIA	HCA07-031
Sales Rep.	**Customer Address**	**Customer Phone #1**	**Customer Phone #2**	
mngconn	410 CAPITOL AVE., MS#13HCA,P.O. BOX	860-418-7001		
Order Taker	HARTFORD, CT, USA 06134-0308	**Customer Fax**	**Customer EMail**	
drobinson		860-418-7053		
Order Source	**Payor Customer**	**Payor Account**	**Special Pricing**	
Phone	CONN, STATE OF/OFFICE HEALTH C	106794	None	

Tear Sheets	Proofs	Affidavits	Blind Box	Promo Type	Materials
0	0	1			
Invoice Text				**Ad Order Notes**	

Net Amount	Tax Amount	Total Amount	Payment Method	Payment Amount	Amount Due
$165.92	$0.00	$165.92		$0.00	$165.92

Ad Number	Ad Type	Ad Size	Color	Production	Production Notes
0001002878-01	Legal Liners	2.0 X 26 Li	<NONE>	AdBooker	
Ad Attributes		**Ad Released**	**Pick Up**		
		No			

Ad Content

PUBLIC NOTICE Statute Reference: 19a-638 Applicant: Family Service Working, Inc. Town: Monroe Docket Number: 07-30911-LOI Proposal: Closure of Adult Outpatient Mental Health Clinic in Monroe Total Capital Expenditure: $75,000 The Applicant may file its Certificate of Need application between April 6, 2007 and June 5, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA, P.O. Box 340308, Hartford, CT 06134-0308. The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

PUBLIC NOTICE

Statute Reference: 19a-638
Applicant: Family Service Workings, Inc.
Town: Monroe
Docket Number: 07-30911-LOI
Proposal: Closure of Adult Outpatient Mental Health Clinic in Monroe

Total Capital Expenditure: $75,000

The Applicant may file its Certificate of Need application between April 6, 2007 and June 5, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA, P.O. Box 340308, Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

RECEIVED
2007 MAR -2 AM 8:19
OFFICE OF HEALTH CARE ACCESS

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 28, 2007

William Hass
Executive Vice President
Family Services Working, Inc.
475 Clinton Avenue
Bridgeport, CT 06605

RE: Certificate of Need Application Forms, Docket Number 07-30911-CON
Family Services Working, Inc.
Closure of Adult Outpatient Mental Health Clinic in Monroe

Dear Mr. Hass:

Enclosed are the application forms for Family Services Working, Inc.'s Certificate of Need ("CON") proposal for the closure of an adult outpatient mental health clinic in Monroe with an associated capital expenditure of $75,000. According to the parameters stated in Sections 19a-638 and 19a-639 of the Connecticut General Statutes the CON application may be filed between April 6, 2007, and June 5, 2007.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and three hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests that the electronic copy be in Adobe or MS Word format and that the Financial Attachment and other data as appropriate be in MS Excel format.

The analyst assigned to the CON application is Paolo Fiducia. Please feel free to contact him at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosure

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than April 6, 2007, and may be submitted no later than June 5, 2007. The Analyst assigned to your application is Paolo Fiducia and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 07-30911-CON

Applicant(s) Name: Family Services Working, Inc.

Contact Person: William Hass
Contact Title: Executive Vice President
Family Services Working, Inc.
Contact Address: 475 Clinton Avenue
Bridgeport, CT 06605

Project Location: Monroe

Project Name: Closure of Adult Outpatient Mental Health Clinic in Monroe

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $75,000

1. Expansion of Existing or New Service

What services are currently offered at your facility? Please list.

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Regarding this termination of services, please answer the following:

i) Explain in detail the Applicant's rationale for this termination of services. Identify the process undertaken by the Applicant in making the decision to terminate.

ii) Did the Applicant determine there was no or insufficient public need for the continuation of this program?

iii) Is the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

iv) Did this termination require the vote of the Board of Directors of the Applicant? If so, please provide a copy of the minutes (excerpted for other unrelated business) for the meeting(s) at which this termination was discussed and voted on.

B. Provide or answer the following:

i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups) that are available and provided at the Monroe location. Identify what the hours of operation were for this service location.

ii) Identify the primary and secondary service area towns for the Monroe service location.

iii) Provide the units of service (i.e. clinic visits) for the past three fiscal or calendar years by patient town of origin, for the Monroe service location.

iv) Please provide a report that lists, for the Monroe location by month, for FYs 2004, 2005, and 2006, to date, the following: average daily census; number of clients on the last day of the month; the number of clients admitted during the month; and the number of clients discharged during the month, also provide a report that lists the number of clients admitted by town of residence for FYs 2004, 2005, and 2006, to date.

v) Discuss any scheduling backlogs that exist at the Monroe service location.

vi) Are there any waiting lists in place? If so, identify the number of patients on the waiting list.

vii) Describe the pattern of referrals to the Monroe service location that currently exist.

