CatholicCharities
FAITH IN ACTION

238 JEWETT AVENUE
BRIDGEPORT, CONNECTICUT 06606-2892
WWW.BRIDGEPORTDIOCESE.COM

January 30, 2007

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 closure of a Psychiatric Outpatient Clinic satellite office located at 452 Howe Avenue, Shelton, CT 06484.

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

Sincerely,

Michael Tintrup
Vice President,
Quality Improvement and Compliance

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

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by an Applicant, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 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	Catholic Charities of Fairfield County, Inc	
Doing Business As	Catholic Charities-Shelton	
Name of Parent Corporation	Catholic Charities of Fairfield County, Inc	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	238 Jewett Avenue Bridgeport,CT06606	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Michael Tintrup Vice President, Quality Improvement and Compliance	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	238 Jewett Avenue Bridgeport,CT06606	

Contact Person's Telephone Number	203.416.1305	
Contact Person's Fax Number	203.372.4555	
Contact Person's e-mail Address	mtintrup@ccfc-ct.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Catholic Charities-Shelton

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 ☒ Service Termination

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

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

☐ Project expenditure/cost cost greater than $ 3,000,000

☐ Equipment Acquisition

☐ New ☐ Replacement ☐ Major Medical (> $3,000,000)

☐ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $3,000,000

c. Location of proposal, identifying Street Address, Town and Zip Code:

452 Howe Avenue, Shelton, CT06484

d. List each town this project is intended to serve:
Shelton

e. Estimated starting date for the project: ___Services Terminated 6/30/06_____

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 or (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ **0**

b. Please provide the following tentative capital expenditure/costs related to the proposal:

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**0**
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	**0**
Total Project Cost	**0**
Capitalized Financing Costs (Informational Purpose Only)	**0**

* Provide an itemized list of all non-medical equipment to be purchased and leased.

c. If the proposal has a total capital expenditure/cost of $20,000,000 or more, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check the your preference as follows:

☐ No ☐ Yes **N/A**

If you checked "Yes" above, please check the appropriate box below:

☐ Energy ☐ Fire Safety Code ☐ Non Substantive

If you checked "Yes" to the Waiver of Public Hearing, please provide the following:

a) Supporting documentation from elected town officials (i.e. letter from Mayor's Office).

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

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

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

☐ Applicant's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

☐ Funded Depreciation ☐ Grant Funding ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please provide a description of the proposed project, 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 items need to be addressed, if applicable.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.
   Project was a satellite counseling office providing licensed (attached) Psychiatric Outpatient Clinic services. Services addressed individual, couple, parent-child and relational coping problems.

2. List the types of services are being proposed and what DPH licensure categories will be sought, if applicable.
   N/A

3. Identify the current population served and who is the target population to be served.
   Target population incorporated Shelton residents 5yrs to 80+yrs

4. Identify any unmet need and describe how this project will fulfill that need.
   N/A-see response to question #6

5. Are there any similar existing service providers in the proposed geographic area?
   Yes

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
   By prior agreement, upon termination of services remaining Catholic Charities-Shelton clients were transferred to Catholic Charities/Catholic Family Services of Ansonia office. Community is served by several additional behavioral health providers

7. Who will be responsible for providing the service?
   See response to question #6

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?
   N/A

AFFIDAVIT

To be completed by each Applicant

Applicant: _Catholic Charities of Fairfield County, Inc_____

Project Title: _Catholic Charities - Shelton_____

I, Al Barber, President, Chief Operating Officer
(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 (Form 2030) is true and accurate to the best of my knowledge,and that Catholic Charities of Fairfield County, Inc complies with the
(Facility Name)

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 1/30/07

Subscribed and sworn to before me on 1/30/07

Elaine Pieger
Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2010

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. PET/CT Scanner
23. Other Imaging Services
24. Lithotripsy
25. Other Medical Equipment
26. Mobile Services
27. Other Outpatient
28. Central Services Facility
29. Occupational Health

Non-Clinical

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

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. C-0125

Psychiatric Outpatient Clinic for Adults

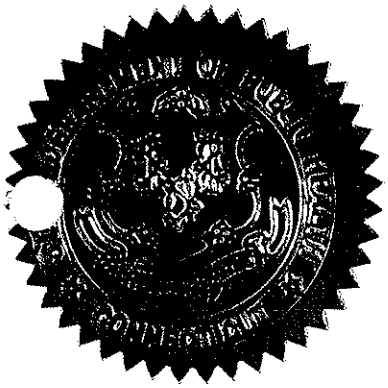
In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

