CMHA
Community Mental Health Affiliates

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

July 15, 2009

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

SUBJECT: Closure of Family Services of Hamden Outpatient Office

Dear Commissioner Vogel:

Enclosed please find the original copy of Community Mental Health Affiliates' Intention to File a Certificate of Need Application (Form 2030) for the Closure of Community Mental Health Affiliates' Site in Hamden.

Please feel free to contact me at (860) 826-1358 if there are any questions regarding this matter.

Thank you.

Sincerely,

Raymond J. Gorman
President/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	Family Services of Hamden	
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: CMHA Family Services Hamden Office Closure

b. Project Proposal: Close an Outpatient office Licensed by DPH (Psychiatric Outpatient Clinic for Adults # 0419 and Facility for the Care or Treatment of Substance Abusive or Dependent Persons, # 0356),

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:
1890 Dixwell Avenue, Hamden CT 06514

g. List each town this project is intended to serve:
Hamden, North Haven, Wallingford, New Haven

h. Estimated starting date for the project: September 30, 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: $2,000

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 cost time and labor_	$2,000
Total Capital Expenditure	**$2,000**
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: Community Mental Health Affiliates Family Services Hamden Office Closure

I, Raymond J. Gorman (name) President & Chief Executive Officer (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 Family Services of Hamden 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 7/15/09 Date

Subscribed and sworn to before me on July 15, 2009

Theresa Carl
Notary Public/Commissioner of Superior Court

My Commission Expires April 30, 2013

My commission expires:

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 Intensive Outpatient Services provided to adults with Substance Abuse Disorders. The site is licensed by DPH as a Psychiatric Outpatient Clinic for Adults (#0419) and as a Facility for the Care and Treatment of Substance Abusive or Dependent Persons (#0356).

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.

3. **Identify the current population served and the target population to be served.** The population served in the past year has been approximately 339 clients (split between psychiatric outpatient and intensive outpatient substance abuse) 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.** Not Applicable. This project is not designed to meet unmet needs, it is a request to close a facility.

5. **Are there any similar existing service providers in the proposed geographic area?** There are similar services in the area. They include Rushford Center, Behavioral Health Services of Hamden, Adult Psychiatric Clinic/ Child and Family Guidance Clinic in North Haven, and Connections in New Haven .

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 minimal to no impact resulting from this closure

7. **Who will be responsible for providing the service?** NA, as we are closing a service.

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, SAGA, and the Behavioral Health Partnership. We do not anticipate any changes to this mix.

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0356

Facility for the Care or Treatment of Substance Abusive or Dependent Persons

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

Community Mental Health Affiliates, Inc. of New Britain, CT, d/b/a Family Services Of Hamden is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Family Services Of Hamden is located at 1890 Dixwell Avenue, Hamden, CT 06514 with:

Raymond J. Gorman as Executive Director

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

Outpatient Treatment

This license expires **June 30, 2009** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2007.

License revised to reflect:
CHANGE OF EXECUTIVE DIRECTOR EFF: 12/6/07

J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0419

Psychiatric Outpatient Clinic for Adults

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

Community Mental Health Affiliates, Inc. of New Britain, CT, d/b/a Family Services Of Hamden is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

Family Services Of Hamden is located at 1890 Dixwell Avenue, Hamden, CT 06514 with:

Steven D. Moore PhD as Director
Raymond J. Gorman as Executive Director

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

MULTI SERVICE

This license expires **June 30, 2011** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2007.

License revised to reflect:
CHANGE OF EXECUTIVE DIRECTOR EFF: 12/6/07

J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 29, 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 09-31416
Termination of Community Mental Health Affiliates Office
Notice of Letter of Intent

Dear Ms. Gillette,

On July 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 termination of Community Mental Health Affiliates office in Hamden, with a total capital expenditure of $2,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The New Haven Register* 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

July 29, 2009

Requisition # HCA010-006
Fax: (203) 865-8360

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

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 **Sunday August 2, 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 Steven Lazarus or Carmen Cotto at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:SWL:CC;lmg

c: Marie Dempsey, OHCA

New Haven Register
Docket Number: 09-31416

Letter of Intent
July 29, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Community Mental Health Affiliates, Inc.
Town:	Hamden
Docket Number:	09-31416-LOI
Proposal:	Termination of Community Mental Health Affiliates office in Hamden
Capital Expenditure:	$2,000

The Applicant may file its Certificate of Need application between September 19, 2009 and November 18, 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.

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

TRANSMISSION OK

TX/RX NO	0421
RECIPIENT ADDRESS	912038658360
DESTINATION ID	
ST. TIME	07/29 16:17
TIME USE	00'20
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 29, 2009

Requisition # HCA010-006
Fax: (203) 865-8360

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

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 **Sunday August 2, 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 Steven Lazarus or Carmen Cotto at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations