REGIONAL NETWORK OF PROGRAMS, INC.
2 TRAP FALLS ROAD
SUITE 405
SHELTON, CT 06484
PHONE (203) 929-1954 FAX (203) 929-1279

September 3, 2009

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

Dear Commissioner Vogel:

This letter is to inform you that Regional Network of Programs, Inc. plans to close our Monroe Builds Communication Program, located at Masuk High School in Monroe. The program is currently located at 1014 Monroe Turnpike, Monroe, CT 06468. We would like to close services at the site indicated by January 5, 2010.

At this time, please find the CON Determination Form 2030 attached. The Department of Public Health and the Department of Mental Health and Addiction Services have been notified of out intention to close the indicated program.

Please feel free to contact me with any questions or concerns at (203) 929-1954. Thank you for your assistance.

Sincerely,

John A. Hamilton
Chief Executive Officer
Regional Network of Programs, Inc.

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	Regional Network of Programs, Inc.	
Doing Business As	Monroe Builds Communication	
Name of Parent Corporation	Regional Network of Programs, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	2 Trap Falls Road Suite 405 Shelton, CT 06484	
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.	John Schultz Director of Risk Management	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	2 Trap Falls Road Suite 405 Shelton, CT 06484	
Contact Person Telephone Number	(203) 929-1954	
Contact Person Fax Number	(203) 929-1279	
Contact Person e-mail Address	john.schultz@rnpinc.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Regional Network of Programs, Inc.: Monroe Builds Communication Outpatient Program.

b. Project Proposal: Closure of an outpatient program licensed by DPH.

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
X☐ 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 X☐ 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:

_____

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

_____

h. Estimated starting date for the project: _____

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: $ _____

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: Computer and Work Station	
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)* _____

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 Attachment)

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

3. Identify the current population served and the target population to be served.
   (See Attachment)

4. Identify any unmet need and describe how this project will fulfill that need.
   (See Attachment)

5. Are there any similar existing service providers in the proposed geographic area?
   (See Attachment)

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

7. Who will be responsible for providing the service?
   (See Attachment)

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

Attachment #1
Regional Network of Programs, Inc.
Monroe Builds Communication

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 Treatment for the care or treatment of substance abusive or dependent persons. The site is licensed by the Department of Public Health. The license # is SA-0121. (Please see copy of attached DPH license).

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. The funding for Monroe Builds Communication was taken out of the Monroe town budget as of July 1, 2009.

3) **Identify the current population served and the target population to be served.**
The program is designed for easy access to adolescents and their parents and provides substance abuse counseling, education, intervention and prevention.

4) **Identify any unmet need and describe how this project will fulfill that need.**
Based on the DMHAS DPAS database, 20 students were seen at Monroe Builds Communication in Fiscal Year 2008/2009. This small number of students could be seen by local mental health providers to meet their needs.

5) **Are there any similar existing service providers in the proposed geographic area?**
Yes, Trumbull Counseling is located at 121 Old Mine Rd., Trumbull. It is 4.8 miles from Masuk High School. They provide all of the services provided by Monroe Builds Communication. (See attached map)

6) **Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.**
Based upon the low level of utilization of Monroe Builds Communication, the impact on the health care delivery system should be minimal.

7) **Who will be responsible for providing the service?**
The small number of students utilizing this service could be seen by local mental health providers to meet their needs.

8) **Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?**
DMHAS currently funds the program. The Town of Monroe pulled their funding from the program as of July 1, 2009. Due to the cessation of funding from Monroe and the 3% decrease of DMHAS funds it is no longer economically feasible for Regional Network of Programs, Inc., to maintain this underutilzed level of care.

AFFIDAVIT

To be completed by each Applicant

Applicant: Regional Network of Programs, Inc.

Project Title: Monroe Builds Communication

I, John Hamilton (Name), CEO (Position – CEO or CFO)

of Regional Network of Programs, 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 Monroe Builds Communication (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.

Signature

9/4/09
Date

Subscribed and sworn to before me on September 8, 2009

Deborah Dedrick
Notary Public/Commissioner of Superior Court

My commission expires: June 30, 2011

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. SA-0121

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:

Regional Network of Programs, Inc. of Shelton, CT, d/b/a Monroe Builds Communications is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Monroe Builds Communications is located at 1014 Monroe Turnpike, Monroe, CT 06468 with:

John A. Hamilton as Executive Director

The maximum number of beds shall not exceed at any time:

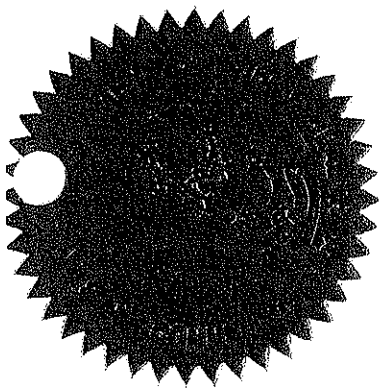
0

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

Outpatient Treatment

This license expires **December 31, 2010** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2009. RENEWAL.



J Robert Galvin MD, MPH, MBA

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

Google maps

Directions to 121 Old Mine Rd, Trumbull, CT 06611
4.8 mi – about **9 mins**

A 1014 Monroe Turnpike, Monroe, CT 06468

111	1. Head **south** on **CT-111/Monroe Turnpike** toward **Old Coach Rd** About 8 mins	go 4.6 mi total 4.6 mi
↰	2. Turn **left** at **Old Mine Rd** About 1 min	go 0.3 mi total 4.8 mi

B 121 Old Mine Rd, Trumbull, CT 06611

These directions are for planning purposes only. You may find that construction projects, traffic, weather, or other events may cause conditions to differ from the map results, and you should plan your route accordingly. You must obey all signs or notices regarding your route.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 24, 2009

via fax and email only

John Schultz
Director of Risk Managment
Regional Network of Programs, Inc.
2 Trap Falls Road
Suite 405
Shelton, CT 06484

RE: Certificate of Need Application Forms; Docket Number: 09-31454-CON
Regional Network of Programs, Inc.
Termination of outpatient behavioral health program in Monroe

Dear Mr. Schultz:

Enclosed are the application forms for Regional Network of Programs, Inc. Certificate of Need ("CON") for termination of an outpatient behavioral health program in Monroe with no capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between November 13, 2009, and January 12, 2010.

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 documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The OHCA analysts assigned to the CON application are Ronald Ciesones and Alexis Fedorjaczenko. Please contact either analyst at (860) 418-7001 if you have questions.

Sincerely,

Harold M. Oberg
CON Supervisor

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 November 13, 2009, and may be submitted no later than January 12, 2010. The Analysts assigned to your application are Ronald Ciesones and Alexis Fedorjaczenko. They may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	09-31454-CON
Applicant(s) Name:	Regional Networks of Programs, Inc.
Contact Person:	John Schultz
Contact Title:	Director of Risk Management Regional Networks of Programs, Inc.
Contact Address:	2 Trap Falls Road Suite 405 Shelton, CT 06484
Project Location:	Monroe
Project Name:	Termination of outpatient behavioral health program in Monroe.
Type proposal:	Section 19a-638, C.G.S.
Est. Capital Expenditure:	$0

1. Project Description and Need

a. For each of the Applicant's programs, identify the location, population served, hours of operation, and whether the program is proposed for termination.

b. Describe the history of the services proposed for termination, including when they were begun and whether CON authorization was received.

c. Explain in detail the Applicant's rationale for this termination of services, and the process undertaken by the Applicant in making the decision to terminate.

d. Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide copy of the minutes (excerpted for other unrelated material) for the meeting(s) the proposed termination was discussed and voted.

2. Impact on Patient and Provider Community

a. List all existing providers (name, address, services provided, hours and days of operation, and current utilization) of the services proposed for termination in the towns served by the Applicant, and in nearby towns.

b. Discuss what steps the Applicant has undertaken to ensure continued access to the services proposed for termination for the Applicant's patients.

c. Identify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes.

d. Provide evidence (e.g. written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients.

e. Describe how clients will be notified about the termination and transferred to other providers.

