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	Dennis S. Gianoli	
Doing Business As	Dennis Gianoli, DDS	
Name of Parent Corporation		
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	5 Webster Sq. Rd. Berlin, CT 06037	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes (No)	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Dennis Gianoli, DDS	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	5 Webster Sq. Rd. Berlin, CT 06037	
Contact Person Telephone Number	(860) 828-3559	
Contact Person Fax Number	(860) 828-1485	
Contact Person e-mail Address	info@drgianoli.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Panoramic X-Ray/Limited Cone Beam Scanner

b. Project Proposal: Purchase of Panoramic X-ray/ Limited Cone Beam Scanner

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s): n/a

- ☐ 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)* Oral & Maxillofacial Surgery Office

Imaging:

- ☐ MRI ☐ CT Scanner ☐ PET Scanner
- ☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
- ☐ Cineangiography Equipment ☒ New Technology: Panorex/Limited Cone Beam Scanner

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:

5 Webster Square Road, Berlin, CT 06037

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

Hartford County (Berlin, Kensington, Cromwell, Meriden, Southington, Plainville, Newington, Hartford, Farmington, Unionville, Rocky Hill)

h. Estimated starting date for the project: 2/2/10

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: $117561.52

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

Major Medical Equipment Purchases*	107,561.52
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	10,000.00
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	117,561.52
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	117,561.52
Total Project Cost	117,561.52
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
Duo Cl 3D Pan	Vatek	PaX-Duo 3D	1	$99,000.00

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):

☒ 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: Dennis S. Gianoli

Project Title: Panorex/Limited Cone Beam Scanner

I, Dennis Gianoli D.D.S. (Name), Oral & Maxillofacial Surgeon (Position – CEO or CFO)

of 5 Webster Sq., Berlin, CT 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 5 Webster Square Rd. Berlin, CT (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 2/2/10 Date

Subscribed and sworn to before me on 2/2/2010

Notary Public/Commissioner of Superior Court

My commission expires: 8/31/2011

RONALD A. BIELOMYZA
NOTARY PUBLIC * CT.
MY COMM. EXPIRES
AUG. 31, 2011

DENNIS S. GIANOLI, D.D.S., P.C.
Oral & Maxillofacial Surgeon

5 Webster Sq. Rd.
Berlin, CT 06037
Telephone: (860) 828-3559

Response Section IV. Project Description

#1 The type of services currently provided are full scope outpatient Oral and Maxillofacial Surgery which would include Dento-Alveolar Surgery, Surgical Pathology, Trauma, Correction of Cranio-Facial Deformities and Implant Surgery. A copy of my license is enclosed.

#2 The scope of services will remain as above and no new licensure will be sought.

#3 The current population serviced includes predominately the Hartford County but is not limited and also includes population throughout the state and surrounding states.

#4 Currently unmet needs can be described as an inability to receive immediate scans with any scheduling ease. The nearest unit is at the University and is a full scan, not limited, which increases the amount of radiation exposure unnecessarily for the majority of cases. Scheduling can be cumbersome with inappropriate delay in procedure turn over.

#5 To my knowledge there are no Limited Cone Beam Scanners/Panoramic units in the immediate area. All the existing units are full scanners which give the patients a greater radiation exposure.

#6 The anticipated effect of this proposal will allow a scan with greatly reduced radiation exposure to Hartford and surrounding counties.

#7 The responsible party for providing this service will be Dennis Gianoli D.D.S., Board Certified Oral and Maxillofacial Surgeon.

#8 The current payers of this service are the Medical Insurance Carriers.

STATEMENT OF MEDICAL NECESSITY

(PLEASE PRINT CLEARLY)

Please note: Physician to complete for insurance reimbursement processing.

ORDERING PHYSICIAN INFORMATION

Name: _____ (Last / First / Middle Initial) Insurance ID#: _____

Address: _____ (Street / City / State / Zip)

Contact #: ( ) _____ ( ) _____ (Phone / Fax) Off. Manager: _____ ( ) _____ (Name / Phone)

PATIENT INFORMATION

Name: _____ (Last / First / Middle Initial) Date of service: _____ (mm/dd/20yy)

Address: _____ (Street / City / State / Zip)

Contact # ( ) _____ ( ) _____ (Phone / Fax) ID# _____ (Health Plan / Group)

DOCUMENTATION

RELEVANT PATIENT HISTORY – The patient reported the following:

PHYSICAL FINDINGS – The patient presented with the following signs and or symptoms:

CONE BEAM COMPUTED TOMOGRAPHY HAS BEEN ORDERED FOR THE FOLLOWING PATIENT TO CONFIRM THE CLINICAL IMPRESSION OF OR RULE OUT ONE OR MORE OF THE FOLLOWING SUSPECTED CONDITIONS (ICD9)

DISEASES OF THE JAWS
- ☐170.1 Malignant neoplasm of bone; mandible
- ☐213.0 Benign neoplasm of bone; maxilla
- ☐213.1 Benign neoplasm of bone; mandible
- ☐237.7 Neurofibromatosis, unspecified
- ☐350.1 Trigeminal neuralgia
- ☐526.0 Developmental odontogenic cysts
- ☐526.1 Fissural cysts of jaw
- ☐526.2 Other cysts of jaws
- ☐526.3 Central giant cell granuloma
- 526.4 Osteitis, Osteomyelitis, Periostitis
- ☐526.5 Alveolitis of Jaw
- ☐526.8 Other specified diseases the jaws
- ☐526.81 Exostosis of jaw
- ☐526.89 Fibrous dysplasia of jaws
- ☐526.89 Osteoradionecrosis
- ☐526.89 Unilateral condylar/coronoid hyperplasia
- ☐526.89 Mandibular hypoplasia
- ☐534.60 TMJ disorders, unspecified

DENTAL - TOOTH
- ☐520.0 Anodontia
- ☐520.1 Supernumerary teeth
- ☐520.2 Abnormalities of size and form (fusion, gemination)
- ☐520.4 Disturbances of tooth formation (enamel hypoplasia)
- ☐520.5 Hereditary disturbances in tooth structure, (i.e. amelogenesis imperfecta)
- ☐520.6 Disturbances in tooth eruption (i.e. impacted)
- ☐521.4 Pathological resorption
- ☐521.6 Ankylosis
- ☐522.4 Acute apical periodontitis of pulpal origin
- ☐522.5 Periapical abscess without sinus
- ☐522.6 Chronic apical periodontitis
- ☐522.7 Periapical abscess with sinus
- ☐522.8 Radicular cyst
- ☐523.3 Acute periodontitis (i.e. periodontal abscess)
- ☐523.4 Chronic periodontitis (i.e. chronic pericoronitis)

TMJ JOINT DISORDERS
- ☐524.60 Unspecified TMJ disorders
- ☐524.61 Adhesions and ankylosis (bony or fibrous)
- ☐524.62 TMJ osteoarthritis
- ☐524.63 Articular disc disorder (reducing or nonreducing)
- ☐524.69 Other specified TMJ disorders

DENTOFACIAL ANOMALIES
- ☐524.00 Unspecified major anomaly of jaw size
- ☐524.01 Maxillary hyperplasia
- ☐524.02 Mandibular hyperplasia
- ☐524.03 Maxillary hypoplasia
- ☐524.04 Mandibular hypoplasia
- ☐524.05 Macrogenia
- ☐524.06 Microgenia
- ☐524.09 Other specified major anomaly of jaw size
- ☐524.1 Anomalies of relationship of jaw to cranial base
- ☐524.10 Unspecified anomaly (Prognathism, Retrognathism)
- 524.11 Maxillary asymmetry
- ☐524.12 Other jaw asymmetry
- ☐524.19 Other specified anomaly
- ☐524.2 Anomalies (dental arch relationship)
- ☐524.3 Anomalies of tooth position
- ☐524.33 Alveolar mandibular hypoplasia
- ☐524.4 Malocclusion, unspecified
- ☐524.5 Dentofacial functional abnormalities

