# Catholic Charities
## Diocese of Norwich

*Providing Help, Creating Hope*

331 Main Street
Norwich, Connecticut 06360

Phone 860 889-8346
Fax 860 889-2658



DATE: 6.15.07 TIME: _____ FAX#: 860 418 7053

PLEASE DELIVER THE FOLLOWING PAGES TO:
NAME: PAOLA Tijerina @ OHCA
COMPANY OR DEPT. _____
THIS FAX IS FROM: Holly

WE ARE TRANSMITTING ___ PAGES INCLUDING THIS COVER SHEET.
IF YOU DO NOT RECEIVE ALL OF THESE PAGES, PLEASE CALL 860-889-8346.



MEMO: re: Letter of Intent
FOR CON —
Affirmation Counseling Center

# 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 | AFFIRMATION COUNSELING CENTER, INC. | |
| Doing Business As | AFFIRMATION COUNSELING CENTER | |
| Name of Parent Corporation | - | |
| Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail | 563 PORTLAND-COBALT RD PORTLAND CT 06480 | |
| 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. | HOLLY E. DREGER, LCSW | |
| Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail | 321 MAIN ST NORWICH CT 06360 | |

| | | |
|---|---|---|
| Contact Person's Telephone Number | 8608898346 x280 | |
| Contact Person's Fax Number | 860 889-2058 | |
| Contact Person's e-mail Address | hollydreger@ccfsn.org | |

## SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

OUTPATIENT BEHAVIORAL HEALTH (PSYCHIATRIC & SUBSTANCE ABUSE)

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.:

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

☐ Equipment Acquisition

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

☐ Imaging ☐ Linear Accelerator

Ø ☐ 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:

553 PORTLAND COBALT RD PORTLAND CT 06480

d. List each town this project is intended to serve: PORTLAND, EAST HAMPTON, CROMWELL, MIDDLETOWN & MIDDLEFIELD

e. Estimated starting date for the project: UPON APPROVAL OF CON

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 |
|---|---|---|---|---|
| N/A | | | | |
| | | | | |

## SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ Ø

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** | Ø |
| 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** | Ø |
| **Total Project Cost** | Ø |
| 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): PENDING APPROVAL FOR SAGA SITE SPECIFIC FUNDING |

**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.

2. List the types of services are being proposed and what DPH licensure categories will be sought, if applicable.
3. Identify the current population served and who is the target population to be served.
4. Identify any unmet need and describe how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.
7. Who will be responsible for providing the service?
8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

**Certificate of Need**
**Section IV**
**Project Description**
**June 14, 2007**

**Affirmation Counseling, Inc.**

1) Affirmation Counseling Center, located at 553 Portland-Cobalt Rd, Portland CT 06480, currently is licensed by DPH to provide outpatient mental health services to adults. A non-profit organization, Affirmation Counseling Center has on staff master's level clinicians who are also licensed by the State of Connecticut. Affirmation also has an MD who is licensed as a psychiatrist, and provides pharmacological and psychiatric services for patients clinically appropriate for medication. Clinicians provide evaluation, diagnosis and ambulatory treatment on an outpatient basis for individuals who have mental, emotional, behavioral, interpersonal disturbances or dysfunctions which are defined in the Diagnostic and Statistical Manual for Mental Disorders-IV. Patients currently served include primarily those who are insured by private commercial insurances, or pay fee for service on a sliding scale. Services are currently provided Monday through Friday from 9:00am to 9:00pm, and on Saturdays from 9:00am to 1:00pm.
2) The types of services we are proposing include current services, which will be covered under the current DPH license for outpatient mental health. Additionally, we are seeking to provide outpatient substance abuse services, and will require a DPH license for treating substance abusing persons. Affirmation Counseling has also begun the process of obtaining site-specific funding through SAGA, so that we may expand services to include those who are underserved in the area, and require treatment. Expansion of the programs offered will include more groups to address behavioral, emotional, and substance use issues.
3) Target population includes adult of varied cultural, ethnic, and economic backgrounds who may be on state insurance, such as SAGA or Husky. Use of a sliding fee scale will continue to be available for our patients. Affirmation Counseling will continue to serve those with commercial insurance.
4) And 5) As noted above, Affirmation Counseling Center hopes to meet the unmet needs of those in the area requiring behavioral health services to address mental health and/or substance abuse issues on an outpatient basis. The Portland area has a very limited number of individual and/or agency based providers for outpatient mental health and/or substance abuse treatment. This is especially true for those on SAGA and need outpatient services. Individuals needing these services typically must access agencies and/or providers in the Middletown area. For some individuals, this may be a hardship for them to travel the additional miles outside of Portland to obtain mental health treatment. A general survey of area agencies revealed limited waiting lists; however, access to services at some agencies is directly impacted by the client's insurance. Again, Affirmation Counseling Center does not have a waiting list. The primary provider of mental health and substance abuse treatment is Rushford, which offers multiple levels of care including inpatient, residential, sober house, intensive outpatient and partial hospital level of

care. They provide services for dually diagnosed individuals who typically access the system at a higher level of care (e.g. inpatient) and 'step down' within the Rushford system to lower levels of care as the client shows stabilization. They primarily provide services in a group format.

In data obtained from the SAMSHA National Mental Health Information Center, the New England area nationally has one of the highest outpatient admission rates, and with the current pressures put on inpatient facilities to reduce length of stay, it can be projected that future need for outpatient services in New England, generally, and Connecticut specifically, will only increase. Affirmation Counseling Center currently serves individuals in and around the following municipalities: Portland, East Hampton, Cromwell, Middletown, and Middlefield.

6) Anticipated effect of this proposal upon the health care delivery system in the State of Connecticut includes increased access to care by those who are most underserved. Additionally, it would increase treatment options for patients who otherwise have limited choices about where they are to seek treatment. Oversight by the Board of Directors in conjunction with Catholic Charities management services will ensure that services are of the highest quality and are cost effective. Increased volume of clients to be served will also enhance agency stability, along with organizational viability. Finally, as stated above, treatment is easy to access based on geographic convenience of the physical plant to area towns, combined with the absence of a waiting list.
7) Clinicians currently on staff will continue to provide services to patients seeking treatment at Affirmation Counseling Center. Additional clinicians will be hired to meet the demand for more services. Affirmation currently employs ten part time clinicians. Catholic Charities, Diocese of Norwich provides managerial and clinical oversight. Additional clinicians are available to provide clinical services to meet the demand for treatment.
8) As indicated above, current payers include commercial insurances, EAP contracted services, and fee for service paid by the patient. Currently Affirmation Counseling Center is awaiting approval for SAGA funding. Once obtained, this funding will enable Affirmation Counseling Center to serve a greater variety of patients who are on SAGA. These services will only expand more once Affirmation Counseling is granted the CON and receives a DPH license for substance abuse and depended persons.

It is our hope that the Office of Health Care Access will support this proposal and recommend us for a CON.

**AFFIDAVIT**

**To be completed by each Applicant**

Applicant: AFFIRMATION COUNSELING, INC

Project Title: OUTPATIENT BEHAVIORAL HEALTH (PSYCHIATRIC & SUBSTANCE ABUSE)

I, MAREK K. KUKULKA, LMFT, CEO
(Name) (Position – CEO or CFO)

of AFFIRMATION COUNSELING, 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 AFFIRMATION COUNSELING (Facility Name) 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.

RECEIVED
2007 JUN 18 AM 8:03
OFFICE OF HEALTH CARE ACCESS

Mark K. Kukulka 6/15/07
Signature Date

Subscribed and sworn to before me on 15th Day of June 2007

Sandra LaClair
Notary Public/Commissioner of Superior Court

My commission expires: 6-30-2012

## 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. 0409

## Psychiatric Outpatient Clinic for Adults

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

Affirmation Counseling Center, Inc. of Portland, CT, d/b/a Affirmation Counseling Center, Inc. is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

**Affirmation Counseling Center, Inc.** is located at 553 Portland-Cobalt Road, Portland, CT 06480 with:

Marek K. Kukulka, LMFT as Executive Director
Holly E. Dreger, LCSW as Director

This license expires **September 30, 2010** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, December 6, 2006. INITIAL.

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
# 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.

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| | Applicant One | Applicant Two |
|---|---|---|
| Full legal name | AFFIRMATION COUNSELING CENTER, INC. | |
| Doing Business As | Affirmation Counseling Center | |
| Name of Parent Corporation | - | |
| Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail | 553 Portland-Cobalt Rd Portland CT 06480 | |
| 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. | Holly E. Dreger, LCSW | |
| Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail | 331 Main St Norwich CT 06360 | |

| | | |
|---|---|---|
| Contact Person's Telephone Number | 860 889 8346 x 280 | |
| Contact Person's Fax Number | 860 889-2658 | |
| Contact Person's e-mail Address | hollydreger@ccfsn.org | |

## SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

OUTPATIENT BEHAVIORAL HEALTH (PSYCHIATRIC & SUBSTANCE ABUSE)

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

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

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

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

☐ Equipment Acquisition

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

☐ Imaging ☐ Linear Accelerator

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

553 PORTLAND COBALT RD PORTLAND CT 06480

d. List each town this project is intended to serve: PORTLAND, EAST HAMPTON, CROMWELL, MIDDLETOWN & MIDDLEFIELD

e. Estimated starting date for the project: UPON APPROVAL OF CON

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 |
|---|---|---|---|---|
| N/A | | | | |
| | | | | |

## SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $ Ø

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** | Ø |
| Medical Equipment – Fair Market Value of Leases | |
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| **Total Capital Cost** | Ø |
| **Total Project Cost** | Ø |
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* 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 |
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**Certificate of Need**
**Section IV**
**Project Description**
**June 14, 2007**

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**AFFIDAVIT**

**To be completed by each Applicant**

Applicant: AFFIRMATION COUNSELING, INC

Project Title: OUTPATIENT BEHAVIORAL HEALTH (PSYCHIATRIC & SUBSTANCE ABUSE)

I, MAREK K. KUKULKA, LMFT, CEO
(Name) (Position – CEO or CFO)

of AFFIRMATION COUNSELING, 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 AFFIRMATION COUNSELING (Facility Name) 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.