3. Actual and Projected Volume

a. Provide volumes for the most recently completed FY by town.

b. Complete the following table for the past three fiscal years ("FY") and current fiscal year ("CFY"), for both number of visits and number of admissions, by service.

Table 1: Historical, Current, and Projected Visits & Admissions

	Actual Volume (Last 3 Completed FYs)			**CFY Volume***
	FY ***	FY ***	FY ***	FY ***
Service**				

Total				

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
** Identify each service type and add lines as necessary. Provide both number of visits and number of admissions for each service listed.
*** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

c. Explain any increases and/or decreases in volume seen in the tables above.

d. For DMHAS-funded programs only, provide a report that provides the following information for the last three full FYs and the current FY to-date:
   i. Average daily census;
   ii. Number of clients on the last day of the month;
   iii. Number of clients admitted during the month; and
   iv. Number of clients discharged during the month.

4. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

b. Explain how this proposal contributes to the quality of health care delivery in the region.

c. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

d. Identify when the Applicants' funding and/or licensing agencies (e.g. DPH, DMHAS) were notified of the proposed termination, and when the Applicants' licenses will be returned.

5. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☐ No

c. Financial Statements

   i. If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the

hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii. If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

a. Submit a final version of all capital expenditures/costs.

a. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

6. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. Complete **Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. Complete **Financial Attachment II.** The projections must include the first three full fiscal years of the project.

c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the service(s).

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

f. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

g. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

h. Describe how this proposal is cost effective.

7. Other Review Criteria

a. Describe the proposal's relationship to the Applicant's long-range plans. Provide supporting documentation.

b. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
   i. Voluntary efforts to improve productivity and contain costs;
   ii. Changes to the Applicant's teaching or research responsibilities; and/or
   iii. Special characteristics of the Applicant's patient or physician mix.

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: _____

Regional Network of Programs, Inc.

12. C (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				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.

Regional Network of Programs, Inc.										
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

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

TRANSMISSION OK

TX/RX NO	0707
RECIPIENT ADDRESS	912039291279
DESTINATION ID	
ST. TIME	09/24 14:55
TIME USE	01'56
PAGES SENT	11
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JOHN SCHULTZ

FAX: (203) 929-1279

AGENCY: REGIONAL NETWORK OF PROGRAMS, INC.

FROM: RONALD CIESONES

DATE: 9/24/09 **TIME:**

NUMBER OF PAGES: 11
(including transmittal sheet

Comments: Docket 09-31454 CON Application

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 F (860) 418-7053

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 28, 2009

John Schultz
Director of Risk Management
Regional Network of Programs, Inc.
2 Trap Fall Road
Suite 405
Shelton, CT 06484

Re: Letter of Intent; Docket Number: 09-31454
Regional Network of Programs, Inc.
Termination of an Outpatient Behavioral Health Program in Monroe

Dear Mr. Schultz:

On September 14, 2009 the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Regional Network of Programs, Inc. ("Applicant") for the termination of an Outpatient Behavioral Health Program in Monroe, with no associated capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published by the *Connecticut Post* 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

September 28, 2009

Requisition # HCA010-025
Fax: (203) 384-1158
Acct# 106794

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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 **Friday, October 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 Ronald Ciesones or Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:RC:AF:lmg

c: Marie Dempsey, OHCA

Connecticut Post
Docket Number: 09-31454

Letter of Intent
September 28, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Regional Network of Programs, Inc.
Town:	Monroe
Docket Number:	09-31454-LOI
Proposal:	Termination of an Outpatient Behavioral Health Program in Monroe
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between November 13, 2009 and January 12, 2010. 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 Applicant.

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

TRANSMISSION OK

TX/RX NO	0713
RECIPIENT ADDRESS	912033841158
DESTINATION ID	
ST. TIME	09/28 16:13
TIME USE	00'22
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

September 28, 2009

Requisition # HCA010-025
Fax: (203) 384-1158
Acct# 106794

Connecticut Post
410 State Street
Bridgeport, CT 06604-4560

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 **Friday, October 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 Ronald Ciesones or Alexis Fedorjaczenko at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations