

# Catholic Charities

Archdiocese of Hartford

RECEIVED

2009 NOV -2 P 12:57

THE MOST REVEREND HENRY J. MANSELL, D.D.,  
President

JOHN RUBÉN FLORES  
Chairperson, Board of Trustees

CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS

ROSE ALMA SENATORE  
Chief Executive Officer

ADMINISTRATIVE OFFICE  
839-841 Asylum Avenue  
Hartford, Connecticut 06105-2801  
(860) 493-1841  
Fax (860) 548-9343  
[www.ccaoh.org](http://www.ccaoh.org)

## FAX COVER SHEET

TO: Paola Felicia

FROM: Linda Smith

DATE: Oct. 23, 2009

FAX#:

Number of pages faxed, including cover sheet: \_\_\_\_\_

I'd Paola, Please review for completeness  
Thank you for your patience in this  
process thus far. Please call if further  
questions.

Linda

### Confidential Notice:

The information contained in this fax transmittal is privileged and confidential intended for the addressee only. If you are neither the intended recipient nor the agent responsible for delivering this message to the intended recipient, any disclosure of this information is strictly prohibited. If you have received this fax in error, please notify the person transmitting the information immediately.





**Section IV. Project Description**  
**For proposed closing**  
**Outpatient Psychiatric Clinic for Adults**  
**Centro San Jose**  
**290 Grand Ave.**  
**New Haven, CT 06513**

**Catholic Charities, Inc.-Archdiocese of Hartford, CT.** is proposing to close its DPH licensed Outpatient Psychiatric Clinic for Adults operating at 290 Grand Ave. in New Haven CT 06513. This service site is named **Centro San Jose** and was initially operated independently as a “drop-in” center for the Latino population in the surrounding neighborhood. It included information and referral resources for children and families in the neighborhood, some basic human needs distribution of clothes and food and some after-school activities for youth. When Catholic Charities was approached to assume administration of **Centro San Jose**, the site was licensed by DPH for clinic services for adults and a few years ago as a **Child Day Care Center** site for children. Always, the intent was to provide bi-lingual services for its clients. The client population served under the adult license never warranted a full-time staff person, and Catholic Charities, through its former office at 478 Orange St. in New Haven, positioned a bi-lingual MSW or LCSW staff part-time at this Grand Ave. site. In the case of an MSW he/she would work under the supervision of an LCSW.

The Spanish-speaking active clients at **Centro San Jose** numbered seven (7) at the time this Catholic Charities Family Service Center was planning to relocate and consolidate its licensed clinics in New Haven. The plan was to relocate clinic services to a newly renovated facility at 501 Lombard St. just  $\frac{1}{2}$  mile from the **Centro** site. The plan also called for relocating the New Haven fiscal office then operating from a site in Hamden. It seemed clear that staffing professional and business offices at the three sites was not the most efficient, effective operating process. In that process, the new Lombard site was licensed by DPH for Adult Outpatient Psychiatric and Substance Abuse Clinic services as well as by DCF for Outpatient Psychiatric Clinic services for Children and Child Placing services.

All client records from **Centro** have been moved to Lombard St., as have all records previously stored at Orange St.

Since 501 Lombard St. is within  $\frac{1}{2}$  mile of **Centro San Jose** at 290 Grand Ave., is in the same primarily Latino neighborhood, and also on the same city bus route, we do not believe closing the **Centro San Jose** clinic services will negatively effect the Spanish-speaking population. The professional staff at Lombard St. includes bi-lingual MSW clinicians who have easily included the **Centro San Jose** clients in their caseloads, again under the supervision of an LCSW. Mr. James Osborne, is the clinical supervisor of the adult clinic staff in New Haven. Ms. Robyn

**Hawley LCSW, Director of Behavioral Health Services for all adult and child clinics of Catholic Charities actively oversees the policies and procedures of clinic services. Ms. Lois Nesci, Chief of Operations serves as Director of the clinic licenses and Ms. Rose Alma Senatore, CEO assumes overall responsibility for the services of Catholic Charities.**

**There will be no unmet need of this population since the DPH license for Child Day Care continues at Centro San Jose which is also accredited by the National Association for the Education of Young Children. Also continuing is the e “drop-in” services and assistance with Basic Human Needs. In fact, services may be enhanced for Centro clients in that the Lombard St. site is additionally licensed to provide services to Substance Abusive individuals.**

**Given the above description and plan, we do not believe this proposal will have any significant effect of the health care delivery system in the State of Connecticut.**

**The current payers of this service include Medicaid, Medicare and very limited private insurance.**



Centro

## 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	Catholic Charities, Inc.-Archdiocese of Hartford	
Doing Business As	Catholic Charities, Inc.-Archdiocese of Hartford	
Name of Parent Corporation	Catholic Charities, Inc.-Archdiocese of Hartford	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	839-841 Asylum Ave. Hartford, CT 06501	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Linda S. Smith LCSW	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	839-841 Asylum Ave. Hartford, CT 06105	
Contact Person Telephone Number	(860) 728-2575	
Contact Person Fax Number	(860) 548-9343	
Contact Person e-mail Address	<u>lsmith@ccaoh.org</u>	

## SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Catholic Charities Psychiatric Outpatient Clinic for Adults  
 (Centro San Jose) 290 Grand Ave. New Haven, CT 06513

b. Project Proposal: Closing Clinic

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:

290 Grand Ave. New Haven, CT 06513

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

New Haven (Spanish-speaking population)

h. Estimated starting date for the project: As soon as possible

i. If the proposal includes change in the number of beds provide the following information: **N/A**

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: \$ 0

b. Please provide the following tentative capital expenditure/costs related to the proposal: **N/A**

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify: _____	
<b>Total Capital Expenditure</b>	
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	
<b>Total Capital Cost</b>	
<b>Total Project Cost</b>	
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
 

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): **N/A**

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?

**AFFIDAVIT****To be completed by each Applicant**Applicant: Catholic Charities, Inc. - Archdiocese of HartfordProject Title: Closing Centro San JoseI, Rose Anna Santore, CEO  
(Name) (Position – CEO or CFO)

of Catholic Charities, 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 Centro San Jose 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.

Rose Anna Santore 10/26/2009  
Signature Date

Subscribed and sworn to before me on October 26, 2009

Shirley M. McCunn  
Notary Public/Commissioner of Superior Court  
**SHIRLEY M. McCUNN**  
**NOTARY PUBLIC**  
My commission expires: OCT. 31, 2012

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0320

**Psychiatric Outpatient Clinic for Adults**

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

Catholic Charities, Inc. - Archdiocese of Hartford of Hartford, CT, d/b/a Centro San Jose is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

**Centro San Jose** is located at 290 Grand Avenue, New Haven, CT 06513 with:

Rose A. Senatore as Executive Director

\*Lois Nesci\* as Director

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

MULTI SERVICE

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

Dated at Hartford, Connecticut, July 1, 2005

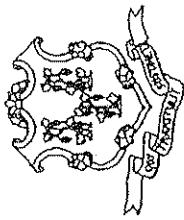
License revised to reflect:

\*CHANGE OF DIRECTOR EFF: 6/26/06



*J. Robert Galvin, M.D., M.P.H.*

J. Robert Galvin, M.D., M.P.H.,  
Commissioner



# State of Connecticut

Department of Public Health  
In Accordance with Connecticut General Statutes, Title 19, Chapter 120, Article 1, Section 1  
the Department of Public Health issues this license, which is non-transferable, to:

CATHOLIC CHARITIES, INC., ARCHDIOCESE OF HARTFORD  
290 GRAND AVENUE  
NEW HAVEN, CT 06513

to operate a

## CHILD DAY CARE CENTER

at

CENTRO SAN JOSE CHILD DEVELOPMENT CTR  
290 GRAND AVENUE  
NEW HAVEN, CT 06513

Maximum Children at One Time: 20  
Children Under 3 Years of Age: 1 0

Approved for the Following Services:

\*Preschool

410 Capitol Avenue, P.O. Box 340308, Hartford, CT 06134-0308  
Telephone: 1-800-282-6063

*J. Robert Galvin* M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H., Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0444

Psychiatric Outpatient Clinic for Adults

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

Catholic Charities, Inc. - Archdiocese of Hartford of Hartford, CT, d/b/a Catholic Charities is hereby licensed to maintain and operate a Psychiatric Outpatient Clinic for Adults.