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

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 6, 2007

Michael Tintrup
Vice President
Catholic Charities of Fairfield, Inc.
238 Jewett Avenue
Bridgeport, CT 06606

RE: Certificate of Need Application Forms, Docket Number 07-30915-CON
Catholic Charities of Fairfield, Inc.
Closure of Catholic Charities Psychiatric Outpatient Clinic for Adults in Shelton

Dear Mr. Tintrup:

Enclosed are the application forms for Catholic Charities of Fairfield, Inc.'s Certificate of Need ("CON") proposal for the closure of Catholic Charities Psychiatric Outpatient Clinic for Adults in Shelton with an associated capital expenditure of $0. According to the parameters stated in Sections 19a-638 of the Connecticut General Statutes the CON application may be filed between April 1, 2007, and May 31, 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 (3) hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Paolo Fiducia. Please feel free to contact him at (860) 418-7035, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

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 1, 2007, and may be submitted no later than May 31, 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: 07-30915-CON

Applicant(s) Name: Catholic Charities of Fairfield County, Inc.

Contact Person: Michael Tintrup
Contact Title: Vice President
Catholic Charities of Fairfield County, Inc.
Contact Address: 238 Jewett Ave
Bridgeport, CT 06606

Project Location: Shelton

Project Name: Closure of Catholic Charities Psychiatric Outpatient Clinic for Adults in Shelton

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

Est. Capital Expenditure: $ 0

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 Shelton location. Identify what the hours of operation were for this service location.

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

iv) Discuss any scheduling backlogs that exist at the Shelton service location.

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

vi) Describe the pattern of referrals to the Shelton 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 is closed.

iii) Provide the information as outlined in the following table concerning the existing providers services in the Shelton 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 Shelton 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 Shelton 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 Shelton 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 Catholic Charities of Fairfield County in Shelton.

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]

[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.

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):

_____

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 Shelton 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 Shelton 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 Shelton 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: _____

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)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental Total Incremental Expenses:		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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

13.C(x). 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: CT Services
Type of Unit Description: CT Scan
# of Months in Operation: 3

Year 1	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:	**$53,513**			Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
Total Facility by Payer Category:										
Medicare		$1,000	42	$42,000	$28,467	$0	$0	$13,533	$17,838	($4,305)
Medicaid		$1,000	3	$3,000	$1,963	$0	$0	$1,037	$1,274	($237)
CHAMPUS/TriCare		$1,000	0	$0	$0	$0	$0	$0	$0	$0
Total Governmental		$1,000	45	$45,000	$30,430	$0	$0	$14,570	$19,112	($4,542)
Commericial Insurers		$1,000	79	$79,000	$42,229	$2,000	$0	$34,771	$33,552	$1,219
Uninsured		$1,000	2	$2,000	$900	$1,050	$0	$50	$849	($799)
Total NonGovenrment		$1,000	81	$81,000	$43,129	$3,050	$0	$34,821	$34,401	$420
Total All Payers		$1,000	126	$126,000	$73,559	$3,050	$0	$49,391	$53,513	***($4,122)***

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	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	Actual Results	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected 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.

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

TRANSMISSION OK

TX/RX NO	1739
RECIPIENT ADDRESS	912033841158
DESTINATION ID	
ST. TIME	02/07 09:59
TIME USE	00'23
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 7, 2007

Requisition # HCA07-118
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, February 11, 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

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 7, 2007

Michael Tintrup ACSW, LCSW
Vice President, Quality Improvement and Compliance
Catholic Charities of Fairfield County, Inc.
238 Jewett Ave.
Bridgeport, CT 06606

Re: Letter of Intent, Docket Number 07-30915
Catholic Charities of Fairfield County, Inc.
Closure of a Psychiatric Outpatient Clinic in Shelton
Notice of Letter of Intent

Dear Mr. Tintrup:

On January 31, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Catholic Charities of Fairfield County, Inc. ("Applicant") for the closure of a psychiatric outpatient clinic in Shelton, at a total capital expenditure of $0.

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:PF:bko

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

February 7, 2007

Requisition # HCA07-118
FAX #: (203) 384-1158

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:bko

c: Sandy Salus, OHCA

Connecticut Post **Letter of Intent**
Docket Number 07-30915 **February 7, 2007**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Catholic Charities of Fairfield County, Inc.
Town:	Shelton
Docket Number:	07-30915-LOI
Proposal:	Closure of a Psychiatric Outpatient Clinic in Shelton
Total Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between April 1, 2007 and May 31, 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.