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	Reinhard W. Straub, LCSW, LADC	
Doing Business As	Solutions For Recovery LLC	
Name of Parent Corporation	NA	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	24 Carolina Main St. Carolina, RI 02812	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes (No)	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Reinhard Straub owner / Director	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	24 Carolina Main St Carolina, RI 02812	
Contact Person Telephone Number	401 741 1574 401 215 4877 860 449 8240	
Contact Person Fax Number	860 449 8240	
Contact Person e-mail Address	rstraub1@cox.net	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Solutions For Recovery LLC

b. Project Proposal: CT Facility License

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:

402 Long Hill Road Groton, CT 06340

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

Groton, New London, Norwich, Stonington, Ledyard, Waterford, Lisbon New London County and environs to R.I. Border to Hartford.

h. Estimated starting date for the project: 6/1/09

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
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $ 10000. est

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: Insurance/office eqp/supplies	
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	$ 10000.
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 N/A

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

N/A

☐ 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:

N/A

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):

- [x] 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

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.

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

3. Identify the current population served and 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. Project Description

I am currently practicing at the proposed project site and provide individual and group therapies on an outpatient basis. I am a CT Licensed Clinical Social Worker and a CT Licensed Alcohol and Drug Counselor (see attached licenses). The owner of the building, my landlord and clinical colleague is Arlene Dumais, MSN, APRN. Ms. Dumais provides psychiatric evaluation, psychopharmacological services and medication management to patients that I refer and carries her own private caseload. Ms. Dumais has agreed to serve as Medical Director for the proposed project.

I am applying for a "Mental Health Day Treatment" license and a "Substance Abuse & Dependence" "Day or Evening Treatment" license in order to provide nonresidential intensive outpatient services. The proposal will augment services currently being provided by myself to addicts, alcoholics, and the dually diagnosed (as well as their families) by offering a higher level of care within a continuum of care i.e. assessment, psychiatric evaluation and treatment, outpatient individual and group therapies, and the proposed 4 hour per day intensive outpatient program for patients in need of more than an outpatient level of care.

I have years of experience working with impaired physicians and other health care workers, uniformed professionals, union workers and other professionals in positions affecting public safety (State Medical Societies, Amtrak, FAA, General Dynamics, GE Knolls Atomic Power Laboratory, etc.) who are affected and impaired by Substance Use Disorders and other psychiatric diagnoses. See attached resume. I propose to provide a treatment experience that would address the specific needs of the aforementioned populations as well as provide the proposed level of care to the general population in the area.

I currently treat doctors, dentists, nurses, police officers, firefighters, and other professionals whose only choice for a higher level is to leave CT for treatment at a national center specializing in their specific clinical needs e.g. Marworth in Pennsylvania, The Farley Center in Virginia, The Betty Ford Center in California, etc. There isn't a similar existing program in the area or for that matter, in the State of Connecticut. My hope is that a homegrown program such as I propose will provide earlier identification and detection of professional impairment by offering local and immediate assistance to those in need. Public safety will be improved as a result and over time, employers and institutions will recognize that their own purposes can be addressed by offering rapid local assistance and treatment to their employees in positions of public trust.

I plan to assemble a team of seasoned and proven professional clinicians to facilitate the proposed program under my supervision as well as the expertise and supervisory oversight of my colleague, Arlene Dumais, MSN, APRN, the proposed medical director. I plan to receive payment for services rendered as I do currently for my outpatient services i.e. private and public insurance.

AFFIDAVIT

To be completed by each Applicant

Applicant: Reinhard Straub

Project Title: Solutions For Recovery LLC

I, Reinhard Straub, LCSW, Owner / Director
(Name) (Position – CEO or CFO)

of _____ 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 Solutions For Recovery LLC complies with the appropriate and
(Facility Name)

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.

Reinhard W. Straub 3/31/09
Signature Date

Subscribed and sworn to before me on 3/31/09

Alan Kennedy
Notary Public/Commissioner of Superior Court

My commission expires: ALAN KENNEDY NOTARY PUBLIC STATE OF RHODE ISLAND MY COMMISSION EXPIRES 8/24/2010

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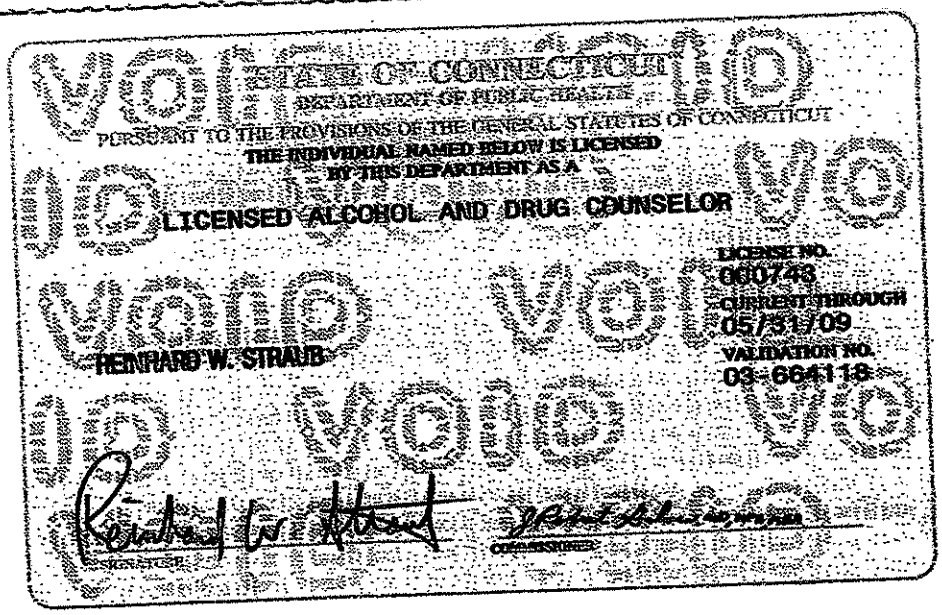
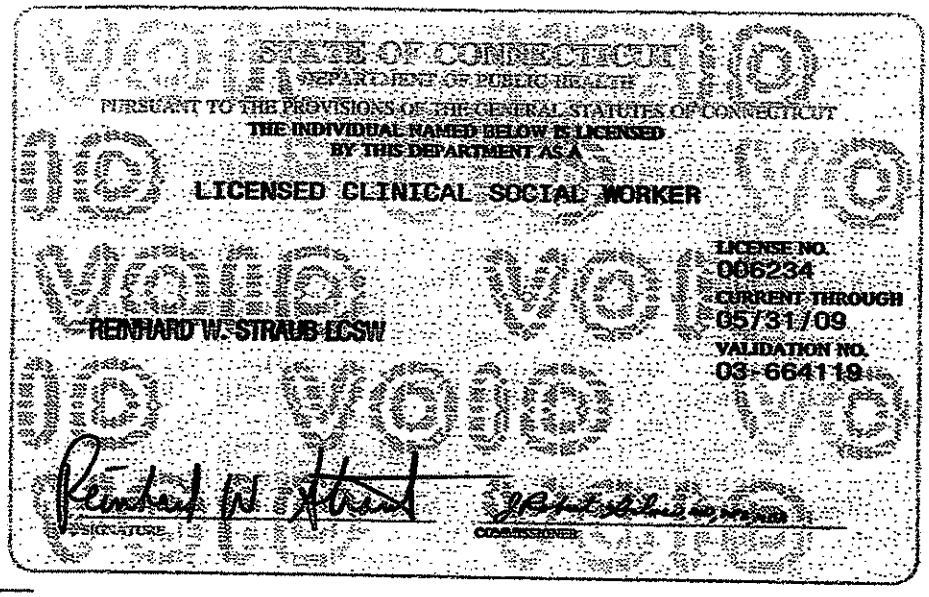
2009 APR -3 A 11: 19
CONNECTICUT OFFICE OF HEALTH CARE ACCESS



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PURSUANT TO THE PROVISIONS OF THE GENERAL STATUTES OF CONNECTICUT
THE INDIVIDUAL NAMED BELOW IS LICENSED
BY THIS DEPARTMENT AS A
LICENSED ALCOHOL AND DRUG COUNSELOR
LICENSE NO.
000743
CURRENT THROUGH
05/31/09
VALIDATION NO.
03-664118
REINHARD W. STRAUB
SIGNATURE
COMMISSIONER



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THE INDIVIDUAL NAMED BELOW IS LICENSED
BY THIS DEPARTMENT AS A
LICENSED CLINICAL SOCIAL WORKER
LICENSE NO.
006234
CURRENT THROUGH
05/31/09
VALIDATION NO.
03-664119
REINHARD W. STRAUB LCSW
SIGNATURE
COMMISSIONER