CMHA
Community Mental Health Affiliates

29 Russell Street | New Britain, CT 06052 | P 860.826.1358 | F 860.229.6575

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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

April 16, 2009

Cristine A. Vogel, Commissioner
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134

Dear Commissioner Vogel:

Community Mental Health Affiliates plans to close our Northwest Center for Family Services Office in Winsted. (licensed as a Psychiatric Outpatient Clinic for Adults, DPH # 0424 and as an Outpatient Psychiatric Clinic for Children # OPCC-52). The program is currently located at 115 Spencer St, Winsted, CT. We would like to close these services by June 30, 2009.

We are submitting CON Determination Form 2030 to you and will notify the Department of Public Health and the Department of Children and Families of our intentions to close the program. We will follow up with the CON Request Form to you in 60 days.

Please let us know if there is any further action you would require of us at this time. Please contact me at (860) 826-1358 if there are any questions or concerns. Thank you for your assistance with this matter.

Sincerely,

Raymond J. Gorman
President and CEO

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	Community Mental Health Affiliates, Inc	
Doing Business As	Northwest Center for Family Service	
Name of Parent Corporation	Central Connecticut Health Alliance, Inc	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	29 Russell Street New Britain, CT 06052	
Identify Applicant 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 Designee to receive all correspondence in this matter.	Mary Gillette, Vice President of Organizational Performance	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	29 Russell Street New Britain, CT 06052	
Contact Person Telephone Number	(860) 826-2702	
Contact Person Fax Number	(860) 348-1214	

Contact Person e-mail Address	mgillette@cmhacc.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Northwest Center for Family Services - Winsted Outpatient Office Closure

b. Project Proposal: Close a small outpatient office Licensed by DPH and DCF

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:

115 Spencer Street, Winsted, CT 06098

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

Winsted, Torrington

h. Estimated starting date for the project: June1,2009

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: $ 2000.00

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: Moving Costs	$2,000
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	$2,000
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)* _____

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.
   (SEE ATTACHED PAGES)

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?

AFFIDAVIT

To be completed by each Applicant

Applicant: Community Mental Health Affiliates, Inc.

Project Title: Northwest Center for Family Service - Winsted Outpatient Office Closure

I, Raymond J. Gorman (name), President and CEO (office)
of Community Mental Health Affiliates, 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 Northwest Center for Family Services and Mental Health's (Facility Name) Winsted Office complies with the appropriate 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 4/7/09 Date

Subscribed and sworn to before me on April 7, 2009

Debora Naegelen
Notary Public/Commissioner of Superior Court

My commission expires: DEBORA NAEGELEN NOTARY PUBLIC MY COMMISSION EXPIRES OCT. 31, 2012

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Section IV Project Description

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.**
The services provided at this site are Outpatient Mental Health services provided to adults and children. The site is licensed by DPH as an Adult Psychiatric Outpatient Clinic for Adults (#0424) and by DCF as an Outpatient Psychiatric Clinic for Children (#OPCC-52)

2. **List the types of services being proposed and what DPH licensure categories will be sought, if applicable.** No services are being proposed at this site. We propose to close the site, and believe that many of the clients currently served there can be seen in our Torrington office, which is also licensed in the same categories as above, by DPH and DCF.

3. **Identify the current population served and the target population to be served.** The population served in the past year has been approximately 40 clients (approximately evenly split between adults and children) with a variety of diagnostic issues suitable for treatment in a generalized, non-specialty outpatient behavioral health clinic.

4. **Identify any unmet need and describe how this project will fulfill that need.** At this point, based on the relatively small number of clients served, we do not believe that this program is necessary to meet the need in this area, and that most of the clients served could be served in a more cost effective manner in the Torrington office.

5. **Are there any similar existing service providers in the proposed geographic area?** CMHA has a large licensed clinic in Torrington CT, which is 9.51 miles and 15 minutes from Winsted.

6. **Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.** We believe that there will be no effect on the health care delivery system in the state of Connecticut as a result of this closure. What will be impacted is CMHA's ability to provide more robust and cost effective services in the other clinics we have sited in Torrington, New Milford and Lakeville. The site in Winsted is currently losing money, has minimal clients and is open relatively few hours. The savings realized from this closure will allow us to better support clinical operations in the other sites.

7. **Who will be responsible for providing the service?** There are very few clients currently being served, and services to them will be offered at our Torrington office. That clinic is staffed with Master's prepared and Licensed Social Workers, Marriage and Family Therapists, Counselors, Psychologists and Psychiatrists.

8. **Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?** The current payers in this location are Medicaid, Commercial Payers, Medicare, and the Behavioral Health Partnership. We do not anticipate any changes to this mix for clients who transfer their care to the Torrington office.

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 24, 2009

Mary Gillette
VP of Organizational Performance
Community Mental Health Affiliates, Inc.
29 Russell Street
New Britain, CT 06052

Re: Letter of Intent, Docket Number 09-31360
Closure of the Northwest Center for Family Services in Winsted
Notice of Letter of Intent

Dear Ms. Gillette:

On April 21, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Community Mental Health Affiliates, Inc. ("Applicant") for the closure of the Northwest Center for Family Services in Winsted, with a capital expenditure of $2,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Register Citizen* 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 24, 2009

Requisition # HCA09-137
Email: dmusler@registercitizen.com

The Register Citizen
190 Water Street
Torrington, CT 06790-0058

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 **Wednesday, April 29, 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

The Register Citizen **Letter of Intent**
Docket Number 09-31360 **April 24, 2009**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Community Mental Health Affiliates, Inc.
Town:	Winsted
Docket Number:	09-31360-LOI
Proposal:	Closure of the Northwest Center for Family Services in Winsted
Capital Expenditure:	$2,000

The Applicant may file its Certificate of Need application between June 20, 2009 and August 19, 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

From: Donna Musler [dmusler@registercitizen.com]
Sent: Friday, April 24, 2009 3:37 PM
To: Greer, Leslie
Subject: Read: Legal Ad 09-31360
Attachments: ATT772532.txt

Your message

To: dmusler@registercitizen.com
Subject: Legal Ad 09-31360
Sent: 4/24/2009 2:57 PM

was read on 4/24/2009 3:36 PM.