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 the Applicant(s), 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	InterCommunity, Inc.	
Doing Business As	InterCommunity, Mental Health Group, Inc.	
Name of Parent Corporation	InterCommunity, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	281 Main Street East Hartford, CT 06118	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Kimberly L. Beauregard, President & CEO	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	281 Main Street East Hartford, CT 06118	
Contact Person Telephone Number	(860) 291-1340	
Contact Person Fax Number	(860) 569-5614	
Contact Person e-mail Address	kimbeauregard@icmhg.org	

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 the Applicant(s), 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	InterCommunity, Inc.	
Doing Business As	InterCommunity, Mental Health Group, Inc.	
Name of Parent Corporation	InterCommunity, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	281 Main Street East Hartford, CT 06118	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes	
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Kimberly L. Beauregard, President & CEO	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	281 Main Street East Hartford, CT 06118	
Contact Person Telephone Number	(860) 291-1340	
Contact Person Fax Number	(860) 569-5614	
Contact Person e-mail Address	kimbeauregard@icmhg.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Close operation at 505 Silas Deane Highway, Wethersfield, CT 06109

b. Project Proposal: Close operation at 505 Silas Deane Highway, Wethersfield, CT 06109

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* _____
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
☒ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Outpatient *(specify)* _____

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
☐ Change in Ownership or Control ☐ Land and/or Building Acquisitions
☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☒ Yes ☐ No

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

☐ New (F, S, Fnc) ☐ Additional (F, S, Fnc) ☐ Replacement
☐ Expansion (F, S, Fnc) ☐ Relocation ☒ Termination of Service
☐ Reduction ☐ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes ☒ No

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

☐ New equipment acquisition and operation

☐ Replacement equipment with disposal of existing equipment

☐ Major medical equipment

☐ Change in ownership or control

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

Close operation at 505 Silas Deane Highway, Wethersfield, CT 06109

g. List each town this project is intended to serve:

Wethersfield

h. Estimated starting date for the project: 11/30/08

i. If the proposal includes change in the number of beds provide the following information:

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

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $0

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Major Medical Equipment – Fair Market Value of Leases 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 medical and non-medical equipment to be purchased and leased.

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☐ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. 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 each major medical/imaging equipment.

e. 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)* None

SECTION IV. PROJECT DESCRIPTION

In paragraph format, 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.

None

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

None

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

None

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

None

5. Are there any similar existing service providers in the proposed geographic area?

Unknown

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

None

7. Who will be responsible for providing the service?

Services have not been provided since 2008 due to lack of client participation at this location.

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

None

AFFIDAVIT

To be completed by each Applicant

Applicant: InterCommunity, Inc.

Project Title: Close operation at 505 Silas Deane Highway, Wethersfield, CT 06109

I, Kimberly L. Beauregard (Name), CEO (Position – CEO or CFO)

of InterCommunity, 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 InterCommunity (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.

Kimberly L. Beauregard CEO 3/18/09
Signature Date

RECEIVED
2009 MAR 31 P 3:10
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Subscribed and sworn to before me on March 18, 2009

Notary Public/~~Commissioner of Superior~~ Court

My commission expires: My Commission Exp. Apr. 30, 2010

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. C-0109

Psychiatric Outpatient Clinic for Adults

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

Inter-Community Mental Health Group, Inc. of East Hartford, CT, d/b/a Inter-Community Mental Health Clinic is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Inter-Community Mental Health Clinic is located at 505 Silas Deane Highway, Wethersfield, CT 06109 with:

Kimberly L. Beauregard LCSW as Executive Director
Kimberly L. Beauregard LCSW as Director

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

MULTI SERVICE

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

Dated at Hartford, Connecticut, April 1, 2005. RENEWAL

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

April 2, 2009

via fax and e-mail

Kimberly L. Beauregard
President & CEO
InterCommunity, Mental Health Group, Inc.
281 Main Street
East Hartford, CT 06118

