Catholic Charities
Archdiocese of Hartford

ADMINISTRATIVE OFFICE
839-841 Asylum Avenue
Hartford, Connecticut 06105-2801
(860) 493-1841
Fax (860) 548-9343
www.ccaoh.org

May 22, 2007

Christine A. Vogel
Commissioner
State of Connecticut
Office of Health Care Access
MS #13HCA
410 Capital Ave
Hartford, CT 06134

Dear Ms. Vogel:

We are submitting a Certificate of Need Letter of Intent (LOI) regarding our plan for a new Institute for the Hispanic Family facility to house our existing mental health, child care and elderly programs currently located at 80 Jefferson and 95 Park Streets in Hartford.
The new 22,000 square foot facility will be located at 43 Wadsworth Street in Hartford. We were uncertain about the start of construction until very recently when the Hartford City Council approved the sale and waiver of liens on the properties sold to us for the project. As indicated in the LOI, Rolando Martinez, Director of the Institute for the Hispanic Family, will be the contact person for your staff.

Sincerely,

Rose Alma Senatore

Rose Alma Senatore
Chief Executive Officer

Enclosure

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, Inc.- Archdiocese of Hartford	
Doing Business As	Institute for the Hispanic Family	
Name of Parent Corporation	Catholic Charities, Inc.- Archdiocese of Hartford	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	839-841 Asylum Avenue Hartford, CT 06105-2801	
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.	Rolando T Martinez, Director Institute for the Hispanic Family	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	80 Jefferson Street Hartford CT 06105	

Contact Person's Telephone Number	860 240-5685	
Contact Person's Fax Number	860 724-2539	
Contact Person's e-mail Address	rmartinez@ccaoh.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Institute for the Hispanic Family

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:

43 Wadsworth Street, Hartford Connecticut 06106

d. List each town this project is intended to serve: Hartford and surrounding towns of East Hartford, Manchester, Windsor, Bloomfield, Avon, Simsbury, West Hartford,

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

f. Type of project: _____18, 30, 31, 32_____
(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
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ 6,425,000

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

Medical Equipment Purchases	0
Major Medical Equipment Purchases	0
Non-Medical Equipment Purchases*	0
Land/Building Purchases	$600,000
Construction/Renovation	$5,515,000
Other (Non-Construction) Specify:Technology & Furniture	$310,000
Total Capital Expenditure	
Medical Equipment – Fair Market Value of Leases	0
Major Medical Equipment – Fair Market Value of Leases	0
Non-Medical Equipment – Fair Market Value of Leases*	0
Fair Market Value of Space – Capital Leases Only	0
Total Capital Cost	
Total Project Cost	$6,425,000
Capitalized Financing Costs (Informational Purpose Only)	

* 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
N/A				

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

The Institute for the Hispanic Family (IHF) Building Project includes purchasing property and constructing a new two story, 22,104 square foot facility at 43-53 Wadsworth St/44-60 Cedar Street in Hartford. The IHF's existing programs and services will be moved to this new facility and will increase the current IHF and the Senior Center from 14,900 sq ft to 22,104 sq ft. This will allow an expansion of services for adults, including seniors and children and their families for all programs currently being provided and could accommodate new programs as they are implemented in the future. Many elderly are not participating in the Senior Center because of the overcrowding in the current facility and the IHF School Readiness Program is not able to enroll children from the wit list in the center.

Motor vehicle parking will be increased from 27 spaces to 35 spaces. Clients are also served from surrounding communities and the lack of space was a deterrent for many to receive services. The Day Care play area will be increased from 1500 square feet to 5000 sq ft. which will allow for an increase in the number of children served from 34 to 60.

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.)

IHF provides the following DPH licensed services: Hispanic Mental Health Services; the Hispanic Alcohol and Substance Abuse Program (HASAP); the Intensive Outpatient Program (IOP); the Substance Abuse Treatment Enhancement Project (SATEP); the Driving While Intoxicated (DWI) program and Pre-Trial Drug Education Program (PDEP); the Latino Outreach program. Other programs include the Family Violence program; and the Hispanic Elderly Program including the elderly network, Hispanic Senior Center, and the Hispanic Elderly Outreach program. For child and adolescents and preschool children IHF provides Hispanic Child Guidance Clinic (licensed by DCF) the School Readiness program; and the Family Center. Each program offers culturally competent and specialized mental health interventions as well as comprehensive approaches to the development and enhancement of Spanish speaking individuals, families, children and elderly of 60 years or more within the Hartford area.