Marek Kukulka
Signature

6/15/07
Date

RECEIVED
2007 JUN 19 A 11:
OFFICE OF HEALTH CARE ACCESS

Subscribed and sworn to before me on 15th Day of June 2007

Sandra LeClair
Notary Public/Commissioner of Superior Court

My commission expires: 6-30-2012

## 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
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5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
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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
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26. Mobile Services
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**Non-Clinical**

30. Facility Development
31. Non-Medical Equipment
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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. 0409

## Psychiatric Outpatient Clinic for Adults

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Marek K. Kukulka, LMFT as Executive Director
Holly E. Dreger, LCSW as Director

This license expires **September 30, 2010** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, December 6, 2006. INITIAL.

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 25, 2007

Holly Dreger
Clinical Director
Affirmation Counseling Center, Inc.
331 Main Street
Norwich, CT 06360

Re: Letter of Intent, Docket Number 07-30986
Affirmation Counseling Center, Inc.
Establish Outpatient Substance Abuse Treatment in Portland
Notice of Letter of Intent

Dear Ms. Dreger:

On June 19, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Affirmation Counseling Center, Inc. ("Applicant") for the establishment of an Outpatient Substance Abuse Treatment Program in Portland, at a total capital expenditure of $0.

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

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:lmg

# STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 25, 2007

Requisition # HCA07-219
FAX #: 347-3380

The Middletown Press
2 Main Street
Box 471
Middletown, CT 06457

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 29, 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 **Diane Duran** at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:DD:lmg

c: Sandy Salus, OHCA

**The Middletown Press**
**Docket Number 07-30986**

**Letter of Intent**
**June 25, 2007**

**PLEASE INSERT THE FOLLOWING:**

| | |
|---|---|
| Statute Reference: | 19a-638 |
| Applicant: | Affirmation Counseling Center, Inc. |
| Town: | Portland |
| Docket Number: | 07-30986 |
| Proposal: | Establish Outpatient Substance Abuse Treatment in Portland |
| Capital Expenditure: | $0 |

The Applicant may file its Certificate of Need application between August 18, 2007 and October 17, 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.

# STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 26, 2007

Holly Dreger
Clinical Director
Affirmation Counseling Center, Inc.
331 Main Street
Norwich, CT 06360

RE: Certificate of Need Application Forms, Docket Number 07-30986-CON
Affirmation Counseling Center, Inc.
Establish Outpatient Substance Abuse Treatment in Portland

Dear Ms. Dreger:

Enclosed are the application forms for Affirmation Counseling Center, Inc.'s Certificate of Need ("CON") proposal for the establishment of Outpatient Substanace Abuse Treatment in Portland, Connecticut with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between August 18, 2007, and October 17, 2007.

When submitting your CON Application:

1. Paginate and date each page contained in your submission.
2. Submit one (1) original and five (4) copies **in binders**; and
3. On a separate CD, include a **scanned** copy of the complete Application, including all attachments in **Adobe** format and provide **an electronic copy** of the Application in original format (i.e. Word, Excel etc.).

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

# 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: _____

# 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 August 18, 2007, and may be submitted no later than October 17, 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:** 07-30986-CON

**Applicant(s) Name:** Affirmation Counseling Center, Inc.

**Contact Person:** Holly Dreger
**Contact Title:** Clinical Director
Affirmation Counseling Center, Inc.
**Contact Address:** 331 Main Street
Norwich, CT 06360

**Project Location:** Portland

**Project Name:** Establish Outpatient Substance Abuse Treatment in Portland

**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 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. 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<br>Source/Entity Name<br>Available Funds | $_____<br>_____ |
| 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.

## 11. 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.

**Affirmation Counseling Center, Inc.**

**11. B (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 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Projected | Projected | Projected | Projected | Projected | Projected | Projected | Projected | Projected |
| Description | Results | W/out Project | Incremental | With Project | W/out Project | Incremental | With Project | W/out Project | Incremental | With Project |
| Revenue from Operations | | | | $0 | | | $0 | | | $0 |
| Non-Operating Revenue | | | | $0 | | | $0 | | | $0 |
| Total Revenue: | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Total Operating Expenses | | | | $0 | | | $0 | | | $0 |
| Revenue Over/(Under) Expense | $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.

**Affirmation Counseling Center, Inc.**

**11.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 |
| **Total Facility by Payer Category:** | | | | Col. 2 * Col. 3 | | | | Col.4 - Col.5 -Col.6 - Col.7 | Col. 1 Total * Col. 4 / Col. 4 Total | Col. 8 - Col. 9 |
| 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 |