RE: Certificate of Need Application Forms, Docket Number 09-31343-CON
InterCommunity, Mental Health Group, Inc.
Termination of Psychiatric Outpatient Clinic for Adults in Wethersfield

Dear Ms. Beauregard:

Enclosed are the application forms for InterCommunity, Mental Health Group, Inc.'s Certificate of Need ("CON") proposal to Terminate a Psychiatric Outpatient Clinic for Adults in Wethersfield, 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 May 30, 2009, and July 29, 2009.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the application and supporting documents in MS Word format.
- Submit completed financial attachments, and other data as appropriate, in MS Excel format.

The analyst assigned to the CON application is Paolo Fiducia. Please contact him at (860) 418-7001 if you have questions.

Sincerely,

Kimberly Martone
Director of Operations

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 May 30, 2009, and may be submitted no later than July 29, 2009. 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: 09-31343-CON

Applicant(s) Name: InterCommunity, Mental Health Group, Inc.

Contact Person: Kimberly L. Beauregard
Contact Title: President & CEO
InterCommunity, Mental Health Group, Inc.
Contact Address: 281 Main Street
East Hartford, CT 06118

Project Location: Wethersfield

Project Name: Termination of Psychiatric Outpatient Clinic for Adults in Wethersfield

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? Please list.

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. Regarding this termination of services in Wethersfield, please answer the following:

i) Explain in detail the Applicant's rationale for this termination of services. Identify the process undertaken by the Applicant in making the decision to terminate.

ii) When did the Applicant start offering Psychiatric Services at Wethersfield?

iii) Did the Applicant seek CON authorization to start offering Psychiatric Outpatient Services for Adults at the Wethersfield location?

iv) When did the Applicant decide to terminate psychiatric services at Wethersfield?

v) When did the Applicant return its "Psychiatric Outpatient Clinic for Adults" license to the Department of Public Health?

vi) When was the Department of Mental Health and Addiction Services notified of the termination of the program at Wethersfield and their role in the provision of this service?

vii) Provide a list of all the InterCommunity, Mental Health Group, Inc.'s facilities, location of each facility, types of services offered and available capacity for each service offered.

viii) Did the Applicant determine there was no or insufficient public need for the continuation of this program?

ix) Was the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

x) Did this termination require the vote of the Board of Directors of the Applicant? If so, please provide a copy of the minutes (excerpted for other unrelated business) for the meeting(s) at which this termination was discussed and voted on.

B. Provide or answer the following:

i) Provide a detailed description of the specific service components (i.e. description of the programs, age groups) that are available and provided at the Wethersfield location. Identify what the hours of operation are for the service location.

ii) List the service area towns. Provide a rationale for choosing the selected towns.

iii) Provide the units of service (i.e. clinic visits) for the past three fiscal or calendar years by patient town of origin, for the Wethersfield service location.

iv) Provide the units of service (i.e. number of admissions) for the past three fiscal or calendar years by patient town of origin, for the Wethersfield service location.

v) Discuss any scheduling backlogs that did exist at the Wethersfield service location.

vi) Were there any waiting lists in place at the Wethersfield service location? If so, identify the number of patients on the waiting list.

vii) Describe the pattern of referrals to the Wethersfield service location that did exist.

viii) Please provide a report that lists, by year, for FYs 2006, 2007, and 2008, to date, the following: average daily census; number of clients on the last day of the month; the number of clients admitted during the month; and the number of clients discharges during the month.