2. List the types of services are being proposed and what DPH licensure categories will be sought, if applicable. Not Applicable – no new services or programs will be sought at this time.

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

Catholic Charities (CC) has been providing community-based services to culturally and ethnically diverse families and youth for more than 80 years in the Greater Hartford, New Haven and Waterbury catchments areas. 84% of all clients served are Hispanic, African American or Asian. CC services include: adult, family, and children's behavioral health; elderly care; early childhood education; case management; substance abuse; comprehensive youth; child welfare; and employment.

4. Identify any unmet need and describe how this project will fulfill that need.

Many elderly are not participating in the Senior Center because of the overcrowding in the current facility and the IHF School Readiness Program is not able to enroll children from the wait list in the center. The new larger facility will enable IHF to service more elders and preschool children. The building will also provide 2 separate service and waiting room areas, one for adults and another for children.

5. Are there any similar existing service providers in the proposed geographic area?
Yes, in the Frog Hollow section of the city where the new facility will be located the Hartford Behavioral Health has some similar but not all the services that IHF has. Village for Children and Families, ADRC, Wheeler Clinic are also providing similar services in other sections of the city and are often filled to capacity and/or have long waiting lists with limited ability to serve mono-lingual Spanish speaking patients/clients.

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut. Not applicable.

7. Who will be responsible for providing the service?
The existing IHF staff and programs will continue to provide the service.

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?
Payers billed for services are the CT Dept. of Social Services: T-19/Medicaid/Husky and SAGA programs. Other revenues from grants and contractual arrangements with other state agency departments include CSSD, DCF, DMHAS, and DOE. The City of Hartford and private foundations (Hartford Foundation for Public Giving & United Way of Greater Hartford) including the Archdiocese of Hartford as well as client fees/co-pays will continue to pay for services with no significant changes anticipated.

AFFIDAVIT

To be completed by each Applicant

Applicant: Catholic Charities, Inc. Archdiocese of Hartford

Project Title: Institute for the Hispanic Family

I, Rose Alma Senatore (Name) CEO (Position – CEO or CFO)

of Catholic Charities, Inc. Archdiocese of Hartford 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 **Institute for the Hispanic Family** 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.

Rose Alma Senatore
Signature

5/22/07
Date

Subscribed and sworn to before me on May 22, 2007

Mary L. Nicolo
Notary Public/Commissioner of Superior Court

My commission expires: Oct. 31, 2008

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

In Accordance with Connecticut General Statutes 19a-77 to 19a-87 inclusive, the Department of Public Health issues this license, which is non-transferable, to:

CATHOLIC CHARITIES, INC.-ARCHDIOCESE OF HARTFORD
80 JEFFERSON STREET
HARTFORD, CT 06106

to operate a

CHILD DAY CARE CENTER

at

CATHOLIC CHARITIES/PARAISO INFANTIL PRESCHOOL
80 JEFFERSON STREET
HARTFORD, CT 06106

License Number: **15177**
Expiration Date: **12/17/2008**
Approved for the Following Services:
***Preschool** *

Maximum Children at One Time: **34**
Children Under 3 Years of Age : **0**

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

410 Capitol Avenue, P.O. Box 340308, Hartford, CT 06134-0308
Telephones: 1-800-282-6063, 1-800-439-0437

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

STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

This is to certify, that in accordance with the provisions of Section 17a-20 of the Connecticut General Statutes, as amended, CATHOLIC CHARITIES, INC. ARCHDIOCESE of HARTFORD located at 839-841 ASYLUM AVENUE in the Town of HARTFORD is hereby licensed as an OUTPATIENT PSYCHIATRIC CLINIC FOR CHILDREN to provide OUTPATIENT PSYCHIATRIC CLINIC SERVICES to children at the locations listed below *.

This license is issued effective SEPTEMBER 1, 2005 for a period of TWENTY-FOUR MONTHS and is conditional upon compliance with all regulations of the Department of Children and Families and may be revoked for cause at any time.

License No. OPCC - 8
Signed at Hartford, Connecticut the 18th day of May 2006

THOMAS De MATTEO
Director, Division of
Administrative Law and Policy

* Institute for the Hispanic Family, 80 Jefferson Street, Hartford

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0335

Facility for the Care or Treatment of Substance Abusive or Dependent Persons

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

Catholic Charities, Inc. - Archdiocese of Hartford of Hartford, CT, d/b/a Institute For The Hispanic Family is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Institute For The Hispanic Family is located at 80 Jefferson Street, Hartford, CT 06106 with:

Rose A. Senatore as Executive Director

The service classification(s) and if applicable, the residential capacities are as follows:

Outpatient Treatment

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

Dated at Hartford, Connecticut, May 8, 2006. INITIAL.

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

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

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. C-0130

Psychiatric Outpatient Clinic for Adults

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

Catholic Charities, Inc. - Archdiocese of Hartford of Hartford, CT, d/b/a Institute For The Hispanic Family is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Institute For The Hispanic Family is located at 80 Jefferson St, Hartford, CT 06016 with:

Rose A. Senatore as Executive Director
Lois Nesci as Director

The service classification(s) and if applicable, the residential capacities are as follows:

MULTI SERVICE

This license expires **March 31, 2010** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2006

License revised to reflect:
CHANGE OF DIRECTOR EFF: 6/26/06

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

June 4, 2007

Rolando Martinez
Director
Institute for the Hispanic Family
80 Jefferson Street
Hartford, CT 06105

Re: Letter of Intent, Docket Number 07-30975
Institute for the Hispanic Family
Establish Institute for the Hispanic Family
Notice of Letter of Intent

Dear Mr. Martinez:

On May 20, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Institute for the Hispanic Family ("Applicant") to establish the Institute for the Hispanic Family, at a total capital expenditure of $6,425,000.

A notice to the public regarding OHCA's receipt of a LOI was published in the *Hartford Courant* pursuant to Sections 19a-638 and 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:PF:bko

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 4, 2007

Requisition # HCA07-204
EMAIL: Publicnotices@courant.com

Hartford Courant
285 Broad Street
Hartford, CT 06115

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 **Friday, June 8, 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:bko

c: Sandy Salus, OHCA

Hartford Courant
Docket Number 07-30975

Letter of Intent
June 4, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638 and 19a-639
Applicant:	Catholic Charities, Inc., Archdiocese of Hartford
Town:	Hartford
Docket Number:	07-30975
Proposal:	Establish Institute for the Hispanic Family
Capital Expenditure:	$6,425,000

The Applicant may file its Certificate of Need application between July 28, 2007 and September 26, 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.

Greer, Leslie

From: HC Public Notice [HCPublicNotice@courant.com]
Sent: Tuesday, June 05, 2007 12:00 PM
To: Greer, Leslie
Subject: RE: Legal Ad 07-30975

We can run the ad statewide tomorrow, June 6, 2x4.00 inches, for $419.00

From: Greer, Leslie [mailto:Leslie.Greer@po.state.ct.us]
Sent: Tuesday, June 05, 2007 9:49 AM
To: publicnotices@courant.com
Subject: Legal Ad 07-30975

June 5, 2007

Legal Ad,
Please place the attached ad in your newspaper no later than June 8, 2007. Please respond to me that you have received this notice.

Thank you,

Leslie Greer
Office of Health Care Access
(860) 418-7001
Leslie.Greer@po.state.ct.us

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 5, 2007

Rolando Martinez
Director Institute for the Hispanic Family
Catholic Charities, Inc. Archdiocese of Hartford
80 Jefferson Street
Hartford, CT 06105

RE: Certificate of Need Application Forms, Docket Number 07-30975-CON
Catholic Charities, Inc. Archdiocese of Hartford
Establish Institute for the Hispanic Family

Dear Mr. Martinez:

Enclosed are the application forms for Catholic Charities, Inc. Archdiocese of Hartford's Certificate of Need ("CON") proposal to establish the Institute for the Hispanic Family with an associated capital expenditure of $6,425,000. According to the parameters stated in Section 19a-638 and 19a-639 of the Connecticut General Statutes the CON application may be filed between July 28, 2007, and September 26, 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

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 July 28, 2007, and may be submitted no later than September 26, 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: 07-30975-CON

Applicant(s) Name: Catholic Charities, Inc. Archdiocese of Hartford d/b/a Institute for the Hispanic Family

Contact Person: Rolando Martinez
Contact Title: Director
Institute for the Hispanic Family
Contact Address: 80 Jefferson Street
Hartford, CT 06105

Project Location: Hartford

Project Name: Establish Institute for the Hispanic Family

Type proposal: Section 19a-638 and 19a-639, C.G.S.

