SOUTHEASTERN COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC.

August 29, 2007

RECEIVED
2007 AUG 30 AM 11:00
OFFICE OF HEALTH CARE ACCESS

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

Dear Commissioner Vogel:

Enclosed please find a Letter of Intent Form, Form 2030. SCADD is terminating the Outpatient Services at 62-64 Coit Street, New London, CT 06320 and Lebanon Pines, 37 Camp Mooween Road, Lebanon, CT 06249.

If you should have any questions or need additional information, please call me at (860) 886-2495 ext. 220 or email sdeschamps@snet.net.

Sincerely,

Susan Deschamps

Susan Deschamps
Contract Monitor

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	Southeastern Council on Alcoholism and Drug Dependence, Inc.	
Doing Business As	SCADD Outpatient Services	
Name of Parent Corporation	Southeastern Council on Alcoholism and Drug Dependence, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	Administration Office 37 Camp Mooween Road Lebanon, CT 06249	
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.	John F. Malone Executive Director	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	Administration Office 37 Camp Mooween Road Lebanon, CT 06249	

Contact Person's Telephone Number	(860) 886-2495 ext. 203	
Contact Person's Fax Number	(860) 887-0007	
Contact Person's e-mail Address	jackmalone@scadd.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Termination of Outpatient 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:

62-64 Coit Street, New London, CT 06320

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

e. Estimated starting date for the project: Termination date 08/29/2007

f. Type of project: 18
(Fill in the appropriate number(s) from page 7 of this Form)

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

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $_____

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	
Medical Equipment – Fair Market Value of Leases	
Major Medical Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	
Total Project Cost	
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

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.

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?

AFFIDAVIT

To be completed by each Applicant

Applicant: Southeastern Council on Alcoholism and Drug Dependence, Inc.

Project Title: Termination of Outpatient Services

I, John F. Malone (Name), Executive Director (Position – CEO or CFO)

of SCADD, 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 SCADD, INC. (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.

Signature

08/29/2007
Date

RECEIVED
2007 AUG 30 A11:00
OFFICE OF HEALTH CARE ACCESS

Subscribed and sworn to before me on 08/29/2007

Stacey L Lawton
Notary Public/~~Commissioner of Superior Court~~

My commission expires: 7/31/09

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. 0248

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:

Southeastern Council on Alcoholism and Drug Dependency, Inc. of Lebanon, CT, d/b/a Altruism House for Women is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Altruism House for Women is located at 62-64 Coit Street, New London, CT 06320 with:

John F. Malone as Executive Director

The maximum number of beds shall not exceed at any time:

11 Intermediate and Long Term Treatment and Rehabilitation Beds

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

Intermediate and Long Term Treatment and Rehabilitation
Outpatient Treatment

This license expires **June 30, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2007. RENEWAL.

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

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

SOUTHEASTERN COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC.

OUTPATIENT SERVICES

Program Description

Type of Service Provided: Outpatient Services Level 1.1.

Goal of the Program: A Non-residential treatment program with no medication monitoring. Treatment goals are established and focus on maintaining functional status within the community. Services include but are not limited to professionally directed evaluation, treatment and recovery services. Services are provided in regularly scheduled sessions of either/or group or individual sessions. The goal of the program is to work with the client toward sobriety and a drug free life.

Target Population: Men and Women age 18+ who are willing to address their issues associated with substance use and abuse.

Admission Criteria: The criteria used for admission is the CCPC criteria. The program cannot accept clients whose mental impairment excludes substance abuse treatment.

Referrals: Most clients are self or family referrals, other treatment program referrals, and social service agency referrals.

Geographic Area: The residents of Southeastern Connecticut are the targeted population.

Other Providers With Whom SCADD Has A Working Relationship: There is limited interaction of outside agency participation on site, but referrals are made to local services as needed. Services include activities with Centro de la Communidad, Care Plus, the Women's Center, the Convenant Shelter, Community Mental Health and Alternatives to Incarceration. Mental Health services are provided by local programs, Community Mental Health, L&M Hospital and Backus Hospital. Other programs are included as needed.

Average Length of Stay: 1 to 13 sessions with an average of 8 depending on managed care company approval and the client treatment plan.

Special Services: Relapse prevention and medical aspects of addiction are subjects included. Referrals are made to local mental health services, for co-occurring disorders. Drug screening is completed on a random basis or for reasonable cause.

Facility Fee and Service Provided by: Southeastern Council on Alcoholism and Drug Dependence, Inc. will be charging a facility fee and will be providing the Services.

Payers of this Service: Aetna Health Plans, Blue Care Family Plan, Blue Choice of New England, Community Health Network, Connecticare, Advanced Behavioral Health, Inc., Oxford Health Plan, Mashantucket Pequot Tribal Nation, and State Medicaid.

SOUTHEASTERN COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC.

INTENSIVE OUTPATIENT SERVICES

Program Description

Type of Service Provided: Outpatient Services Level 2.1.

Goal of the Program: An intensive outpatient program that offers a higher level of treatment than a regular outpatient program. This program meets 3 days a week, 3 hours a day and focuses on relapse prevention, psycho educational groups, trigger identification, and integration of the recovery philosophy into one's life style. Leisure management, spirituality, and alternative coping skills are also included in our treatment program. Individual and group therapy are provided by Masters Level and Certified Clinicians. Medication management and treatment for mental disorders is provided through a referral process to William Backus Hospital, Sound Community, Inc. and United Community and Family Services.

Target Population: Men and Women age 18+ who are willing to address their issues associated with substance use and abuse.

Admission Criteria: The criteria used for admission is the CCPC criteria. The program cannot accept clients whose mental impairment excludes substance abuse treatment.

Referrals: Most clients are self or family referrals, other treatment program referrals, and social service agency referrals.

Geographic Area: The residents of Southeastern Connecticut are the targeted population.

Other Providers With Whom SCADD Has A Working Relationship: There is unlimited opportunity for participation with other agencies in providing services for this population. Services include activities with Centro de la Communidad, Care Plus, the Women's Center, the Convenant Shelter, Alternatives to Incarceration, William Backus Hospital, Sound Community, Inc. and United Community and Family Services. Other programs are included as needed.

Average Length of Stay: 10 to 12 visits depending on managed care company approval and the client treatment plan.

Special Services: Relapse prevention and medical aspects of addiction are subjects included. Referrals are made to local mental health services, for co-occurring disorder to William Backus Hospital, Sound Community, Inc. and United Community and Family Services.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 5, 2007

Mr. Jack Malone
Executive Director
SE Council on Alcoholism and Drug Dependence, Inc.
37 Camp Moween Rd.
Lebanon, CT 06249

Re: Letter of Intent, Docket Number 07-31030
SE Council on Alcoholism and Drug Dependence, Inc.
Termination of Outpatient Treatment in New London and Lebanon
Notice of Letter of Intent

Dear Mr. Malone:

On August 30, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of SE Council on Alcoholism and Drug Dependence, Inc. ("Applicant") for the Termination of Outpatient Treatment in New London and Lebanon, at a total capital expenditure of $0.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Norwich Bulletin and The Day Publishing Co.* 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

September 5, 2007

Requisition # HCA08-042
FAX: (860) 442-5443

The Day Publishing Co.
47 Eugene O'Neil Drive
Box 1231
New London, CT 06360

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, September 9, 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

The Day Publishing Co.
Docket Number 07-31030

Letter of Intent
September 5, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	SE Council on Alcoholism and Drug Dependence, Inc.
Town:	Lebanon
Docket Number:	07-31030
Proposal:	Termination of Outpatient Treatment in New London and Lebanon
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between October 29, 2007 and December 28, 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	2585
RECIPIENT ADDRESS	918604425443
DESTINATION ID	
ST. TIME	09/06 09:16
TIME USE	00'23
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 5, 2007

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 5, 2007

Requisition # HCA08-041
EMAIL: ndouglas@norwich.gannett.com

Norwich Bulletin
66 Franklin Street
Norwich, CT 06360

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, September 9, 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

Norwich Bulletin
Docket Number 07-31030

Letter of Intent
September 5, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	SE Council on Alcoholism and Drug Dependence, Inc.
Town:	Lebanon
Docket Number:	07-31030
Proposal:	Termination of Outpatient Treatment in New London and Lebanon
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between October 29, 2007 and December 28, 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.

PUBLISHER'S CERTIFICATE

State of Connecticut
County of New London, ss. New London

Personally appeared before the undersigned, a Notary Public within and for said County and State, Priscilla Melecio, Legal Adverising Clerk, of The Day Publishing Company Classifieds dept, a newspaper published at New London, County of New London, state of Connecticut who being duly sworn, states on oath, that the Order of Notice in the case of

4526 State of Connecticut Statute Reference:19a-638 App

A true copy of which is hereunto annexed, was published in said newspaper in its issue(s) of

09/08/2007

Cust: CT OFFICE OF HEALTH CARE
Ad #: d00061860

Subscribed and sworn to before me
This Tuesday, September 11, 2007

Notary Public

My commission expires 9-30-2008

4526

State of Connecticut

Statute Reference:19a-638 Applicant:SE Council on Alcoholism and Drug Dependence, Inc. Town:Lebanon Docket Number:07-31030 Proposal:Termination of Outpatient Treatment In New London and Lebanon Capital Expenditure:$0

The Applicant may file its Certificate of Need application between October 29, 2007 and December 28, 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.