C. Regarding the impact on the patient and provider community of the termination of services at the Wethersfield service location, provide the following information:

i) Explain the procedures that the Applicant followed in terminating these services and transferring patients to other community providers.

ii) Discuss how the services described above will continue to be made available to the patients that had previously utilized the Wethersfield service locations. List any special populations that utilized the services and explain how these clients will continue to access this service after the Wethersfield service location closed.

iii) Provide the information as outlined in the following table concerning the existing providers services in the Wethersfield service area:

Description of Service	Provider Name and Location	Hours and Days of Operation[1]	Current Utilization[2]

[1] Specify days of the week and start and end time for each day.
[2] Number of clients served by Provider for the most recent 12 month period, if known.

iv) Did your facility contact any other providers in the Wethersfield service area to see if they were willing and able to absorb the patient population base for displaced patients? Please provide a detailed explanation, including any written agreements or memorandum of understanding between the Applicant and any other facilities as related to the proposal.

v) What was the effect of the termination of the Wethersfield service location on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

vi) Did this termination of services create any barriers to access in the region? If so, please discuss such barriers, as they now exist.

vii) Provide information and supporting documentation addressing the issue of transportation for the Wethersfield patients.

D. Did 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.

E. 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. Provide or answer the following:

i) Provide a copy of the State of Connecticut Department of Public Health license(s) currently held by InterCommunity, Mental Health Group, Inc. in Wethersfield.

ii) Are there any unique characteristics of your patient/physician mix?

☐ Yes ☐ No

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

B. 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.

C. 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]

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. Provide or answer the following:

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

ii) 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.

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. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

C. Verify that this termination of services did not result in any capital expenditures or capital costs to the Applicant.

9. Revenue, Expense and Volume Projections

A) Provide the following financial information for the Wethersfield service location:

i) Please submit an audited or unaudited Balance Sheet and Income Statement or Statement of Operations for the two most recently completed fiscal years. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Provide a discussion of any incremental gains or losses from operations that will be a direct result of the termination of the services

B) 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:

	Provider's Payer Mix
Medicare*	
Medicaid* (includes other medical assistance)	
TriCare (CHAMPUS)	
Total Government Payers	
Commercial Insurers*	
Self-Pay	
Workers Compensation	
Total Non-Government Payers	
Uncompensated Care	
Total Payer Mix	100.0%

*Includes managed care activity.

D. Provide the following for the financial and statistical projections for the Wethersfield service location:

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, Financial Attachment I.** 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.

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: _____

Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description

Type of Unit Description:

# of Months in Operation

FY _____	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
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

13. 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
Description	Actual Results	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected With Project	Projected W/out Project	Projected Incremental	Projected 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.

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

TRANSMISSION OK

TX/RX NO	4971
RECIPIENT ADDRESS	95695614
DESTINATION ID	
ST. TIME	04/02 13:46
TIME USE	01'32
PAGES SENT	13
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: KIMBERLY L. BEAUREGARD

FAX: 569-5614

AGENCY: INTERCOMMUNITY MENTAL HEALTH GROUP, INC.

FROM: PAOLO FIDUCIA

DATE: 4/2/09 **TIME:**

NUMBER OF PAGES: 13
(including transmittal sheet

Comments: Docket 09-31343 CON Application

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 2, 2009

Kim Beauregard
CEO
Inter-Community Mental Health Group, Inc.
281 Main Street
East Hartford, CT 06118

Re: Letter of Intent, Docket Number 09-31343
Inter-Community Mental Health Group, Inc.
Termination of Psychiatric Outpatient Clinic for Adults in Wethersfield

Dear Ms. Beauregard ,

On March 31, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Inter-Community Mental Health Group, Inc. ("Applicant") for the termination of Psychiatric Outpatient Clinic for Adults in Wethersfield, with no associated capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Hartford Courant* 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
Director of Operations

KRM:lmg

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 2, 2009

Requisition # HCA09-129
Email: Publicnotices@courant.com

Hartford Courant
285 Broad Street
Hartford, CT 06115

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Monday, April 6, 2009.**

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
Director of Operations

Attachment

KRM:PF:lmg

c: Sandy Salus, OHCA

Hartford Courant
Docket Number 09-31343

Letter of Intent
April 2, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Inter-Community Mental Health Group, Inc.
Town:	Wethersfield
Docket Number:	08-31343-LOI
Proposal:	Termination of Psychiatric Outpatient Clinic for Adults in Wethersfield
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between May 30, 2009 and July 29, 2009. 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 at OHCA or on OHCA's website at www.ct.gov/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 Applicants.

Greer, Leslie

Sent: Thursday, April 02, 2009 1:45 PM

----IMA2c0f99d.49d4/pop.state.ct.us
Content-Type: text/plain; charset=us-ascii

Your message was successfully relayed to a system that does not support delivery confirmations.
Unless the delivery fails, this will be the only delivery notification.

----IMA2c0f99d.49d4/pop.state.ct.us
Content-Type: message/delivery-status

Reporting-MTA: pop.state.ct.us
Final-Recipient: rfc8222;publicnotices@courant.com
Action: relayed
Status: 2.0.0

----IMA2c0f99d.49d4/pop.state.ct.us
Content-Type: message/rfc822

Received: from doit-mstwmms1 [159.247.5.80] by pop.state.ct.us with ESMTP
(SMTPD-10.02) id A99B063C; Thu, 02 Apr 2009 13:44:59 -0400
Received: from 159.247.77.53 by doit-mstwmms1 with ESMTP (Tumbleweed EMF SMTP Relay (Email Firewall v6.0.0)); Thu, 02 Apr 2009 13:54:10 -0400
X-Server-Uuid: AAF81055-C3E5-43F1-82D3-EBCFC44FF42A
X-MimeOLE: Produced By Microsoft Exchange V6.5
Content-class: urn:content-classes:message
Return-Receipt-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
MIME-Version: 1.0
Disposition-Notification-To: "Greer, Leslie" <Leslie.Greer@ct.gov>
Subject: Legal Ad 09-31343
Date: Thu, 2 Apr 2009 13:43:39 -0400
Message-ID: <741BDEFB9A5C9A4F9421A255626F70B1028AD54C@DOIT-EX401.exec.ds.state.ct.us>
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
Thread-Topic: Legal Ad 09-31343
Thread-Index: AcmzuO6pQPjIrzGrSWqbK0ssGhw3GQ==
From: "Greer, Leslie" <Leslie.Greer@ct.gov>
To: publicnotices@courant.com
X-WSS-ID: 65CA24482CC463888-01-01
Content-Type: multipart/mixed;
boundary="----_=_NextPart_001_01C9B3BA.8ED77F4F"

----IMA2c0f99d.49d4/pop.state.ct.us--

Greer, Leslie

From: HC Public Notice [HCPublicNotice@courant.com]
Sent: Friday, April 03, 2009 9:09 AM
To: Greer, Leslie
Subject: RE: STATEWIDE BY 4/6 - Legal Ad 09-31343

YOUR AD NO 2285287 IS SCHEDULED FOR 4/6. CHARE IS 218.08

NOTICE

Statute Reference: 19a-638
Applicant: Inter-Community Mental Health Group, Inc.
Town: Wethersfield
Docket Number: 08-31343-LOI
Proposal: Termination of Psychiatric Out patient Clinic for Adults in Wethersfield

Capital Expenditure: $0

The Applicant may file its Certificate of Need application between May 30, 2009 and July 29, 2009. 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 at OHCA or on OHCA's website at www.ct.gov/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 Applicants.

From: Greer, Leslie [mailto:Leslie.Greer@ct.gov]
Sent: Thursday, April 02, 2009 1:44 PM
To: publicnotices@courant.com
Subject: STATEWIDE BY 4/6 - Legal Ad 09-31343

Legal Ad,
Please run the attached public notice in your newspaper by April 6, 2009. Please notify me when this has been completed.

Thank you,

Leslie M. Greer
Office of Health Care Access
State of Connecticut
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7001
Fax: (860) 418-7053
Website: www.ct.gov/ohca