STATE OF CONNECTICUT
*DEPARTMENT OF SOCIAL SERVICES*
25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

# Memorandum

**Date:** June 9, 2010

**To:** Private Residential Providers

**From:** Gary M. Richter, Director, CON & Rate Setting, DSS
Vincent O'Connell, Chief, Fiscal & Administrative Services, DDS

**Re:** Public Act 10-179 (Section 37) Implementation
Capital Repairs and Improvement Requests

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Section 37 of Public Act 10-179 (PA 10-179), provides for adjustments to Community Living Arrangements (CLA) rates for the July 1, 2009 through June 30, 2010 and July 1, 2010 through June 30, 2011 rate periods for capital improvements. Specifically, PA 10-179 modified rate provisions applicable to these rate periods as highlighted in bold below:

> "For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except that (1) the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2009, **if a capital improvement required by the Commissioner of Developmental Services for the health or safety of the residents was made to the facility during the fiscal years ending June 30, 2010, or June 30, 2011**, and (2) any facility that would have been issued a lower rate for the fiscal years ending June 30, 2010, or June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate."

In order to implement this change, the departments of Developmental Services (DDS) and Social Services (DSS) developed the attached form for CLA operators to complete and submit a request for a rate adjustment for a health and safety related capital project (CLA Rate Adjustment Request).

The CLA Rate Adjustment Request forms should be submitted to:

Krista Pender, Director of Audit, Billing, and Rate Setting
State of Connecticut – Department of Developmental Services
460 Capital Avenue
Hartford, CT 06106

DDS will review requests to determine whether the project meets a health and safety requirement, and DSS will review project cost data and make associated rate adjustments.

Capital Improvement forms have been modified to include an additional DDS sign-off indicating that the project meets a health and safety requirement. The new capital improvement and CLA Rate Adjustment Request forms can be found on the DDS website, www.ct.gov/dds. Providers with new projects that receive a DDS health and safety sign-off must still file a CLA Rate Adjustment Request form upon project completion.

If you have any questions concerning the revised process, please contact Paula Pfistner at DSS 860-424-5666 or Krista Pender at DDS 860-418-6109.

# CLA Rate Adjustment Request
# Per Public Act 10-179

**Provider:** **Date:**

**CLA Name and Address:**

**Project Description:**

**Project Approval Date:**

**Approved Amount:**

**Project Completion Date:**

**Final Project Cost**

| Schedule of Attachments: | Invoice Date | Invoice Number | Vendor | Amount | Check # Date Paid |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**TOTAL:** _____

**Proposed by:**

By signing below, I hereby certify that the information contained in this request is true and accurate.

**Private Residential Provider Signature** **Date**

**Print/Type Name and Title**

**Approved by:**

By signing below, I hereby certify that this capital improvement project is considered by the Department of Developmental Services to be a required project for the health or safety of the residents as detailed in CGS 17b-244.

**Commissioner** **Date**
**Department of Developmental Services**
**(Or Authorized Designee)**

**6/9/2010**

State of Connecticut
Department of Developmental Services

DDS

M. Jodi Rell
Governor

Peter H. O'Meara
Commissioner

Kathryn du Pree
Deputy Commissioner

**DEPARTMENT OF DEVELOPMENTAL SERVICES**
**REQUEST FOR CAPITAL IMPROVEMENT TO EXISTING**
**COMMUNITY LIVING ARRANGEMENTS**

DATE (A)

APPROVAL IS REQUESTED FOR THE CAPITAL IMPROVEMENT DETAILED BELOW AT:

Property Address (B)

Improvement Requested (C):

Description of Need (D):

Scope of Work (E):

Estimated Total Project Cost (F): $

Expense Incurred by: (check one) ☐ Provider ☐ CIL

Explanation of Cost Estimate (G):

**REQUEST FOR CAPITAL IMPROVEMENTS TO EXISTING COMMUNITY LIVING ARRANGEMENTS**

**BID SUMMARY FORM**

Provider: Date:

Address:

Project Location: Number:

Description of Work:

Type of Contractor (General, Trade)

Contractors Requests to Submit Bids

| | Date Received | Bid Amount |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Contract Award To:

If exception to bidding process is requested, check reason:

☐ Unable to solicit three bids ☐ Urgency to complete work
☐ Other:

If lowest bid is not selected, write justification for choice:

Remarks:

Prepared by: Approved By:
Provider Region

**REQUEST FOR CAPITAL IMPROVEMENTS TO EXISTING COMMUNITY LIVING ARRANGEMENTS**

Property Address:

(H)

The undersigned acknowledge that this document does not constitute a contract for development of a property and further acknowledges that any payments by the State of Connecticut related to this property may only be made pursuant to Sections 17b-244 and 17a-228 of the General Statutes and the regulations promulgated thereunder.

PROPOSED BY:

Private Residential Provider

_____

Signature (Name) (I) (Date)

Print/Type Name

Tel No.:

PROPOSED BY:

Development Staff/Property Developer (if Applicable)

_____

Signature (Name) ( J) (Date)

Print/Type Name

Tel.No.

REVIEWED BY:

_____ _____

Signature (Name) (L) (Date)
Regional Director for Region
Department of Developmental Services
(Or Authorized Designee)

Print/Type Name

Tel.No:

AFTER CONSULTATION WITH:

_____ _____

(Signature) (Name) (M) (Date)
Commissioner
Department of Social Services
(Or Authorized Designee)

APPROVED BY

_____ _____

(Signature) (Name) (N) (Date)
Commissioner
Department of Developmental Services
(Or Authorized Designee)

**REQUEST FOR CAPITAL IMPROVEMENTS TO EXISTING COMMUNITY LIVING ARRANGEMENTS**

By signing below, I hereby certify that this capital improvement project is considered by the Department of Developmental Services to be a required project for the health or safety of the residents as detailed in CGS 17b-244.

_____ _____

(Signature) (Name) (O) (Date)
Commissioner
Department of Developmental Services
(Or Authorized Designee)