**Catholic Charities** is located at 501 Lombard St, New Haven, CT 06513 with:

Rose A. Senatore as Executive Director  
Lois Nesci as Director

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

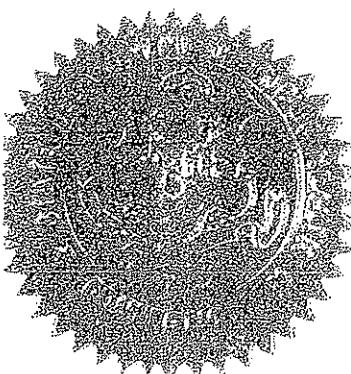
MULTI SERVICE

This license expires **June 30, 2012** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, August 26, 2008 RELOCATION.

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

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



STATE OF CONNECTICUT

Department of Public Health

License No. 0375

**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:

Catholic Charities, Inc. - Archdiocese of Hartford of Hartford, CT, d/b/a Catholic Charities is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

**Catholic Charities** is located at 501 Lombard St, New Haven, CT 06513 with:

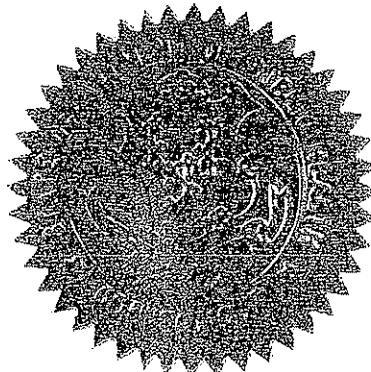
Rose A. Senatore as Executive Director

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

Outpatient Treatment

This license expires **June 30, 2010** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, August 26, 2008 RELOCATION.



*J. Robert Galvin MD, MPH, MBA*

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

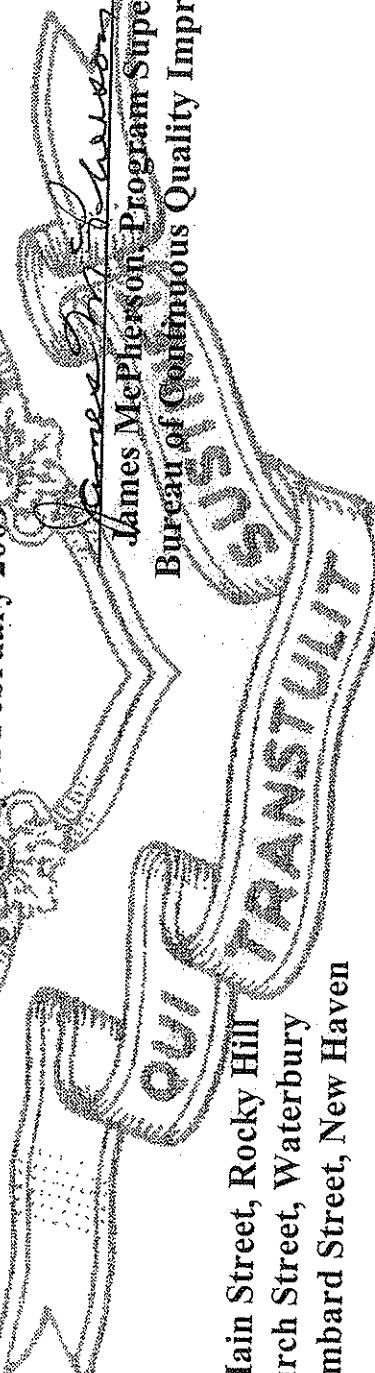
STATE OF CONNECTICUT  
DEPARTMENT OF CHILDREN AND FAMILIES

This is to certify, that in accordance with the provisions of Sections 17a-149 and 17a-151 of the Connecticut General Statutes, as amended, CATHOLIC CHARITIES, INC., located at 839-841 in the Town of HARTFORD is hereby licensed as a CHILD RACING AGENCY to provide a program of ADOPTION and FOSTER CARE SERVICES at the locations listed below.\*

This license is issued effective OCTOBER 1, 2007 for a period of TWENTY-FOUR MONTHS, and conditional upon compliance with all regulations of the Department of Children and Families and may be revoked for cause at any time.

License No. CPA - 5

Signed at Hartford, Connecticut the 23<sup>rd</sup> day of February 2009



James McPherson, Program Supervisor  
Bureau of Continuous Quality Improvement

\* 2433 Main Street, Rocky Hill  
56 Church Street, Waterbury  
501 Lombard Street, New Haven

Amended on 2/23/09 to reflect a change of licensed site from Orange St. to Lombard St. in New Haven.



Centro

ADMINISTRATIVE OFFICE  
839-841 Asylum Avenue  
Hartford, Connecticut 06105-2801  
(860) 493-1841  
Fax (860) 548-9343  
[www.ccaoh.org](http://www.ccaoh.org)

THE MOST REVEREND HENRY J. MANSELL, D.D.,  
President

JOHN RUBÉN FLORES  
Chairperson, Board of Trustees

ROSE ALMA SENATORE  
Chief Executive Officer

July 17, 2009

Ms. Sandra Bauer  
License Examination  
CT. Dept. of Public Health  
410 Capitol Ave. MS #12HSR  
P.O. Box 340308  
Hartford, CT. 06134-0308

RE: DPH License # 0320  
Centro San Jose  
290 Grand Ave.  
New Haven, CT. 06513

Dear Ms. Bauer:

Pursuant to your phone conversation with Ms. Linda Smith, Director of Quality Assurance, on July 16, 2009, please be advised that:

1. **Outpatient Psychiatric Services for Adults in the above-identified clinic were suspended as of March 31, 2009 and relocated to the newly-renovated DPH licensed Catholic Charities facility at 501 Lombard Street in New Haven. I sincerely apologize for the delay in contacting your office. As Ms. Smith stated, it appears we were confused about the processes we needed to follow both for DPH and OHCA, and the timeframe for each. We had applied to DPH in a letter dated July 8, 2008, to relocate all licensed services from our former licensed facility at 478 Orange Street to Lombard Street, and that was accomplished last August 26, 2008 when DPH granted a license to the Lombard Street site. Clients and staff of Catholic Charities realized the very close proximity of the Lombard Street and Grand Ave. clinics and, with the next staffing change at Centro San Jose, we began to explore the most efficient, effective staffing pattern, to serve clients in both clinics. The reality that the two clinics were both in the same Latino neighborhood (within 1/2 mile of each other), logically led us to believe we could best serve all clinic clients at one site. Clients at Centro San Jose were informed of the potential relocation of services and all indicated it would not be problematic, since the parking would be much improved at Lombard Street, and both were on the local bus line.**

2. **As of March 31, 2009, all case records of clients in the Centro San Jose clinic were moved to the Lombard Street clinic for filing and storage. The files and storage area were deemed acceptable during the DPH licensure visit to Lombard Street prior to issuance of the facility license #0375.**

3. Mr. James Osborne, Clinical Director, is responsible for clinic clients, files and staff at the Lombard Street site.

I hope this information is helpful to DPH and I again apologize for the confusion and delay in following the proper DPH protocols. Should you require additional information or have other concerns, please do not hesitate to contact Linda Smith at 860-728-2575.

Thank you for your patience and assistance in this matter.

Rose Alma Senatore  
(Signature)

7/17/09  
(Date)

Rose Alma Senatore, CEO  
Catholic Charities, Inc.-Archdiocese of Hartford

Subscribed and sworn to before me on: July 17, 2009  
(Date)

Alyson M. Karpic  
Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2013



**STATE OF CONNECTICUT**  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

December 2, 2009

VIA Facsimile Only

Linda S. Smith, LCSW  
Catholic Charities, Inc. - Archdiocese of Hartford  
839-841 Asylum Avenue  
Hartford, CT 06501

Re: Letter of Intent, Docket Number 09-31489  
Termination of Outpatient Psychiatric Services Clinic in New Haven  
Notice of Letter of Intent

Dear Ms. Smith,

On November 2, 2009, the Office of Health Care Access (“OHCA”) received the Letter of Intent (“LOI”) Form of Catholic Charities, Inc. - Archdiocese of Hartford (“Applicant”) for the termination of outpatient psychiatric services clinic in New Haven, with no associated capital expenditure.

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,

A handwritten signature in black ink, appearing to read "Kimberly R. Martone".

Kimberly R. Martone  
Director of Operations

KRM:lmg



**STATE OF CONNECTICUT**  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

December 2, 2009

Requisition # 29664

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, December 6, 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 at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

A handwritten signature in black ink, appearing to read "Kimberly R. Martone".

\_\_\_\_\_  
Kimberly R. Martone  
Director of Operations

Attachment

KRM:SWL:lmg

c: Danielle Pare, DPH

*An Equal Opportunity Employer*

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308  
Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688  
Fax: (860) 418-7053

**PLEASE INSERT THE FOLLOWING:**

Statute Reference: 19a-638  
Applicant: Catholic Charities, Inc.- Archdiocese of Hartford  
Town: New Haven  
Docket Number: 09-31489-LOI  
Proposal: Termination of Outpatient Psychiatric Services clinic  
Capital Expenditure: \$0

The Applicant may file its Certificate of Need application between January 1, 2010 and March 1, 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](http://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 0931  
RECIPIENT ADDRESS 98605489343  
DESTINATION ID  
ST. TIME 12/02 17:00  
TIME USE 00 '29  
PAGES SENT 4  
RESULT OK



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: LINDA S. SMITH, LCSW  
FAX: (860) 548-9243 9343  
AGENCY: CATHOLIC CHARITIES – ARCHDIOCESE OF HARTFORD  
FROM: STEVEN LAZARUS  
DATE: 12/2/09 TIME: \_\_\_\_\_  
NUMBER OF PAGES: 4  
(including transmittal sheet)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: Docket 09-31489 Notice of Letter of Intent

**PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.**

**Greer, Leslie**

---

**From:** ads [ads@graystoneadv.com]  
**Sent:** Wednesday, December 02, 2009 3:55 PM  
**To:** Greer, Leslie  
**Subject:** Re: Legal Notice Requisition 29664

Good day!

Thanks so much for your ad submission.  
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,  
Graystone Group Advertising

2710 North Avenue  
Bridgeport, CT 06604  
Phone: 800-544-0005  
Fax: 203-549-0061  
E-mail: ads@graystoneadv.com  
<http://www.graystoneadv.com/>

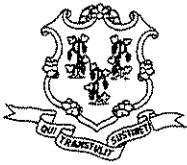
On 12/2/09 3:46 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

Good Afternoon,  
Please run the attached public notice in the New Haven Register by 12/6/09. Please call me if  
you have any questions.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
A Division of Department of Public Health  
State of Connecticut  
410 Capitol Avenue, MS#13HCA  
Hartford, CT 06134  
Phone: (860) 418-7001  
Fax: (860) 418-7053  
Website: [www.ct.gov/ohca](http://www.ct.gov/ohca) <<http://www.ct.gov/ohca>>

 Please consider the environment before printing this message



## STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

*Office of Health Care Access*

December 2, 2009

VIA FAX & EMAIL ONLY

Linda S. Smith, LCSW  
Catholic Charities, Inc.-Archdiocese of Hartford  
839-841 Asylum Avenue,  
Hartford, Connecticut 06501

RE: Certificate of Need Application Forms, Docket Number 09-31489-CON  
Chatholic Charties, Inc.-Archdiocese of Hartford  
Termination of Outpatient Psychiatric Service Clinic for Adults in New Haven

Dear Ms. Smith:

Enclosed are the application forms for the Chatholic Charities, Inc.- Archdiocese of Hartford (“Applicant”) Certificate of Need (“CON”) proposal for termination of outpatient psychiatric service clinic for adults in New Haven, Connecticut with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between ***January 1, 2010, and March 2, 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 five (5) hard copies of each submission in 3-ring binders.

*An Equal Opportunity Employer*

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308

Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688

Fax: (860) 418-7053

- 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 analyst assigned to the CON application is Steven W. Lazarus. Please contact him at (860) 418-7012 if you have questions.

Sincerely,



Kaila Riggott  
Planning Specialist

Enclosure

## GENERAL AFFIDAVIT

Applicant: \_\_\_\_\_

Project Title: \_\_\_\_\_

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.

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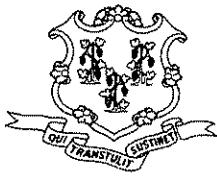
**Signature**

Date

Subscribed and sworn to before me on \_\_\_\_\_

Notary Public/Commissioner of Superior Court

My commission expires: \_\_\_\_\_



## 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, a response of "Not Applicable" may be acceptable. Your Certificate of Need application will be eligible for submission no earlier than January 1, 2010, and may be submitted no later than March 2, 2010. The OHCA analyst assigned to your application is Steven W. Lazarus. They may be reached at the Office of Health Care Access by dialing (860) 418-7012.

**Docket Number:** 09-31489-CON

**Applicant Name:** Chatholic Charities, Inc.-Archdiocese of Hartford

**Contact Person:** Linda S. Smith, LCSW  
**Contact Address:** 839-841 Asylum Avenue  
Hartford, CT 06501

**Project Location:** New Hvaen

**Project Name:** Termination of Outpatient Psychiatric Services for Adults  
in New Haven

**Proposal Type:** Section 19a-638, C.G.S.

**Estimated Total  
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. For each provider to whom the Applicant proposes to transfer or refer clients, provide the current available capacity, as well as the total capacity and actual utilization for the current year and last completed year.
- c. Discuss what steps the Applicant has undertaken to ensure continued access to the services proposed for termination for the Applicant's patients.
- d. Identify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes.
- e. 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.
- f. 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 ***	
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:

- Average daily census;
- Number of clients on the last day of the month;
- Number of clients admitted during the month; and
- Number of clients discharged during the month.

#### **4. Quality Measures**

- Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.
- Explain how this proposal contributes to the quality of health care delivery in the region.
- Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.
- 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.

8.

<b>Financial Attachment I</b>									
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	(1)	(2)	(3)	(4)	(5)	(6)	(7)
<b>FY</b>									
<b>FY Projected Incremental</b>									
Total Incremental Expenses:									
Total Facility by Payer Category:									
Medicare									
Medicaid									
CHAMPS/TriCare									
<b>Total Governmental</b>			0		\$0	\$0	\$0	\$0	\$0
Commercial Insurers									
Uninsured									
<b>Total NonGovernment</b>			\$0	0	\$0	\$0	\$0	\$0	\$0
<b>Total All Payers</b>			\$0	0	\$0	\$0	\$0	\$0	\$0

**Financial Attachment II**

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

<u>Total Facility:</u> <u>Description</u>	<u>FY Actual Results</u>	<u>FY Projected W/out Project</u>	<u>FY Projected Incremental</u>	<u>FY Projected With Project</u>	<u>FY Projected W/out Project</u>	<u>FY Projected Incremental</u>	<u>FY Projected With Project</u>	<u>FY Projected W/out Project</u>	<u>FY Projected Incremental</u>	<u>FY Projected With Project</u>
Revenue from Operations										
Non-Operating Revenue										
Total Revenue:	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total Operating Expenses										
Revenue Over/(Under) Expense	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$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.

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\*\*\* TX REPORT \*\*\*  
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STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS

**FAX SHEET**

TO: LINDA S. SMITH, LCSW

FAX: (860) 548-9343

AGENCY: CATHOLIC CHARITIES, INC. – ARCHDIOCESE OF HARTFORD

FROM: STEVEN LAZARUS

DATE: 12/3/09 TIME: \_\_\_\_\_

NUMBER OF PAGES: 11

*(including transmittal sheet)*

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Comments: Docket 09-31489-CON

***PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.***