DENTAL ALVEOLAR ANOMALIES
- ☐524.7 Dental alveolar anomalies
- ☐524.70 Unspecified alveolar anomaly
- ☐524.71 Alveolar maxillary hyperplasia
- ☐524.72 Alveolar mandibular hyperplasia
- ☐524.73 Alveolar maxillary hypoplasia
- ☐524.74 Alveolar mandibular hypoplasia
- ☐524.79 Other specified alveolar anomaly
- ☐525.1 Loss of teeth due to trauma, extraction or periodontal disease
- 525.10 Acquired absence of teeth, unspecified
- ☐525.11 Loss of teeth due to trauma
- ☐525.20 Unspecified atrophy of edentulous alveolar ridge
- ☐525.21 Minimal atrophy of mandible
- ☐525.22 Moderate atrophy of mandible
- ☐525.23 Severe atrophy of mandible
- ☐525.24 Minimal atrophy of maxilla
- ☐525.25 Moderate atrophy of maxilla
- ☐525.26 Severe atrophy of maxilla
- ☐525.3 Retained dental root
- 525.8 Enlargement of alveolar ridge NOS

CRANIOFACIAL
- ☐749.2 Cleft palate with cleft lip
- ☐754.0 Hemifacial atrophy or hypertrophy
- ☐755.59 Cleidocranial dysplasia
- ☐756.0 Anomalies of Skull/Face
- ☐759.89 Basal Cell Nevus Syn

FRACTURE
- ☐802.31 Mandible Fx; condylar, closed
- ☐802.32 Mandible Fx; subcondylar, closed
- ☐802.35 Mandible Fx; angle, closed
- ☐802.36 Mandible Fx; symphysis, closed
- ☐802.37 Mandible Fx; alveolar, closed
- ☐802.38 Mandible Fx; body, closed
- ☐802.39 Mandible Fx; multiple, closed
- ☐802.4 Maxilla Fx; closed
- ☐802.6 Orbit Fx; closed
- ☐802.8 Facial Fx; alveolus, palate, closed
- ☐873.63 Fractured tooth/teeth
- ☐873.73 Fractured tooth/teeth, complicated

MISCELLANEOUS
- ☐733.29 Fibrous dysplasia; monostotic
- ☐733.10 Pathologic fracture, unspecified site
- ☐733.4 Aseptic necrosis of bone
- ☐733.81 Malunion
- ☐714.0 Rheumatoid arthritis
- ☐714.30 Juvenile rheumatoid arthritis
- ☐715.8 Osteoarthritis; other specified sites
- ☐784.0 Headache; Facial pain

TEMPORAL BONE / SINUS
- ☐387.2 Otosclerosis, cochlear
- ☐461 Sinusitis, acute
- ☐473.7 Pan-sinusitis, chronic
- ☐473.9 Sinusitis, chronic
- ☐784.2 Mass in nose or sinus

Other:

STATEMENT OF MEDICAL NECESSITY

(PLEASE PRINT CLEARLY)

MAXILLOFACIAL CONE BEAM COMPUTED TOMOGRAPHY (CPT: 70486) AND THREE DIMENSIONAL (3D) REFORMATTING OF THE AXIAL DATA (CPT: 76377) IS THE OPTIMUM IMAGING MODALITY IN THIS CASE BECAUSE IT:

- ❑ Provides accurate assessment of location, size shape, extent of involvement of pathology affecting the maxillofacial structures.
- ❑ Clearly identifies all pertinent bony anatomic structures (e.g. inferior alveolar canal, maxillary sinus) in three dimensions prior to surgery, minimizing untoward sequelae.
- ❑ Can confirm or rule out the presence of pathology or a condition accounting or contributing to the clinical diagnostic impression.

Other: _____

_____

_____

_____

Physician Certification: I certify the medical necessity of the above item(s) for this patient. I have personally completed this form, or directly supervised the completion of this form by my employees. The foregoing information is true, accurate, and complete, to the best of my knowledge.