C. Regarding the impact on the patient and provider community of the termination of services, provide the following information:

i) Explain the procedures that the Applicant follows in terminating these services and transferring patients to other community providers.

ii) Discuss how the services described above will continue to be made available to the patients that had previously utilized this service location. List any special populations that utilize the services and explain how these clients will continue to access this service after it was closed.

iii) Provide the information as outlined in the following table concerning the existing providers services in the Monroe service area:

Description of Service	Provider Name and Location	Hours and Days of Operation[1]	Current Utilization[2]

[1] Specify days of the week and start and end time for each day.
[2] Number of clients served by Provider for the most recent 12 month period, if known.

iv) Has your facility contacted any other providers in the Monroe service area to see if they are willing and able to absorb the patient population base for displaced patients? Please provide a detailed explanation, including any written agreements or memorandum of understanding between the Applicant and any other facilities as related to the proposal.

v) What will be the effect of the termination of the Monroe service location on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

vi) Will this termination of services create any barriers to access in the region? If so, please discuss such barriers, as they now exist.

vii) Provide information and supporting documentation addressing the issue of transportation for the Monroe patients. Describe how patients would be able to travel to a new service location if without benefit of a personal vehicle.

D. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

_____

If you checked other than None of the above, please provide an explanation.

E. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

☐ None: *explain* why no reports, studies or market share analysis was undertaken related to the proposal:

_____
_____
_____
_____

5. Quality Measures

A. Provide or answer the following:

i) Provide a copy of the State of Connecticut Department of Public Health license(s) currently held by Family Services Working, Inc. in Monroe.

ii) Are there any unique characteristics of your patient/physician mix?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

C. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH ☐ JCAHO

☐ Fire Marshall Report ☐ Other States Health Dept. Reports (new out-of-state providers)

☐ AAAHC ☐ AAAASF

☐ Other: _____

Note: Above referenced acronyms are defined below. [1]

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

- ☐ Energy conservation
- ☐ Group purchasing
- ☐ Reengineering
- ☐ None of the above
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ Other (identify)_____

7. Miscellaneous

A. Provide or answer the following:

i) Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

ii) Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

- ☐ Corporation (Inc.)
- ☐ Limited Liability Company (LLC)
- ☐ Partnership
- ☐ Professional Corporation (PC)
- ☐ Joint Venture
- ☐ Other (Specify):

_____

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

B. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

C. Verify that this termination of services has not resulted in any capital expenditures or capital costs to the Applicant.

9. Revenue, Expense and Volume Projections

A) Provide the following financial information for the Monroe location:

i) Please submit an audited or unaudited Balance Sheet and Income Statement or Statement of Operations for the two most recently completed fiscal years. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Provide a discussion of any incremental gains or losses from operations that were a direct result of the termination of the services

B) Please provide the current payer mix for the Total Facility based on Net Patient Revenue in the following reporting format for the Monroe location:

	Provider's Payer Mix
Medicare*	
Medicaid* (includes other medical assistance)	
TriCare (CHAMPUS)	
Total Government Payers	
Commercial Insurers*	
Self-Pay	
Workers Compensation	
Total Non-Government Payers	
Uncompensated Care	
Total Payer Mix	100.0%

*Includes managed care activity.

D. Provide the following for the financial and statistical projections for the Monroe location:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached, Financial Attachment I.** Please note that the actual results for the fiscal year reported in the

first column must agree with the Applicant's audited financial statements.

ii) Please complete the enclosed, OHCA's **Financial Attachment II.**

iii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iv) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

GENERAL 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 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: _____

Office of Health Care Access

13.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description
Type of Unit Description:
# of Months in Operation

FY _____	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
FY Projected Incremental Total Incremental Expenses:										
Total Facility by Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0	5	$0				$0	$0	$0
Uninsured		$0	2	$0				$0	$0	$0
Total NonGovernment		$0	7	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	7	$0	$0	$0	$0	$0	$0	$0

12. C (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and if applicable, volume statistics without, incremental to and with the proposal in the following reporting format:

Total Facility:	FY Actual	FY Projected	FY Projected	FY Projected	FY Projected	FY Projected	FY Projected	FY Projected	FY Projected	FY Projected
Description	Results	W/out Project	Incremental	With Project	W/out Project	Incremental	With Project	W/out Project	Incremental	With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes				$0			$0			$0
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

*Volume Statistics:

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 28, 2007

William Hass
Executive Vice President
Family Services Working, Inc.
475 Clinton Avenue
Bridgeport, CT 06605

Re: Letter of Intent, Docket Number 07-30911
Family Services Working, Inc.
Closure of Adult Outpatient Mental Health Clinic in Monroe
Notice of Letter of Intent

Dear Mr. Hass:

On February 5, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Family Services Working, Inc. ("Applicant") for Closure of Adult Outpatient Mental Health Clinic in Monroe, at a total capital expenditure of $75,000.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Connecticut Post* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 28, 2007

Requisition # HCA07-031
FAX #: (203) 384-1158

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Sunday, March 4, 2007**.

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact **Paolo Fiducia** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

Connecticut Post
Docket Number 07-30911

Letter of Intent
February 28, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Family Service Working, Inc.
Town:	Monroe
Docket Number:	07-30911-LOI
Proposal:	Closure of Adult Outpatient Mental Health Clinic in Monroe
Total Capital Expenditure:	$75,000

The Applicant may file its Certificate of Need application between April 6, 2007 and June 5, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1826
RECIPIENT ADDRESS	912033841158
DESTINATION ID	
ST. TIME	02/28 17:19
TIME USE	00'22
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 28, 2007

Requisition # HCA07-031
FAX #: (203) 384-1158

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact **Paolo Fiducia** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment