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	The Center for Women and Families of Eastern Fairfield County, Inc.	
Doing Business As	The Center for Women and Families of Eastern Fairfield County, Inc.	
Name of Parent Corporation	The Center for Women and Families of Eastern Fairfield County, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	753 Fairfield Avenue Bridgeport, CT 06604	
What is the Applicant's Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes X No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.	Susan Schnitzer Grants Manager	

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	753 Fairfield Avenue Bridgeport, CT 06604	
Contact Person's Telephone Number	203.334.6154 x-14	
Contact Person's Fax Number	203.579.8882	
Contact Person's e-mail Address	sschnitzer@cwfefc.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

___Clinical 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:

__753 Fairfield Avenue Bridgeport, CT 06604_____

d. List each town this project is intended to serve:
__Bridgeport, Fairfield, Munroe, Easton, Stratford and Trumbull_

e. Estimated starting date for the project: ____December 1, 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: $_____0_____

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 *(See attached)*

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?

SECTION IV. PROPOSAL DESCRIPTION

1. Current Services

CWF provides comprehensive services addressing the numerous issues resulting from the impact of **domestic violence and sexual assault** and is the primary resource for victims of abuse in Eastern Fairfield County's six towns of Bridgeport, Easton, Fairfield, Monroe, Stratford and Trumbull. CWF's core services and activities include: **bilingual hotlines** that are available 24 hours per day, 7 days a week for victims of domestic violence and sexual assault; **emergency shelter** for victims of domestic violence; support for victims at hospitals and police departments; **assessment, referrals and safety planning** for victims; **individual and group education and support**; **criminal and civil court-based advocacy services**, including assistance with applying for restraining orders, advocacy throughout court procedures, and information about arrests of abusive partners; **forensic interviews and case management** for children alleging sexual abuse; **education, support and case management for pre- and post-release women offenders**; and **school and community based education** on topics related to the prevention of domestic violence and sexual assault.

2. Proposed Services

CWF is proposing the addition of therapeutic outpatient counseling services focused on addressing symptoms of Post Traumatic Stress Disorder (PTSD) resulting from experiencing violence or abuse, either directly as a victim, or indirectly as a witness. Services will include an assessment utilizing several validated and widely used tools, including:

- Traumatic Events Screening Inventory
- Parenting Stress Index
- Trauma Symptom Checklist for Young Children
- Brief Infant-Toddler Social & Emotional Assessment

Clinicians may also choose to observe the family dynamic in the home setting. In addition to the assessment of trauma, clinicians will also determine if the prospective client/family is prepared and equipped to commit to treatment, i.e. appear regularly for sessions, demonstrate motivation to participate, and show that family members are supportive of the process. Based on these assessments, clinicians devise a family-driven treatment plan for the client and family. Clinicians will determine the number of sessions, the participants (child, parent, siblings or all), and the venue (at CWF's offices, the Safe House, the family's home) based on the evaluation.

In addition to individual counseling, clinicians will also provide group counseling, education and support. Adult groups will be offered using the "Seeking Safety" model and the Trauma Recovery and Empowerment Model(TREM) of treatment to address symptoms of PTSD resulting from the trauma of abuse.

3. Target Population

Clinical services will target CWF's current client population including adults and children who have been victims of sexual assault/abuse, adults and children who have been victims of domestic violence and women offenders with a history of abuse. Two distinct components will be created, one to serve children who have been exposed to violence and/or abuse, and one to

serve adults who have been traumatized by violence and/or abuse, including women ex-offenders who are re-integrating into the community.

4. Filling an Unmet Need

In the course of providing advocacy and case management services, CWF staff frequently identify clients that would benefit from therapeutic counseling by a licensed clinician. The need to refer clients to outside providers for these services has a negative impact on clients in several ways. First, clinical agencies in the greater Bridgeport region frequently have prohibitively long waiting lists, up to 30 days. Second, clients referred to outside agencies are forced to withstand a second intake process that not only requires them to re-state their basic personal and economic information, but also to re-state the traumatic events that led them to seek services. Third, outside clinical agencies that do not have specific expertise in the areas of domestic violence and sexual assault are not always sensitive to the unique issues victims face. This can sometimes result in referred clients feeling misunderstood, judged or even re-traumatized. Lastly, the need to connect with a new agency for clinical services sometimes prematurely severs clients' bond with CWF staff and services and potentially puts client safety at risk. CWF recognized that positive, sustained outcomes for this population could be realized if clinical services were provided in-house.

5. Existing Services

While there are a number of providers of mental health services in the geographic area we serve, CWF is the only provider that has the experience to address the issues unique to domestic violence and sexual assault survivors. As detailed in #4 above, the addition of clinical services to the continuum of care offered by CWF facilitates meeting clients needs in a comprehensive, appropriate and timely manner.

6. Anticipated Effect on Healthcare Delivery in Connecticut

This proposal will have a positive effect on the delivery of mental health services in the State of Connecticut by providing comprehensive services to victims of domestic violence and sexual assault that are not currently readily available and will help to alleviate the heavy caseload of existing mental health resources in CWF's catchment area.

7. Responsible for Provision of Services

The Center for Women and Families of Eastern Fairfield County, Inc.

8. Current Payers and Anticipated Changes

The cost of service development for children and their families was covered in the pilot phase by a Safe Start grant from the Office of Juvenile Justice and Delinquency Prevention and is currently being covered by a grant from The Florence V. Burden Foundation. The cost of the trauma work is being covered by grants from The Department of Corrections and The Edward S. Moore Foundation. Upon licensing approval, the services will be covered by a combination of third party payments, sliding fee scale payments by clients, and private foundation sources that will help to subsidize the cost of services to clients who cannot afford payment.

AFFIDAVIT

To be completed by each Applicant

Applicant: The Center for Women and Families of Eastern Fairfield County, Inc.

Project Title: Clinical Services

I, Debra A. Greenwood, CEO,
(Name) (Position – CEO or CFO)

of The Center for Women and Families, EFC, 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 The Center for Women and Families, EFC, 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.

Debra A Greenwood
Signature

October 22, 2007
Date

RECEIVED
2007 OCT 22 A11:58
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Subscribed and sworn to before me on October 17, 2007

Carol Roberto
Notary Public/Commissioner of Superior Court

My commission expires: _____

CAROL ROBERTO
NOTARY PUBLIC
MY COMMISSION EXPIRES OCT. 31, 2010

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

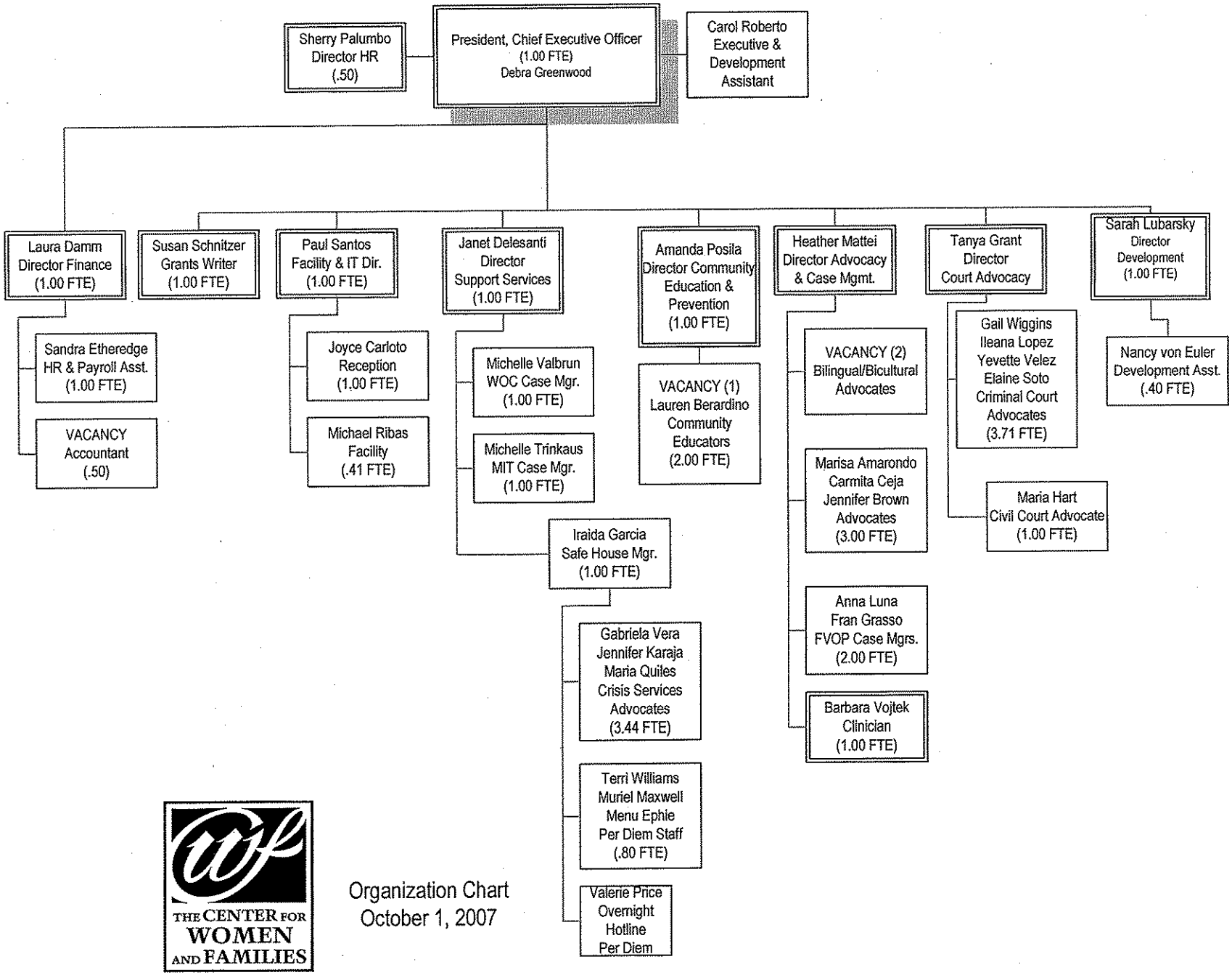
1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

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



THE CENTER FOR WOMEN AND FAMILIES

Organization Chart
October 1, 2007

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 15, 2007

Susan Schnitzer
Grants Manager
The Center for Women and Families of Eastern Fairfield County, Inc.
753 Fairfield Avenue
Bridgeport, CT 06604

Re: Letter of Intent, Docket Number 07-31063
The Center for Women and Families of Eastern Fairfield County, Inc.
Establish Psychiatric Outpatient Clinic for Adults in Bridgeport
Notice of Letter of Intent

Dear Ms. Schnitzer:

On October 25, 2007, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of The Center for Women and Families of Eastern Fairfield County, Inc. ("Applicant") to establish a Psychiatric Outpatient Clinic for adults in Bridgeport, at a total capital expenditure of $0.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Connecticut Post* 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

November 15, 2007

Requisition # HCA08-085
Fax: (203) 384-1158

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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 **Tuesday, November 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

Connecticut Post
Docket Number 07-31063

Letter of Intent
November 15, 2007

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	The Center for Women and Families of Eastern Fairfield County, Inc.
Town:	Bridgeport
Docket Number:	07-31063
Proposal:	Establish Psychiatric Outpatient Clinic for Adults in Bridgeport
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between December 24, 2007 and February 22, 2008. 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	2885
RECIPIENT ADDRESS	912033841158
DESTINATION ID	
ST. TIME	11/15 15:16
TIME USE	00'22
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

November 15, 2007

Requisition # HCA08-085
Fax: (203) 384-1158

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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 **Tuesday, November 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

STATE OF CONNECTICUT LETTER OF INTENT Novembe...

Source: Connecticut Post & Brooks Community Newspapers

Item: 10948892

Item Description

STATE OF CONNECTICUT LETTER OF INTENT November 15 2007 DOCKET NUMBER 07-31063 Statute Reference: 19a - 638 Applicant: The Center for Women and Families of Eastern Fairfield County Inc. Town: Bridgeport Docket Number: 07-31063 Proposal: Establish Psychiatric Outpatient Clinic for Adults in Bridgeport Capital Expenditure: $0 The Applicant may file its Certificate of Need application between December 24 2007 and February 22 2008. Interested persons are invited to submit written comments to Cristine A. Vogel Commissioner Office of Health Care Access 410 Capitol Avenue MS13HCA PO 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.

CONNPOST.com
CONNECTICUTPOST

CLASSIFIED DEPARTMENT
LEGAL NOTICES *(only)*
410 State Street, Bridgeport, CT 06604
Fax 203-384-1158
publicnotices@ctpost.com

Call 203 330 6213
800-423-8058
DIANE – IN LEGALS

TO: Kimberly

OUTGOING FAX NUMBER:
860-418-7053

DATE: 11/16/07

YOUR AD FOR PROOF AND PAYMENT.

THANK YOU.

DIANE - LEGALS

STATE OF CONNECTICUT
LETTER OF INTENT
November 15, 2007
DOCKET NUMBER 07-31063

Statute Reference:	19a - 638
Applicant:	The Center for Women and Families of Eastern Fairfield County, Inc.
Town:	Bridgeport
Docket Number:	07-31063
Proposal:	Establish Psychiatric Outpatient Clinic for Adults in Bridgeport
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between December 24, 2007 and February 22, 2008. Interested persons are invited to submit written comments to Cristine A. Vogel, Commissioner Office of Health Care Access, 410 Capitol Avenue, MS13HCA, PO 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

November 21, 2007

Susan Schnitzer
Grants Manager
The Center for Women and Families of Eastern Fairfield County, Inc.
753 Fairfield Avenue
Bridgeport, CT 06604

RE: Certificate of Need Application Forms, Docket Number 05-31063-CON
The Center for Women and Families of Eastern Fairfield County, Inc.
Establish Psychiatric Outpatient Clinic for Adults in Bridgeport

Dear Ms. Schnitzer:

Enclosed are the application forms for The Center for Women and Families of Eastern Fairfield County, Inc.'s Certificate of Need ("CON") proposal to establish a psychiatric outpatient clinic for adults in Bridgeport with an associated capital expenditure of $0. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between December 24, 2007, and February 22, 2008.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette in Adobe PDF format. OHCA requests that the electronic copy of the Application (attachments optionsl) be in MS Word format and that the Financial Attachments 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 December 24, 2007, and may be submitted no later than February 22, 2008. 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: 07-31063-CON

Applicant(s) Name: The Center for Women and Families of Eastern Fairfield County, Inc.

Contact Person: Susan Schnitzer
Contact Title: Grants Manager
The Center for Women and Families of Eastern Fairfield County, Inc.
Contact Address: 753 Fairfield Avenue
Bridgeport, CT 06604

Project Location: Bridgeport

Project Name: Establish Psychiatric Outpatient Clinic for Adults in Bridgeport

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) The population to be served, including the number of individuals to receive the proposed service(s).
- b) Where are patients currently receiving the proposed services.
- 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) List the service area towns. Provide a rationale for choosing the selected towns.

F) Provide the information as outlined in the following table concerning the existing providers' in your service area:

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

G) 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.

H) 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):

[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.

☐ 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:

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. 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.

10. 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 actual patient payor mix 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(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) Rate	(3) Units	(4) Gross Revenue	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue	(9) Operating Expenses	(10) Gain/(Loss) from Operations
FY Projected Incremental Total Incremental Expenses:			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

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.

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