Chemical Abuse Services Agency, Inc.

CASA HOSTOS
690 Arctic St.
Bridgeport, CT 06608
(203) 339-4112
(203) 339-4115 Fax

MAAS
426 East St.
New Haven, CT 06511
(203) 495-7710
(203) 495-7713 Fax

PROJECT COURAGE
592 Kossuth St.
Bridgeport, CT 06608
(203) 339-4777
(203) 339-4110 Fax

March 2, 2010

Asher Delerme, MS, LADC, CCS
Executive Director

Kristin Bonilla, MS, CADC
Associate Director

Commissioner of the Office of Health Care Access
410 Capitol Avenue
3rd floor, MS, 13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner:

Enclosed please find the OHCA Completed form 2030. If you have any questions or require any additional information, I can be reached at 203-495-7710 ext. 122.

Respectfully,

Kristin Bonilla, MS, CAC, CCDP, LADC
Associate Director, CASA, Inc.

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

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by the Applicant(s), pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

	Applicant One	Applicant Two
Full legal name	Chemical Abuse Services Agency, Inc.	
Doing Business As	Multicultural Ambulatory Addiction Services	
Name of Parent Corporation	Chemical Abuse Services Agency, Inc.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	690 Arctic Street, Bridgeport, CT 06608	
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	
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.	Kristin Bonilla Associate Director	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	426 East Street New Haven, CT 06511	
Contact Person Telephone Number	203-495-7710	
Contact Person Fax Number	203-495-7713	

Contact Person e-mail Address	kbonilla@casaincct.org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Primary Care Licensure Application/Multicultural Ambulatory Addiction Services

b. Project Proposal: Addition of Primary Care Licensure

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 x 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 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:

426 East Street, New Haven, CT 06511

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

Greater New Haven Area, New Haven, West Haven, East Haven, North Haven

h. Estimated starting date for the project: 4/1/10

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:_____	
Total Capital Expenditure	
Major Medical Equipment – Fair Market Value of Leases Medical	
Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

* Provide an itemized list of all medical and non-medical equipment to be purchased and leased.

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☐ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide a copy of the vendor contract or quotation for each major medical/imaging equipment.

e. Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity ☐ Capital Lease ☐ Conventional Loan
☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing
☐ Funded Depreciation ☐ Grant Funding
☐ Other *(specify)* _____

SECTION IV. PROJECT DESCRIPTION

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant. Multicultural Ambulatory Addiction Services is licensed as a Substance Abuse Treatment Facility and Psychiatric Outpatient Facility. Current services included outpatient treatment, chemical maintenance, (methadone) ambulatory detoxification and Day Treatment.

2. List the types of services being proposed and what DPH licensure categories will be sought, if applicable. Services being proposed include the provision of Primary Care/General Medicine Services to clients at MAAS. Services are being proposed in order to be able to provide more integrated care to a population where non-compliance is common. Primary Care involves providing physical exams, as well as health promotion, disease prevention, health maintenance, counseling, patient education, evaluation, diagnosis and treatment of acute and chronic illnesses. Common acute illnesses include, but are not limited to, colds, flu, allergies, ear infections, absecesses, sexually transmitted infections, fungal and other skin infections, and sprains/strains. Common chronic illnesses include, but are not limited to hypertension, asthma, diabetes, depression, anxiety, hepatitis C, and HIV. Minor procedures will be provided such as vaccination (hepatitis A/B, influenza) tuberculosis testing and wound care.

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

Target population is inner-city, traditionally underserved Latino and African American men and women. Target population for primary care services will include only the MAAS clientele.

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

Many patients at MAAS are not currently seeking any primary medical services. As in many primary care settings, patients do not seek care until they are ill and in the case of substance users, when ill they often seek care in Emergency Rooms. Clients at MAAS often are attending the program several times a week – in some cases, daily. Frequent visits mean that, were primary health care available on site, many patients with diabetes, hypertension, etc. would be able to access healthcare, avoid going to the Emergency Room, and lead healthier

and more productive lives. In the past, we have sought to refer patients to existing FQHCs in the New Haven area; however, the show rate for these patients is quite low. Again, patients seek care when they feel ill – not necessarily when they need care. The unmet need of Primary Care would met if patients were able to see a medical provider while at MAAS receiving his/her Methadone dose, just as they are able to seek psychiatric care then.

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

The Fair Haven Health Center provides services to the MAAS patients who are residents of the Fair Haven section of New Haven. Those individuals who are not part of Fair Haven, must be seen at the Hill Health Center. Both clinics, however, book appointments months out, and sometimes are not in a position to take new patients. When this occurs, there are no providers for continued primary care.

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

Individuals not currently receiving primary health care would be able to receive such care outside of the more expensive Emergency Departments these patients frequent. Vaccination, well visits, blood pressure checks, and routine care for high blood pressure and diabetes will result in over all cost savings to the state as these patients are living healthier lives and able to stay out of the more expensive hospital system.

7. Who will be responsible for providing the service?

Medical services will be provided by a Physician and Physician Assistant with specialized training in the health care of substance users.

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

Current payers include SAGA and Title 19. When the proposed change becomes operational we do not anticipate a change in payer sources.

AFF**IDAVIT**

To be completed by each Applicant

Applicant: _____Asher Delerme_____

Project Title: _Primary Care Licensure Application/Multicultural Ambulatory Addiction Services

I, _____Asher Delerme_____, _____Executive Director
(Name) (Position – CEO or CFO)

of Chemical Abuse Services Agency, 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 _____MAAS_____ 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.

_____ 02/16/2010
Signature Date

Subscribed and sworn to before me on Feb. 16, 2010

_____
Notary Public/Commissioner of Superior Court

My commission expires: 5/31/13

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

March 15, 2010

VIA Facsimile Only

Kristin Bonilla
Associate Director
Chemical Abuse Services Agency, Inc.
426 East Street
New Haven, CT 06511

Re: Letter of Intent, Docket Number 10-31562
Expansioin of Primary Care Services in New Haven
Notice of Letter of Intent

Dear Ms. Bonilla,

On March 3, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Chemical Abuse Services Agency, Inc. ("Applicant") for the expansion of primary care services 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,

Kimberly R. Martone
Director of Operations

KRM:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

March 15, 2010 Requisition # 30743

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 **Friday, March 19, 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 or 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:CC:SWL:lmg

c: Danielle Pare, DPH

New Haven Register
Docket 10-31562

Letter of Intent
March 15, 2010

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Chemical Abuse Services Agency, Inc.
Town:	New Haven
Docket Number:	10-31562-LOI
Proposal:	Expansion of Primary Care Services
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between May 2, 2010 and July 1, 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 Applicants.

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

TRANSMISSION OK

TX/RX NO	1360
RECIPIENT ADDRESS	912034957713
DESTINATION ID	
ST. TIME	03/16 12:04
TIME USE	00'36
PAGES SENT	4
RESULT	OK

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

FAX SHEET

TO: KRISTIN BONILLA

FAX: (203) 495-7713

AGENCY: CHEMICAL ABUSE SERVICES AGENCY, INC.

FROM: CARMEN COTTO

DATE: 3/16/10 **TIME:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Docket 10-31562

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Tuesday, March 16, 2010 9:27 AM
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 3/16/10 9:10 AM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

> To Whom It May Concern,
> Please run the attached public notice(s) in the following newspapers by March 19, 2010. For billing purposes please refer to requisition 30743 for each ad placed.
>
> New Haven Register 10-31562
> Hartford Courant 10-31558
> Journal Inquirer 10-31549
>
> If you have any questions do not hesitate to call me.
>
> 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