Est. Capital Expenditure: $6,425,000

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

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. Explain how it was determined there was a need for the proposal in your service area.

B) Provide the following information:
- a) Primary and secondary service area towns
- b) The population to be served, including the number of individuals to receive the proposed service(s). Provide the # of referrals for the proposed service for the past year.
- c) Hours of operation of existing/proposed service

C) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

D) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

E) Provide the information as outlined in the following table concerning the existing providers' in the Applicant PSA & SSA current operations:

Primary Service Area:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

Secondary Service Area:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

F) 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.

G) 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. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology	☐ National Committee for Quality Assurance	☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers	☐ American College of Obstetricians & Gynecologists	☐ American College of Surgeons
☐ Report of the Inter-Council for Radiation Oncology	☐ American College of Radiology	☐ Substance Society Abuse and Mental Health Services Administration

☐Other: Specify _____

B. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

C. 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.

D. 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]

E. Provide a copy of the following (as applicable):

☐ A copy of the related Quality Assurance plan

☐ Protocols for service (new service only)

☐ Patient Selection Criteria/Intake form

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. 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.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

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

C. Provide the following licensing information:

[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.

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

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. Provide the following financial information:

i) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	

Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

10. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			
Other (Specify)_____			
Total Construction/Renov. Cost			

D. Explain how the proposed new construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	_____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	_____
CON Proposed debt financing	_____
Interest rate	_____%
Monthly payment	_____
Term	_____ Years
Debt service reserve fund	_____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	_____
CON Proposed lease financing	_____
Fair market value of leased assets at lease inception	_____
Interest rate	_____%
Monthly payment	_____
Term	_____ Years

☐ Other financing alternatives:

Amount	
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

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

C. Provide the following for the financial and statistical projections:

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.** 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.

v) Provide a copy of the rate schedule for the proposed service.

vi) Describe how this proposal is cost effective.

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____ 19a-638.Additional function or service, change of ownership, service termination. **No Fee Required.** _____ 19a-639 Capital expenditure exceeding $3,000,000 or capital expenditure exceeding $3,000,000 for major medical equipment, CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator. **Fee Required.** ___ 19a-638 and 19a-639. **Fee Required.**	
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.	
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005) c. Sum of base fee plus additional fee: (Lines A4a + A4b)_____ d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	$ 1,000.00 $_____.00 $_____.00
SECTION B TOTAL FEE DUE:_____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

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: _____

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

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				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.

12.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		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				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				$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

The Hartford Courant.

A TRIBUNE PUBLISHING COMPANY

Affidavit of Publication

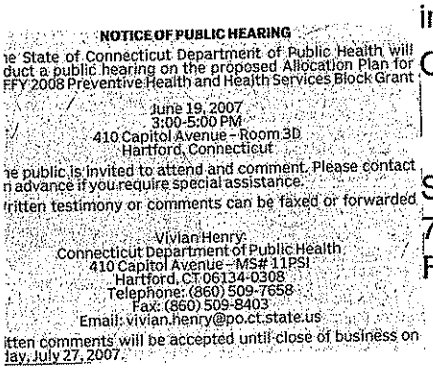
State of Connecticut

Thursday, June 07, 2007

County of Hartford

I, Joy Shroyer, do solemnly swear that I am Financial Operations Assistant of the Hartford Courant, printed and published daily, in the state of Connecticut and that from my own personal knowledge and reference to the files of said publication the advertisement of Public Notice was inserted in the regular edition.

On dates as follows: 06/07/2007



NOTICE OF PUBLIC HEARING

ıe State of Connecticut Department of Public Health will duct a public hearing on the proposed Allocation Plan for FFY 2008 Preventive Health and Health Services Block Grant

June 19, 2007
3:00-5:00 PM
410 Capitol Avenue - Room 3D
Hartford, Connecticut

ıe public is invited to attend and comment. Please contact n advance if you require special assistance.

ritten testimony or comments can be faxed or forwarded

Vivian Henry
Connecticut Department of Public Health
410 Capitol Avenue - MS# 11PSI
Hartford, CT 06134-0308
Telephone: (860) 509-7658
Fax: (860) 509-8403
Email: vivian.henry@po.ct.state.us

itten comments will be accepted until close of business on lay, July 27, 2007.

ST OF CT OFFICE OF HLTH.ACC 07-30975
700309
Full Run

Financial Operations Assistant
Joy Shroyer

Subscribed and sworn to before me on June 7, 2007

Notary Public

LISA CARDINI
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2011

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Class A office space, all Tom 860-871-2987 x 5 Brokers Protected

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pes at Drake Hill, 2400SF, Call RLM Co. 236-1253

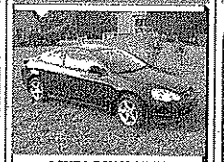
Hartford Center, Farming- venue, Store Front, 633SF 860-236-2595

WEST HARTFORD
Hartford Center 750 SF- SF, traditional retail use call RLM Co. 860-236-1253

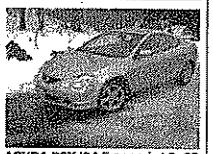
AUTOS, ETC.

tiques & Classics

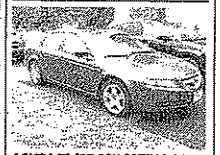
Automobiles



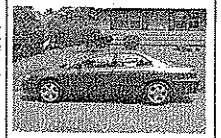
ACURA RSX '04 44K $16250 Excellent "Sporty" car. Good on gas. Bought new for Daughter, she got married and bought an SUV. Call Jim 860-644-9711 blueknight0517 @yahoo.com



ACURA RSX '04 5 speed, AC, CD player & more. 18,300 miles. Silver. $16,400 (860)693-6227



ACURA TL '05 28K $27500.00 Green, 4-Door, FWD, V-6, Auto. Excellent cond. TL pkg plus navi. Call Steve 860-748-8390 or ppenn2@sbcglobal.net



ACURA TL '03 Type S. 90K, $14,999. Purchased new, single driver, excellent condition, very clean car, new brakes, tires, retail on NADA GUIDES is $15,500 with current mileage, serious inquires only please. Call Michael 860-632-1799 sirois_michael_j@

Automobiles

Certified Pre-Owned by BMW

★ Z-Series ★

'04 Z4 2.5i..... $27,986
#P4734 - Sterling gray, heated front seats, premium & convenience pkgs, 15K miles. LR68292

★ X-Series ★

'04 X5 3.0i..... $33,864
#P4736 - Toledo blue, AT, panoramic moonroof, cold weather/premium pkgs, heated steering wheel, rear climate control, AT, parking distance control, 39K miles. LU36434

'06 X5 3.0i..... $43,865
#B5008A - Highland green, panoramic moonroof, heated steering wheel, cold weather pkg, 26K miles. LY33268

'05 X3 3.0i..... $29,886
#P4744 - Black sapphire, AT, panoramic moonroof, cold weather/premium pkgs, AT, 42K miles. WD03804

'04 X5 4.4i..... $37,886
#P4746 - Toledo blue, navigation, panoramic moonroof, rear climate pkg, 43K miles, cold weather/premium pkgs. LV07238

'04 X3 3.0i..... $28,986
#P4745 - Alpine white, AT, cold weather/premium pkgs, 44K miles, xenon headlights. WA65690

★ 6-Series ★

'04 645cic..... $58,864
#P4740 - **CONVERTIBLE** Mystic blue, navigation, heated front seats, Premium sound pkg, sequencial manual gear box, sport pkg, parking distance control, 49K miles. B260085

★ 5-Series ★

'06 530xi..... $45,886
#B4480A - Titanium silver, Premium/cold weather pkgs, xenon

Public Notices

BLOOMFIELD

Notice of Public Hearing Town of Bloomfield

In accordance with the requirements of Section 307 of the Bloomfield Town Charter, the Bloomfield Town Council will conduct a public hearing on Monday, June 11, 2007 at 7:30 p.m. in Council Chambers, Bloomfield Town Hall, 800 Bloomfield Avenue, Bloomfield, CT to consider making a nonbudgeted appropriation in Fiscal Year 2007/2008 in the amount of $1,250,000.00 to settle pending litigation.

Dated at Bloomfield, CT this 5th day of June, 2007.

Bainie D. Wild
Clerk of Council

WEATHER ALERTS

Sign-up today at courant.com

MESSAGE BOARDS

Join the discussion on courant.com

CONNECTICUT

Sealed Bid Notices

All bid notices for the State of Connecticut, Department of Administrative Services (DAS)/Procurement are available for review, download and printing at www.das.state.ct.us/busopp.asp. Bid notices may also be obtained through DAS's public access computers at the State of Connecticut, DAS/Procurement, Room 110, 165 Capitol Avenue, Hartford, CT 06106. Questions can be directed to the Procurement Office at 860-713-5095.

ROCKY HILL

LEGAL NOTICE

HARTFORD

CAPITOL REGION INVITATION TO BID

The Capitol Region Purchasing Council, on behalf of a number of Capitol Region Towns, including East Hartford, Hartford and Manchester, invites sealed bids covering:

TREATED ROAD SALT
Bid documents are available at www.rfpdepot.com (vendors must register to place bids) or on the CRPC website, http://www.crcog.org/purchasing%20_coun/current_bids.html until, but not later than, 12:00 p.m. Wednesday, June 20, 2007. If you have any questions, please contact the office of the CRPC 860-522-2217 x 37, or e-mail mbarton@crcog.org.

The towns reserve the right to reject any or all bids, or any part of any or all bids, if such action is deemed to be in the best interest of the towns.

Maureen H. Barton
Administrative Secretary for Community Development

CAPITOL REGION INVITATION TO BID

The Capitol Region Purchasing Council, on behalf of a number of Capitol Region Towns, including East Hartford, Hartford and Manchester, invites sealed bids covering:

SAND FOR SNOW AND ICE CONTROL
Bid documents are available at www.rfpdepot.com (vendors must register to place bids) or on the CRPC website, http://www.crcog.org/purchasing%20_coun/current_bids.html until, but not later than, 1:00 p.m. Wednesday, June 20, 2007. If you have any questions, please contact the office of the CRPC 860-522-2217 x 37, or e-mail mbarton@crcog.org.

The towns reserve the right to reject any or all bids, or any part of any or all bids, if such action is deemed to be in the best interest of the towns.

Maureen H. Barton
Administrative Secretary for Community Development

MANSFIELD

INVITATION TO BID TOWN OF MANSFIELD MANSFIELD MIDDLE SCHOOL FLOORING REPLACEMENT MANSFIELD, CT

Sealed Bids are invited by the Town of Mansfield for the Mansfield Middle School Flooring Replacement, Mansfield, CT and will be received by Linda Patenaude, Capital Projects & Personnel Assistant, Audrey Beck Municipal Building, 4 South Eagleville Road, Mansfield, CT 06268, until 2:00 p.m., Thursday, June 21 2007, at which time they will be publicly opened and read. Bidding Documents, including specifications and bid forms may be obtained at the above address.

The Town reserves the right to reject any and all bids or to waive any defect, irregularities or informalities in the bidding.

Linda Patenaude
Capital Projects & Personnel Assistant

CONNECTICUT

NOTICE OF PUBLIC HEARING

The State of Connecticut Department of Public Health will conduct a public hearing on the proposed Allocation Plan for the FFY 2008 Preventive Health and Health Services Block Grant on:

June 19, 2007
3:00-5:00 PM
410 Capitol Avenue – Room 3D
Hartford, Connecticut

The public is invited to attend and comment. Please contact us in advance if you require special assistance.