Physician Signature:_____ Date: _____/_____/ 20____

INSTRUCTIONS:

1. Detach and sign each of the cards on this form.
2. Display the large card in a prominent place in your office or place of business.
3. The wallet card is for you to carry on your person. If you do not wish to carry the wallet card, place it in a secure place.
4. The employer's copy is for persons who must demonstrate current licensure/certification in order to retain employment or privileges. The employer's card is to be presented to the employer and kept by them as a part of your personnel file. Only one copy of this card can be supplied to you.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

PURSUANT TO THE PROVISIONS OF THE GENERAL STATUTES OF CONNECTICUT

THE INDIVIDUAL NAMED BELOW IS LICENSED BY THIS DEPARTMENT AS A

DENTIST

LICENSE NO. 004901

CURRENT THROUGH 08/31/10

VALIDATION NO. 03-865648

DENNIS S. GIANOLI DDS

SIGNATURE

J Robert Galvin, MD, MPH, MBA
COMMISSIONER

EMPLOYER'S COPY

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

NAME

DENNIS S. GIANOLI DDS

VALIDATION NO.	LICENSE NO.	CURRENT THROUGH
03-865648	004901	08/31/10

PROFESSION

DENTIST

SIGNATURE

J Robert Galvin, MD, MPH, MBA
COMMISSIONER

WALLET CARD

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

NAME

DENNIS S. GIANOLI DDS

VALIDATION NO.	LICENSE NO.	CURRENT THROUGH
03-865648	004901	08/31/10

PROFESSION

DENTIST

SIGNATURE

J Robert Galvin, MD, MPH, MBA
COMMISSIONER

Dennis Gianoli

From: <annual.registration@aboms.org>
To: <info@drgianoli.com>
Sent: Monday, November 02, 2009 12:52 PM
Subject: ABOMS - 2010 Annual Registration Complete

Thank you for completing your 2010 Annual Registration at the American Board of Oral and Maxillofacial Surgery website (www.aboms.org). Keep this confirmation for your records.

Name: Dennis Gianoli
Diplomate ID: 9528
Transaction Number: VPFN4BD870C9
Transaction Amount: $125.00
Transaction Date: 11/02/2009

Should you have questions concerning your 2010 Annual Registration please call (866) 880-3201 or email annual.registration@aboms.org.

American Board of Oral and Maxillofacial Surgery

THIS IS TO CERTIFY THAT

DENNIS S. GIANOLI

HAS FULFILLED THE REQUIREMENTS OF THIS BOARD AND IS HEREBY GRANTED THIS

CERTIFICATE OF QUALIFICATION

FOR THE PRACTICE OF ORAL AND MAXILLOFACIAL SURGERY

APRIL 6, 1984

CORPORATE SEAL ILLINOIS

VICE PRESIDENT

PRESIDENT

SECRETARY-TREASURER

Benco Dental

Equipment Proposal

Equipment Specialist:
Territory Rep:

Sold To:	Ship To	
92106044	SAME	98
EQAC DR DENNIS GIANOLI		
5 WEBSTER SQUARE		
BERLIN, CT 06037-2436		
860-828-3559		

Contact:	None
Quote # :	721
Reference # :	0000000721
Ship Via:	USUAL METHOD
Coupon:	
Req Date:	
Exp Date:	3/3/2010
Tax %:	8.00%

Qty	Benco #	Mfgr.	Mfgr #	Description	U/M	Retail	Price	Ext. Price H
1	4168-616	VATEC	DUOC112X8	DUO C1 3D PAN 12X8	EA	$110,000.00	$99,000.00	$99,000.00

Sub Total	$99,000.00
Freight	$594.00
Estimated Tax	$7,967.52
Total Investment	$107,561.52

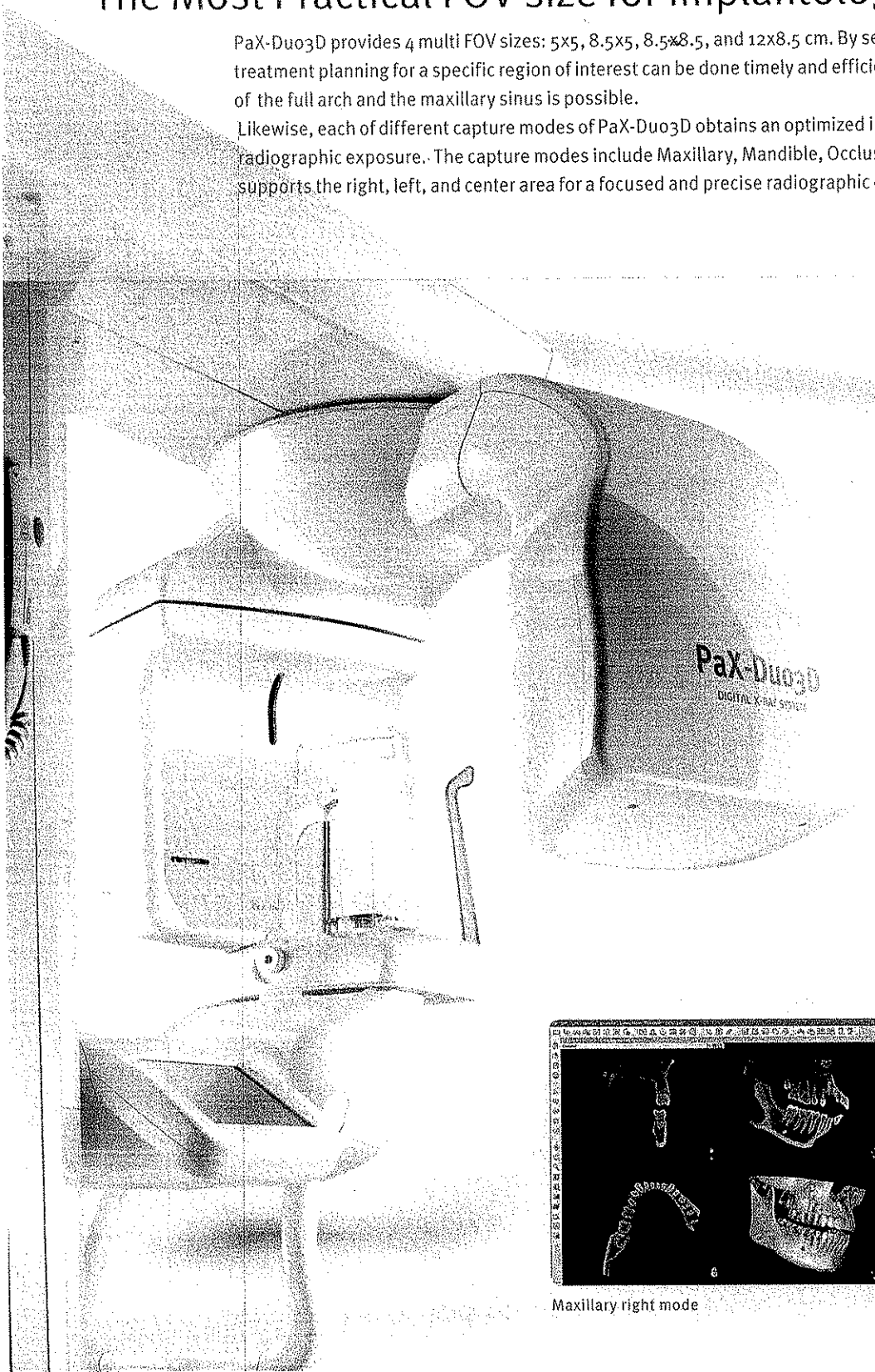
H = Hazardous item, special shipping charge will apply.

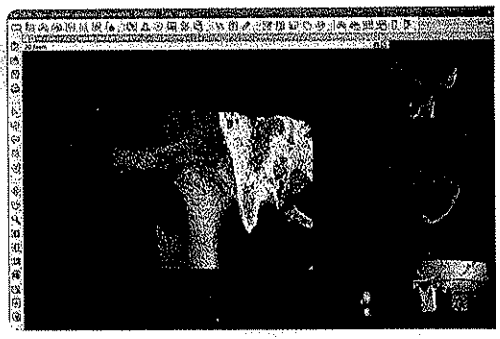
:PaX-Duo3D _ Flexible Diagnosis System

The Most Practical FOV size for Implantologists & Oral Surgeons

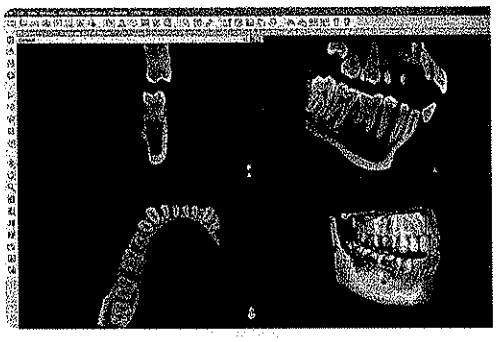
PaX-Duo3D provides 4 multi FOV sizes: 5x5, 8.5x5, 8.5x8.5, and 12x8.5 cm. By selecting an appropriate FOV size, a case diagnosis and a treatment planning for a specific region of interest can be done timely and efficiently. With the 12x8.5 FOV size, a simultaneous review of the full arch and the maxillary sinus is possible.

Likewise, each of different capture modes of PaX-Duo3D obtains an optimized image of the region of interest with a miminum radiographic exposure. The capture modes include Maxillary, Mandible, Occlusion, and TMJ. Furthermore, each mode specifically supports the right, left, and center area for a focused and precise radiographic diagnosis.



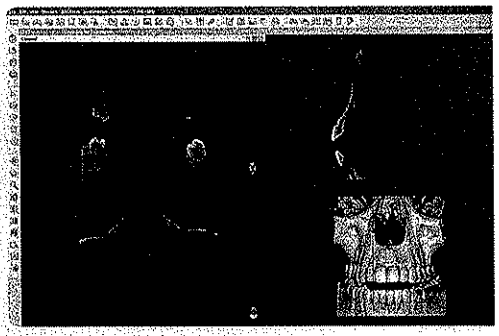


TMJ right mode



Mandible right mode

Maxillary right mode



Maxillary center mode

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

February 11, 2010 Facsimile Only

Dennis Gianoli
Dennis Gianoli, DDS
5 Webster Square Road
Berlin, CT 06037

Re: Letter of Intent; Docket Number: 10-31537
Dennis Gianoli, DDS
Acquisition of a Cone Beam CT Scanner

Dear Dr. Gianoli,

On February 4, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Dennis Gianoli, DDS ("Applicant") for the acquisition of a Cone Beam CT Scanner in Berlin, with a total capital expenditure of $117,562.

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

February 11, 2010 Requisition # 30304

The Herald
One Herald Square
New Britain, CT 06050

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 Steven Lazarus at 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 Herald **Letter of Intent**
Docket Number: 10-31537 **February 11, 2010**

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-639
Applicant:	Dennis Gianoli, DDS
Town:	Berlin
Docket Number:	10-31537-LOI
Proposal:	Acquisition of a Cone Beam CT Scanner
Capital Expenditure:	$117,562

The Applicant may file its Certificate of Need application between April 5, 2010 and June 4, 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. 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	1232
RECIPIENT ADDRESS	98608281485
DESTINATION ID	
ST. TIME	02/10 11:49
TIME USE	01'04
PAGES SENT	4
RESULT	OK

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

FAX SHEET

TO: **DENNIS GIANOLI, DDS**

FAX: **(860) 828-1485**
DENNIS GIANOLI, DDS

AGENCY:

FROM: **STEVEN LAZARUS**
2/10/10

DATE: **TIME:**

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

Comments: Docket 10-31537

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Tuesday, February 09, 2010 3:47 PM
To: Greer, Leslie
Subject: Re: Various Newspaper Notices

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 2/9/10 3:44 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

> To Whom It May Concern,
> Please run the attached newspaper notice in the following newspapers:
>
> The Herald Docket 10-31537
> The Day Publishing Co. 10-31532
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