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	Hill Health Corporation	
Doing Business As	Hill Health Center	
Name of Parent Corporation	Hill Health Corporation	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	400 Columbus Ave. New Haven, CT 06519	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes XX No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Robert Kilpatrick Development Director	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	400 Columbus Ave. New Haven, CT 06519	

Contact Person's Telephone Number	203-503-3276	
Contact Person's Fax Number	203-503-3254	
Contact Person's e-mail Address	rkilpatrick@hillhealthcenter.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

____Hill Health Center Expansion and Renovation_____

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:

_____400-428 Columbus Ave., New Haven, Ct 06519_____

d. List each town this project is intended to serve: ___New Haven, East Haven West Haven, Hamden, North Haven, Branford, Milford._____

e. Estimated starting date for the project: _ June 1, 2007

f. Type of project: __16,18, 34_____
(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
NA				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 6.2 Million

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	$5,420,365
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$5,420,365**
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	
Total Project Cost	$6,256,772
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

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
none				

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): _____

Hill Health Corporation letter of intent (2030)
2/9/7

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.

Medical
Behavioral Health

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

No new services are proposed
Two mental health services will be relocated and need new licenses from the State.

3. Identify the current population served and who is the target population to be served.

Hill Health Center serves a predominantly low-income population in the greater New Haven area.

4. Identify any unmet need and describe how this project will fulfill that need.
The project will help to reduce waiting lists for medical and behavioral health services, as well as to enable new patients to be seen in a timely fashion.

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

The Fair Haven Community Health Center serves only the Fair Haven neighborhood of New Haven.
Yale-New Hav en Hospital and the Hospital of St. Raphael both operate outpatient primary care centers.

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

It will enable greater access to medical and behavioral health care to uninsured, Medicaid, SAGA and HUSKY populations.

7. Who will be responsible for providing the service?

The Hill Health Corporation

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

Current payers are the State Department of Social Services, Medicaid Managed Care Plans (Community Health Network, Healthnet and Preferred One), Medicare. Medicaid, private insurance companies, various grants and consumers.
No new payers are foreseen.

AFFIDAVIT

To be completed by each Applicant

Applicant: ___Hill Health Corporation_____
Project Title: Hill Health Center Expansion and Renovation

I, _Robert Kilpatrick, Development Director

of Hill Health Center, 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 _Hill Health Corporation complies with the appropriate and
(Facility Name)

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.

Robert Kilpatrick
Signature

2-9-7
Date

Subscribed and sworn to before me on February 9th, 2007

Margie W. Ford
Notary Public/Commissioner of Superior Court

Margie W. Ford
Notary Public
My Commission Expires
Nov 30. 2011

My commission expires: _____

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 24, 2007

Mr. Robert Kilpatrick
Development Director
Hill Health Corporation
400 Columbus Avenue
New Haven, CT 06519

Re: Letter of Intent, Docket Number 07-30922
Hill Health Corporation
Expansion and Renovation Project Affecting the Medical and Behavioral Health Services
Notice of Letter of Intent

Dear Mr. Kilpatrick:

On February 13, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Hill Health Corporation ("Applicant") for the Expansion and Renovation Project Affecting the Medical and Behavioral Health Services Offered at FQHC, at a total capital expenditure of $6,256,772.

A notice to the public regarding OHCA's receipt of a LOI was published in *The New Haven Register* pursuant to Section 19a-639 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

April 24, 2007

Requisition # HCA07-168
FAX: (203) 865-8360

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

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 **Saturday, April 28, 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 **Jack Huber** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:JH:lmg

c: Sandy Salus, OHCA

New Haven Register **Letter of Intent**
Docket Number 07-30922 **April 24, 2007**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Hill Health Corporation
Town:	New Haven
Docket Number:	07-30922
Proposal:	Expansion and Renovation Project Affecting the Medical and Behavioral Health Services
Capital Expenditure:	$6,256,772

The Applicant may file its Certificate of Need application between April 14, 2007 and June 13, 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.

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	2045
RECIPIENT ADDRESS	912038658360
DESTINATION ID	
ST. TIME	04/25 12:08
TIME USE	00'24
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
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