Written testimony or comments can be faxed or forwarded to:

Vivian Henry
Connecticut Department of Public Health
410 Capitol Avenue – MS# 11PSI
Hartford, CT 06134-0308

CONNECTICUT

LEGAL NOTICE
STATE OF CONNECTICUT
DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT (DECD)
NOTICE OF A PUBLIC HEARING

Public Notice is hereby given that the State of Connecticut Department of Economic and Community Development (DECD), pursuant to the Connecticut Environmental Policy Act (CEPA) section 22a-1d of the Connecticut General Statutes, will hold a public hearing on the Environmental Impact Evaluation (EIE), South Windsor Interstate 291 Gateway Zone Project, on Monday, June 11, 2007 at 7:00 PM at the Town Council Chambers, 1540 Sullivan Ave., South Windsor, CT 06074.

The EIE is currently under circulation for public comments. The comment period started on May 11, 2007 and ends on June 26, 2007. Please provide your comments to Dimple Desai, DECD, 505 Hudson Street, Hartford, CT 06106, by the close of business on June 26, 2007.

CONNECTICUT

NOTICE OF INTENT

Statute Reference:	19a-638 and 19a-639
Applicant:	Catholic Charities, Inc., Archdiocese of Hartford
Town:	Hartford
Docket Number:	07-30975
Proposal:	Establish Institute for the Hispanic Family
Capital Expenditure:	$6,425,000

The Applicant may file its Certificate of Need application between July 28, 2007 and September 26, 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.

INVITATION TO SUBMIT LEASE PROPOSAL

The State of Connecticut, Department of Public Works, will accept lease proposals/site offerings from property owners or

CONNECTICUT

Invitation-to-Bid UConn Health Center

Notice: State of Connecticut non-discrimination and affirmative provisions are incorporated pursuant to Chapter 58, sections 4a-60 and 4a-60a of the Connecticut General Statutes

Sealed proposals are requested for the Bids/RFPs listed below

RFP 5-1820, Dental Implant Management System, Due July 16, 2007 at 3:30 PM

Bid 4-1821, Cancer Center Renovations, Due July 25, 2007 at 3:30 PM. Mandatory Prebid meeting at 10:30 AM on June 14, 2007 in Facilities Conference Room C. The bid is restricted to State of CT Certified Small or Minority Businesses. Plans and specifications are available at Joseph Merritt & Company, 860-296-2500.

Plans and/or specifications may be obtained by written or fax (860-679-2508) request to UConn Health Center Purchasing Department, P.O. Box 4036, Farmington, CT 06034-4036, during the hours of 8:30 AM to 4:00 PM. Bid documents may also be available on the UCHC Bid Portal Website: http://bids.uchc.edu.

PUBLIC NOTICE OF INTENT NOT TO PREPARE AN ENVIRONMENTAL IMPACT EVALUATION

Project Name: Sewer Improvements to the Town of Canton Dowd Avenue Sewer

Project Location: Dowd Avenue, Canton, Connecticut

Project Description:
The Town of Canton has proposed modifications to the Dowd Avenue Sewer in accordance with the documents prepared by Tighe & Bond, "Dowd Avenue Sewer Replacement Project". Specifically, the proposed work will include the reconstruction of 4,629 feet of the Dowd Avenue Sewer from East Hill Road to the Canton Valley Circle Pump Station on Route 44 to remove

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Susan I. Hamilton, M.S.W., J.D.
Commissioner

M. Jodi Rell
Governor

July 6, 2007

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

Dear Commissioner Vogel:

Please accept this letter in support of the decision made by Catholic Charities to move their Institute for the Hispanic Family program from 80 Jefferson Street, Hartford, CT 06106 to 53 Wadsworth Street, Hartford, CT 06106. This is a program that has been used by the Department for some time and it continues to address a need of DCF clients. It is our understanding that the program will remain the same and serve the same clients.

We are aware that the agency must proceed with a complete "Certificate of Need" and am writing in support of that process.

The architectural plans for the new construction at 53 Wadsworth Street were reviewed by the DCF Licensing and Engineering Divisions. This verification process ensured that the architectural drawings meet the requirements of licensing regulations as they relate to the sufficiency of space for waiting areas, clinical offices, bathrooms, bedrooms, etc. On the basis of these reviews there are no apparent obstacles to either the building itself or the activity of relocating the license.

It should be noted however that the Department did not review the drawings for compliance with building codes. Local authorities conduct that review.

If I can provide any further information please contact me. Thank you.

Sincerely,

Susan I. Hamilton, M.S.W., J.D.
Commissioner

SH:LA:ma

STATE OF CONNECTICUT
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