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**State of Connecticut  
Office of Health Care Access  
Letter of Intent Form  
Form 2030**

CONNECTICUT OFFICE OF  
HEALTH CARE ACCESS

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	Children's Home Community Services, Inc.	
Doing Business As	Children's Home Community Services, Inc.	
Name of Parent Corporation	Children's Home Community Services, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	58 Missionary Rd Cromwell, CT 06416	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
Does the Applicant have Tax Exempt Status?	Yes      No <input checked="" type="checkbox"/>	Yes      No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Tony Gibson Director, Community Services, Inc.	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	58 Missionary Rd Cromwell, CT 06416	
Contact Person Telephone Number	860-635-6010 x325	
Contact Person Fax Number	860-632-3216	
Contact Person e-mail Address	TGibson@childhome.org	

**SECTION II. GENERAL APPLICATION INFORMATION**

- a. Project Title: Family Counseling Center
- b. Project Proposal: expand to include adult outpatient servicing
- 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:  
58 Missionary Road, Cromwell, CT 06416

- g. List each town this project is intended to serve:  
All CT towns

- h. Estimated starting date for the project: upon approval

- 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: \$ n/a
- 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: _____	
<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

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):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Applicant's Equity       | <input type="checkbox"/> Capital Lease   | <input type="checkbox"/> Conventional Loan |
| <input type="checkbox"/> Charitable Contributions | <input type="checkbox"/> Operating Lease | <input type="checkbox"/> CHEFA Financing   |
| <input type="checkbox"/> Funded Depreciation      | <input type="checkbox"/> Grant Funding   |  |
| <input type="checkbox"/> 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.

PLEASE SEE ATTACHED

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

PLEASE SEE ATTACHED

3. Identify the current population served and the target population to be served.

PLEASE SEE ATTACHED

4. Identify any unmet need and describe how this project will fulfill that need.

PLEASE SEE ATTACHED

5. Are there any similar existing service providers in the proposed geographic area?

PLEASE SEE ATTACHED

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

PLEASE SEE ATTACHED

7. Who will be responsible for providing the service?

PLEASE SEE ATTACHED

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

PLEASE SEE ATTACHED

**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.

**The Children's Home Community Services, Inc. (TCH CSI) hosts a number of programs to include the Family Counseling Center - a DCF licensed Outpatient Psychiatric Clinic for Children & Adolescents. This center provides child-centered psychiatric and therapeutic servicing utilizing individual, family and group modalities. Group offerings include gender-specific Anger Management programs, Social-Relational Skill groups for adolescents, a "Friendship Circle" for young children, parenting psychoeducational groups, and Substance Abuse Prevention groups and seminars. The center is credentialed through Advanced Behavioral Health to provide a Military Support Program supported by the governor's initiative of 2007. The center maintains DCF credentialing for Supervised Visitation (SV) and also provides private SV services for attorneys and courts in the greater Middletown area.**

**TCH CSI programs also include 3 DCF-licensed Therapeutic (Level II) Group Homes for young women ages 13-21 with intensive psychiatric challenge; 2 DCF contracts to provide Ansel-Casey Community Based Life Skills in Middletown and Meriden; and a school-based contract with the Southington BOE working with identified students at risk of educational outplacement due to behavioral health issues.**

**TCH CSI holds current COA (Council of Accreditation). CSI's corporate partner, The Children's Home of Cromwell, provides residential services for children ages 12-18, residential care for developmentally disabled children with behavioral health challenge, a clinical residential and day school, and a Training Academy with full Ropes Course.**

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

**The Family Counseling Center proposes to expand outpatient servicing to provide for the adult population (Behavioral Health – Psychiatric).**

3. Identify the current population served and the target population to be served.

**Current populations served are children and adolescents ages 5-18 and their parents, guardians or caregivers. The center accepts both DCF clients as well as private / 3<sup>rd</sup>-party payers from the community-at-large.**

**Target for expansion is the adult population not connected to a child in treatment (individuals, couples, marital & partnerships, adult groups).**

4. Identify any unmet need and describe how this project will fulfill that need.

**The outpatient center has identified this need through continual requests from consumers in the community for adult-centered servicing, both independent and/or concurrent with a child's treatment. The center already possesses all necessary resources (both psychiatric and therapeutic) for provision of this treatment. All clinical staff meet educational and professional criteria for delivery of adult servicing. Service provision will better enable full family system involvement and healing. Expansion to provide adult services will increase availability of community-based continuity of care as TCH CSI is able to provide comprehensive psychiatric, therapeutic and case management services at one location.**

**The center is successful in providing aftercare for clients being discharged from Intensive Outpatient and Partial Hospitalization programs due to the ability to provide psychiatric evaluation and medication monitoring alongside conventional therapy and discharge planning assistance.**

**Provision of adult services will reduce lengthy wait lists for our geographic area and will also diminish the need for residents to travel to other regions such as Hartford/New Britain or Meriden/Wallingford for psychiatric and therapeutic intervention.**

5. Are there any similar existing service providers in the proposed geographic area?

**Connecticut Valley Hospital, Community Health Center, Middlesex Hospital in Middletown, with which we share a collaborative networking for program initiatives and community outreach. The Children's Home is a member and active proponent of the Greater Middlesex Community Collaborative and the Middletown Area Advisory Council.**

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

**This proposal will provide adults greater access to comprehensive psychiatric, therapeutic, case management, process groups, military support and supervised visitation services. As the state seeks to privatize needed servicing and to find ways of reducing deficit this expansion will assist, at least in part, to provide more expansive community-based behavioral healthcare. The agency's outpatient center rarely waitlists referrals and we hold an established reputation for immediate therapist assignment, client intake and processing. Our outcome data reflects that callers are given a date for diagnostic assessment by the therapist assigned within 3 business days of initial contact.**

7. Who will be responsible for providing the service?

**The Family Counseling Center maintains long-standing contracts with a psychiatrist who serves as Medical Director, APRN (as census dictates), LMFT's, LCSW's, LPC's, CAC's and a CPP-R. The center also has access to a psychologist, dietician, and behavioral consultant when needed. The center currently has 7 licensed clinicians, 3 master-level license eligible clinicians and graduate-level clinical interns. Clinical contracts are increased/ added as demand dictates.**

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

**The Family Counseling Center accepts most major commercial insurance to include Anthem BC/BS and its subsidiaries, Aetna, United Health Care, Magellan Health Network, United Behavioral Health, Advanced Behavioral Health. We are currently seeking to credential with Oxford, Connecticut, TriCare and Cigna. Cigna contracts with the center for out-of-network benefits. The center also accepts Husky, Charter Oak, Medicaid, CT-BHP, and Title 19.**

**AFFIDAVIT****To be completed by each Applicant**Applicant: Children's Home Community Services, Inc.Project Title: Family Counseling Center

I, Garrell S. Mullaney, CEO  
 (Name) (Position – CEO or CFO)  
 of Children's Home Community Services, 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 Children's Home Community Services, Inc. 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.

Signature

Date

Subscribed and sworn to before me on

Notary Public/Commissioner of Superior Court

**DAVID W. MAIBAUM**  
**NOTARY PUBLIC**

My commission expires:

MY COMMISSION EXPIRES MAR 31, 2010

RECEIVED  
 2010 FEB - 1 12:10  
 CONNECTICUT OFFICE OF  
 HEALTH CARE ACCESS





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

February 11, 2010

Facsimile Only

Tony Gibson  
Director, Community Services  
Children's Home Community Services, Inc.  
58 Missionary Road  
Cromwell, CT 06416

Re: Letter of Intent; Docket Number: 10-31534  
Children's Home Community Services, Inc.  
Expansion of Outpatient Psychiatric Behavioral Health Services to Adults in  
Cromwell

Dear Mr. Gibson,

On February 10, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Children's Home Community Services, Inc. ("Applicant") for the expansion of outpatient psychiatric behavioral health services to adults in Cromwell, with no capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Middletown Press* 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 "Kim Martone".

Kimberly R. Martone  
Director of Operations

KRM:lmg



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

February 11, 2010

Requisition # 30333

The Middletown Press  
2 Main Street, Box 471  
Middletown, CT 06457

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 **Monday, February 15, 2010**.

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 Carmen Cotto at 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim Martone", written over a horizontal line.

Kimberly R. Martone  
Director of Operations

Attachment

KRM:CC:lmg

c: Danielle Pare, DPH

**PLEASE INSERT THE FOLLOWING:**

Statute Reference:	19a-638
Applicant:	Children's Home Community Services, Inc.
Town:	Cromwell
Docket Number:	10-31534-LOI
Proposal:	Expansion of Outpatient Psychiatric Behavioral Health Services to adults
Capital Expenditure:	\$0

The Applicant may file its Certificate of Need application between April 11, 2010 and June 10, 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 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 Applicant.

\*\*\*\*\*  
\*\*\* TX REPORT \*\*\*  
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RECIPIENT ADDRESS 98606323216  
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RESULT OK



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

FAX SHEET

TO: TONY GIBSON

FAX: (860) 632-3216

AGENCY: CHILDREN'S HOME COMMUNITY SERVICES, INC.

FROM: CARMEN COTTO  
2/11/10

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

NUMBER OF PAGES: 4  
*(including transmittal sheet)*

Comments: Docket 10-31534

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

**Greer, Leslie**

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**From:** Laurie [Laurie@graystoneadv.com]  
**Sent:** Thursday, February 11, 2010 3:36 PM  
**To:** Greer, Leslie  
**Subject:** FW: Legal Ad Middletown Press  
**Attachments:** 10-31534 Middletown Press.doc

Your legal notice is all set to run as follows:

Middletown Press, 2/15 issue - \$83.19

Let me know your PO # when you get a chance...

Thanks,  
Laurie Miller

Graystone Group Advertising  
2710 North Ave., Ste 200, Bridgeport, CT 06604  
Ph: 203-549-0060, Fax: 203-549-0061  
email: [laurie@graystoneadv.com](mailto:laurie@graystoneadv.com)  
[www.graystoneadv.com](http://www.graystoneadv.com)


----- Forwarded Message

**From:** "Greer, Leslie" <Leslie.Greer@ct.gov>  
**Date:** Thu, 11 Feb 2010 15:01:41 -0500  
**To:** ads <ads@graystoneadv.com>  
**Conversation:** Legal Ad Middletown Press  
**Subject:** Legal Ad Middletown Press

To Whom It May Concern,  
Please run the attached public notice in The Middletown Press by February 15, 2010. Please do hesitate to contact me if you have any questions regarding this request.

Thank you,

Leslie M. Greer x  
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

----- End of Forwarded Message

----- End of Forwarded Message

2/11/2010