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

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by an Applicant, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

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

Certified Mail	06519	
Contact Person's Telephone Number	203-503-3276	
Contact Person's Fax Number	203-503-3254	
Contact Person's e-mail Address	rkilpatrick@hillhealthcenter.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

___State Street Counseling Services_____

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:

____911 State St., New Haven, CT 06511_____

d. List each town this project is intended to serve: ___New Haven, East Haven, Hamden, North Haven_____

e. Estimated starting date for the project: ____1 Oct. 2007_____

f. Type of project: ___18 Behavioral Health_____

(Fill in the appropriate number(s) from page 7 of this Form)

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed
na				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $50,000

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	$50,000
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	$50,000
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	$50,000

Total Project Cost	$50,000
Capitalized Financing Costs (Informational Purpose Only)	0

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

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

☒ No ☐ Yes

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

☐ Energy ☐ Fire Safety Code ☐ Non Substantive

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

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

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
na				

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

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

☒	Applicant's Equity	☐	Capital Lease	☐	Conventional Loan
☐	Charitable Contributions	☐	Operating Lease	☐	CHEFA Financing
☐	Funded Depreciation	☐	Grant Funding	☐	Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

Family Planning (license attached)

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

Outpatient mental health treatment.

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

Low-income, uninsured people are both the current and target populations.

4. Identify any unmet need and describe how this project will fulfill that need.
   This project will address a waiting list for mental health services.
5. Are there any similar existing service providers in the proposed geographic area?

No

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

It will increase the number of people who will be treated for mental health services by about 300 a year.

7. Who will be responsible for providing the service?
8. Hill Health Corporation

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

Current and anticipated payers are: Medicaid, HUSKY, SAGA, Medicare, private insurance.

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

AFFIDAVIT

To be completed by each Applicant

Applicant: ___Hill Health Corporation_____

Project Title: __State Street Counseling Services_____

I, ___Robert Kilpatrick, Development Director, of Hill Health Corporation, being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that _Hill Health Corporation complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Robert Kilpatrick
Signature

7-30-7
Date

Subscribed and sworn to before me on 30th Day of July, 2007

Margie W. Ford
Notary Public/Commissioner of Superior Court

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

My commission expires: _____

RECEIVED
2007 AUG -1 PM 12:26
OFFICE OF POLICY AND MANAGEMENT
HEALTH CARE ACCESS

Form 2030
Revised 7/06

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0019

Outpatient Clinic

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493, Connecticut Public Health Code, Section 19-13-D54 and Section 19a-116-1:

Hill Health Corporation of New Haven, Ct, d/b/a Women's Health Services is hereby licensed to maintain and operate a Family Planning Clinic.

Women's Health Services is located at 911 State Street, New Haven, Ct 06511.

This license expires **December 31, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2006. RENEWAL

License revised to reflect:

*New expiration date December 31, 2009.

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

August 14, 2007

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

RE: Certificate of Need Application Forms, Docket Number 07-31013-CON
Hill Health Corporation d/b/a State Street Health Services
Establish an Adult Outpatient Mental Health Clinic in New Haven

Dear Mr. Kilpatrick:

Enclosed are the application forms for Hill Health Corporation's Certificate of Need ("CON") proposal to Establish an Adult Outpatient Mental Health Clinic in New Haven with an associated capital expenditure of $50,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between September 30, 2007, and November 29, 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 /pf

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 September 30, 2007, and may be submitted no later than November 29, 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: 07-31013-CON

Applicant(s) Name: Hill Health Corporation d/b/a State Street Health Services

Contact Person: Robert Kilpatrick
Contact Title: Development Director
Hill Health Corporation d/b/a State Street Health Services
Contact Address: 400 Columbus Boulevard
New Haven, CT 06519

Project Location: New Haven

Project Name: Establish an Adult Outpatient Mental Health Clinic in New Haven

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 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.

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.

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:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	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 Total Incremental Expenses:		Rate	Units	Gross Revenue	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue	Operating Expenses	Gain/(Loss) from Operations
Total Facility by				Col. 2 * Col. 3				Col.4 - Col.5 -Col.6 - Col.7	Col. 1 Total * Col. 4 / Col. 4 Total	Col. 8 - Col. 9
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

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 14, 2007

Mr. Robert Kilpatrick
Development Director
Hill Health Corporation
d/b/a State Street Health Services
400 Columbus Avenue
New Haven, CT 06519

Re: Letter of Intent, Docket Number 07-31013
Hill Health Corporation d/b/a State Street Health Services
Establish an Adult Outpatient Mental Health Clinic in New Haven
Notice of Letter of Intent

Dear Mr. Kilpatrick:

On August 1, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Hill Health Corporation d/b/a State Street Health Services ("Applicant") to establish an adult outpatient mental health clinic in New Haven, at a total capital expenditure of $50,000.

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

August 14, 2007

Requisition # HCA08-030
FAX: (203) 865-8360

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

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Sunday, August 19, 2007.**

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

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

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

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

New Haven Register
Docket Number 07-31013

Letter of Intent
August 14, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Hill Haven Corporation d/b/a State Street Health Services
Town:	New Haven
Docket Number:	07-31013
Proposal:	Establish an Adult Outpatient Mental Health Clinic in New Haven
Capital Expenditure:	$50,000

The Applicant may file its Certificate of Need application between September 30, 2007 and November 29, 2007. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

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

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

TRANSMISSION OK

TX/RX NO	2445
RECIPIENT ADDRESS	912038658360
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ST. TIME	08/14 15:51
TIME USE	00'20
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 14, 2007

Requisition # HCA08-030
FAX: (203) 865-8360

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

Gentlemen/Ladies:

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor