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	University of Connecticut	NA
Doing Business As	University of Connecticut Nayden Rehabilitation Clinic	
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)		
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.	Morgan Hills, Clinic Director	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	843 Bolton Rd, Storrs CT 06269	
Contact Person Telephone Number	860-486-8080	
Contact Person Fax Number	860-486-8081	

Contact Person e-mail Address	Morgan.hills@uconn.edu	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Nayden Rehabilitation Clinic
b.
c. Project Proposal: _____

d. 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
X Rehabilitation *(specify type)* PT, OT and ST ☐ 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: _____

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

X Yes ☐ No

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

X New (F, S, Fnc) ☐ Additional (F, S, Fnc) ☐ Replacement

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Termination of Service

☐ Reduction ☐ Change in Ownership/Control

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

☐ Yes X 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:

843 Bolton Rd, Storrs CT 06269

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

Storrs, Mansfield, Coventry, Ashford

h. Estimated starting date for the project: July 1, 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
NA				

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $_____

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 X 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
NA				

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.

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?

The purpose of this request is to obtain a Certificate of Need (CON) for the University of Connecticut to operate an outpatient patient rehabilitation clinic in Storrs, CT.

The initial impetus for this venture was to provide UConn students, faculty and residents of Storrs/Mansfield the access to physical therapy, occupational and speech therapy. The clinic will be managed and staffed by clinical faculty in the University's Physical Therapy Program. The clinic will also be utilized as a site for clinical education for our physical therapy students. The clinic is organized to operate within the university financial system as a self sustaining entity, receiving no tuition dollars for operational expenses. Revenue would be obtained through third party reimbursement for federal, state and managed care insurance plans.

The university has operated an outpatient clinic in partnership with Windham Community Memorial Hospital (WCMH) since 1998. In the winter of 2007, WCMH requested significant contractual modifications to continue the venture. The university was unable to agree with contractual changes and opted to pursue a transition to an independent venture. The University of Connecticut proposes to provide physical, occupational and speech therapy to the greater UConn Community. The target population to be served by this clinic will be child and adult patients with orthopedic and neurological physical impairments.

The proposed clinic is a clinical entity of the Department of Kinesiology, in the Neag School of Education. The clinicians are clinical faculty members, who have been recruited for advanced clinical credentials and their contribution to best practice. The clinic will have stream- lined operating procedures utilizing electronic health record and integrated practice management software. The clinic is designed to more reflective of the non hospital based outpatient therapy setting. The new clinic would increase the scope and scale of patient care with the local market, increasing healthcare access to physical rehabilitation to students, faculty and to the community in general. Patient will have access to clinicians who are tenured track faculty and who perform research in areas critical to patient care such as biomechanics, and motor control. Directly related to its connection to the Department of Kinesiology this clinical will afford its patient population access to the expertise of biomechanist and motor control experts. The marriage of clinical research and clinical practice is unique in this part of the state.

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AFFIDAVIT

To be completed by each Applicant

Applicant: University of Connecticut

Project Title: Nayden Rehabilitation Clinic

I, Richard D. Gray, Vice President and Chief Financial Officer of the University of Connecticut 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 University of Connecticut- Nayden Rehabilitation Clinic 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 5/12/2009

Subscribed and sworn to before me on May 12, 2009

Notary Public/Commissioner of Superior Court

My commission expires: DEBBIE L. CARONE NOTARY PUBLIC MY COMMISSION EXPIRES MAY 31, 2014