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	JACK DEGRADO, DDS	
Doing Business As	STAFMORD DETNAL GROUP LLC	
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	P	
Does the Applicant have Tax Exempt Status?	No	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	DR JACK DEGRADO OWNER AND MANAGING AGENT	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	47 OAK STREET, STAMFORD, CT 06905	
Contact Person Telephone Number	203 325 4700	
Contact Person Fax Number	203 327 7832	
Contact Person e-mail Address	DRJACK@STAMFORDDENTALGROUP.COM	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: AQISITION OF A CONE BEAM CT UNIT

b. Project Proposal: _____

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 X New Technology: ____CONE BEAM CT UNIT_____

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 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:

__47 OAK STREET, STAMFORD, CT 06905_____

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

_____STAMFORD_____

h. Estimated starting date for the project: _____JANUARY 2010_____

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: $ $120,000.00

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

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	120,000.00
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	120,000.00
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
CONE BEAM CT	9500	KODAK	1	120,000.00

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):

X Applicant's Equity	☐ Capital Lease	X 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: Jack DeGrado DDS

Project Title: Cone Beam CT Acquisition

I, Jack Degrado (Name), Managing Agent (Position – CEO or CFO)

of Stamford Dental Group LLC 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 Stamford Dental Group LLC (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 11/20/09 Date

Subscribed and sworn to before me on 11/20/2009

Notary Public/Commissioner of Superior Court

My commission expires: ALBERT J. PALATELLO JR. NOTARY PUBLIC MY COMMISSION EXPIRES OCT. 31, 2013

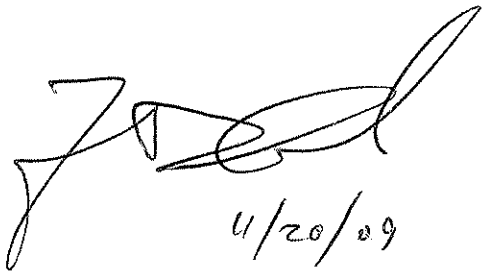
CERTIFICATE OF NEED DETERMINATION
Jack DeGrado, DDS, prosthodontist
Stamford Dental Group, LLC

Cone Beam CT is quickly becoming the standard of care in dentistry. It is a modality by which three dimensional imaging of jaws and dental structures can be viewed with great detail and much less radiation than conventional CT imaging. Currently, there are no other cone beam CT units in Fairfield County.

The imaging services will be provided to people who are patients of Stamford Dental Group, LLC. The imaging will help diagnose bone infections, third molar impactions, pathology, tooth fractures as well as dental implant planning with much more detail and less radiation than conventional CT units. The current patients of record at our office, as well as the remaining Stamford population, have to travel to Hartford or New York for this type of imaging.

The imaging would be done at Stamford Dental Group LLC, for our patients. The studies would be taken and interpreted by a licensed provider.

Cone beam CT is becoming recognized nationally as the standard of care in three dimensional imaging for dentistry. At the present time, dentists in Connecticut do not have access to this technology and are being forced to perform surgical procedures below the standard of care. There is a case in California where a dentist was sued for not having this technology. A Connecticut dentist could be next. Further more, cone beam imaging is significantly less expensive than traditional CT. CT imaging for dental procedures is not reimbursed by dental or medical insurance, therefore patients are reluctant to pay for CT imaging because it is a big out of pocket expense. Cone beam CT imaging is less expensive, provides more detail and is over 40 times less radiation to the patient. Cone beat CT will have a great beneficial impact in the way we provide dental care to our patients.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 8, 2009 Facsimile Only

Jack Degrado, DDS
Owner and Managing Agent
Stamford Dental Group, LLC
47 Oak Street
Stamford, CT 06905

Re: Letter of Intent, Docket Number 09-31501
Acquisition of a 3-D Cone Beam Computed Tomography Scanner
Notice of Letter of Intent

Dear Dr. Degrado,

On November 24, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Stamford Dental Group, LLC ("Applicant") for acquisition of a 3-D Cone Beam Computed Tomography Scanner in Stamford, with a total capital expenditure of $120,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Advocate* pursuant to Section 19a-639 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

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 8, 2009 Requisition # 029713

The Advocate
75 Tresser Blvd.
Stamford, CT 06903

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 **Saturday, December 12, 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,

Kimberly R. Martone
Director of Operations

Attachment

KRM:SWL:lmg

c: Danielle Pare, DPH

The Advocate
Docket Number 09-31501

Letter of Intent
December 8, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Stamford Dental Group, LLC
Town(s):	Stamford
Docket Number:	09-31501-LOI
Proposal:	Acquisition of a 3-D Cone Beam Computed Tomography Scanner
Capital Expenditure:	$120,000

The Applicant may file its Certificate of Need application between January 23, 2010 and March 24, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health , 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available for inspection at 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.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Tuesday, December 08, 2009 3:20 PM
To: Greer, Leslie
Subject: Re: Legal Ads

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 12/8/09 3:15 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

> Laurie,
> Please run the attached public notices by 12/12/09. I have attached a notice for the Norwich Bulletin & Stamford Advocate. Please call me if you have any questions. Requisition # along with approval to follow shortly, 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>*
> Please consider the environment before printing this message

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*** TX REPORT ***
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TRANSMISSION OK

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RECIPIENT ADDRESS	912033277832
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ST. TIME	12/09 11:17
TIME USE	00'39
PAGES SENT	4
RESULT	OK

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

FAX SHEET

TO: JACK DEGRADO, DDS

FAX: (203) 327-7832

AGENCY: STAMFORD DENTAL GROUP, LLC

FROM: STEVEN LAZARUS

DATE: 12/9/09 **TIME:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Docket 09-31501

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.