

**STATE OF CONNECTICUT**

**Department of Public Health**

**LICENSE**

**License No. 0005**

**Outpatient Clinic**

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:  
Connecticut Public Health Code Section 19-13-D54:

Planned Parenthood of Southern New England of New Haven, CT d/b/a Planned Parent of  
Southern, New England, Inc. is hereby licensed to maintain and operate a Family Planning  
Clinic.

**Planned Parenthood of Southern New England, Inc.** is located at 87 Westcott Road,  
Danielson, CT 06239.

This license expires **September 30, 2019** and may be revoked for cause at any time.  
Dated at Hartford Connecticut October 1, 2015. **RENEWAL**



Jewel Mullen, MD, MPH, MPA  
Commissioner

**STATE OF CONNECTICUT**

**Department of Public Health**

**LICENSE**

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*Jewel Mullen*

Jewel Mullen, MD, MPH, MPA  
Commissioner





STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
FACILITY LICENSE & INVESTIGATIONS SECTION

Page 1 of 4

LICENSURE APPLICATION

☐ INITIAL ☒ RENEWAL ☐ CHANGE OF OWNERSHIP ☐ RELOCATION

**NOTICE:** Any nursing home licensee, owner or officer, including, but not limited to, a director, trustee, limited partner, managing partner, general partner or any person having at least 10 per cent (10%) ownership interest, and any administrator, assistant administrator, medical director, director of nursing or assistant director of nursing, may be subject to criminal liability, in addition to civil and administrative sanctions under federal and state law, for the abuse or neglect of a resident of the nursing home perpetrated by an employee of the nursing home.

**NOTE:** A separate application must be completed for each licensed level of care, whether or not, that level is located at the same address

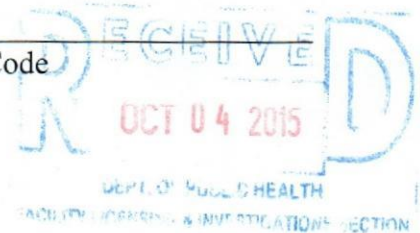
1. Planned Parenthood of Southern New England INC.  
Facility "d/b/a" (doing business as) Name

87 Westcott Rd Danielson CT 06239 860-774-0533  
Business Address City State Zip Code Telephone

Mailing Address (if applicable) City State Zip Code

2. 060263565  
Federal Employer Identification Number

3. Is the above named entity authorized by the Office of the Secretary of State to transact business in the State of Connecticut and considered in Good Standing? ☒ YES ☐ NO



Phone: (860) 509-7444  
Telephone Device for the Deaf (860) 509-719  
410 Capitol Avenue - MS # 12HFL  
P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer

In accordance with Section 19a-491 and/or Section 19a-506 of the Connecticut General Statutes, application is hereby made for a license to operate the following (please check the appropriate box that applies):

- |  |   |
|--|---|
| <input type="checkbox"/> Assisted Living Services Agency       | <input type="checkbox"/> Infirmary Operated by an Educational Institution |
| <input type="checkbox"/> Children's Hospital                   | <input type="checkbox"/> Maternity Home                                   |
| <input type="checkbox"/> Chronic and Convalescent Nursing Home | <input type="checkbox"/> Maternity Hospital                               |
| <input type="checkbox"/> Chronic Disease Hospital              | <input type="checkbox"/> Outpatient Clinic/Primary Care/Dental            |
| <input checked="" type="checkbox"/> Family Planning Clinic     | <input type="checkbox"/> Outpatient Dialysis Unit                         |
| <input type="checkbox"/> General Hospital                      | <input type="checkbox"/> Outpatient Surgical Facility                     |
| <input type="checkbox"/> Home Health Care Agency               | <input type="checkbox"/> Residential Care Home                            |
| <input type="checkbox"/> Homemaker-Home Health Aide Agency     | <input type="checkbox"/> Rest Home with Nursing Supervision               |
| <input type="checkbox"/> Hospice/19a-495-5a & 19-13-D1(C)      | <input type="checkbox"/> In-Patient Hospice Unit                          |
| <input type="checkbox"/> Hospital for Mentally Ill Persons     | <input type="checkbox"/> Well Child Clinic                                |

4. Bed Capacity Requested (if applicable). If submitting this application for multiple levels of care, please list the bed capacity for each level of care being requested.

Level of Care	Beds/ Hemodialysis Stations	Bassinets (if applicable)
<u>N/A</u>	_____	_____
_____	_____	_____
_____	_____	_____

5. Disclose the **legal entity which owns/operates the facility**. (Note: The license will be issued to this entity.)

Planned Parenthood of Southern New England  
Licensee Incorporated

345 Whitney Avenue New Haven, CT 06511 203-865-5158  
Business Address City State Zip Code Telephone

Mailing Address (if applicable)

6. Is the above named legal entity a (please check the box which applies):

- |  |   |
|--|---|
| <input type="checkbox"/> Individual/Sole proprietor        | <input type="checkbox"/> Municipality       |
| <input type="checkbox"/> General Partnership               | <input type="checkbox"/> Trust              |
| <input type="checkbox"/> Limited Partnership               | <input type="checkbox"/> Profit Corporation |
| <input type="checkbox"/> Limited Liability Company         |   |
| <input type="checkbox"/> Other: _____                      |   |
| <input checked="" type="checkbox"/> Non-profit Corporation |   |

7. Please disclose the name, business address and telephone number of the Agent for Service for the Licensee.

Judy Tabar 345 Whitney Ave New Haven, CT 203-865-5158  
Name Address Telephone



8. Attach an organizational chart which reflects the current ownership structure of the licensee and the licensee's relationship with the facility/agency.
9. Respond to the specific question that reflects the ownership structure of the licensee. **The Licensee is the legal entity which will be issued the license to operate.**
- A. If the Licensee is a general partnership, limited partnership or limited liability company, complete Form 1 (attached).
- B. If the Licensee is a trust, complete Form 2 (attached) for the Licensee.
- i. Attach a list including the name, address and telephone number of all trustees.
- C. If the Licensee is a corporation (profit or non-profit), complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.
- i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.
- ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.
10. Attach a current copy of the facility's Certificate of malpractice and public liability insurance. (Note: Information Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.). Please note that All Behavioral Health levels of care, except hospitals, and RCH facilities are exempt from the malpractice requirement.
11. Attach evidence of current compliance with the worker's compensation insurance coverage requirements in the form of one of the following:
- A. a certificate of self-insurance issued by a worker's compensation commissioner pursuant to Section 31-284 of the Conn. General Statutes; or
- B. a certificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 of the Conn. General Statutes; or
- C. a Certificate of Insurance issued by any stock or mutual insurance company or mutual association authorized to write worker's compensation insurance in this state. (Note: Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)
12. Ownership of Real Property
- JDM E Management LLC
- Name
- P.O. Box 370366 West Hartford CT 06137 607.413.1045
- Business Address City State Zip Code Telephone





# CERTIFICATE OF LIABILITY INSURANCE

 DATE (MM/DD/YYYY)  
12/31/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER  
Marsh USA, Inc.  
1166 Avenue of the Americas  
New York, NY 10036  
Attn: healthcare.accounts@marsh.com Fax: 212-948-1307

CONTACT  
NAME:  
PHONE  
(A/C, No, Ext):  
E-MAIL  
ADDRESS:

FAX  
(A/C, No):

109210-NIP-CAS-15-16 NEW, C GL

INSURED  
PLANNED PARENTHOOD OF SOUTHERN NEW  
ENGLAND, INC.  
AN AFFILIATE OF PLANNED PARENTHOOD  
FEDERATION OF AMERICA, INC.  
345 WHITNEY AVENUE  
NEW HAVEN, CT 06511

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	New Hampshire Insurance Company	23841
INSURER B:	N/A	N/A
INSURER C:		
INSURER D:		
INSURER E:		
INSURER F:		

## COVERAGES

CERTIFICATE NUMBER:

NYC-005769998-33

REVISION NUMBER: 10

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY		082695195	01/01/2015	01/01/2016	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COM/OP AGG \$ 2,000,000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> SIR: \$100,000 GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC					
	AUTOMOBILE LIABILITY					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ \$
	<input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A			WC STATU-TORY LIMITS OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

LEVY PROPERTIES, LLC IS INCLUDED AS AN ADDITIONAL INSURED BUT ONLY WITH RESPECT TO LIABILITIES ARISING OUT OF CLINIC LOCATED AT 87 WESTCOTT ROAD, DANIELSON, CT 06239

## CERTIFICATE HOLDER

LEVY PROPERTIES, LLC  
P.O. BOX 370366  
WEST HARTFORD, CT 06137-0366

## CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE  
of Marsh USA Inc.

Ricki Fitzsimmons





# CERTIFICATE OF LIABILITY INSURANCE

 DATE (MM/DD/YYYY)  
01/15/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-948-1307	<b>CONTACT</b> NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL: ADDRESS:														
109210-WC-5-5-15-16 NEW,C WC	<b>INSURER(S) AFFORDING COVERAGE</b> <table border="1"> <tr> <th>INSURER</th> <th>NAIC #</th> </tr> <tr> <td>INSURER A: N/A</td> <td>N/A</td> </tr> <tr> <td>INSURER B: ACE American Insurance Company</td> <td>22667</td> </tr> <tr> <td>INSURER C: N/A</td> <td>N/A</td> </tr> <tr> <td>INSURER D:</td> <td></td> </tr> <tr> <td>INSURER E:</td> <td></td> </tr> <tr> <td>INSURER F:</td> <td></td> </tr> </table>	INSURER	NAIC #	INSURER A: N/A	N/A	INSURER B: ACE American Insurance Company	22667	INSURER C: N/A	N/A	INSURER D:		INSURER E:		INSURER F:	
INSURER	NAIC #														
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INSURER C: N/A	N/A														
INSURER D:															
INSURER E:															
INSURER F:															
<b>INSURED</b> PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC., AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511															

**COVERAGES**
**CERTIFICATE NUMBER:**

NYC-006791908-03

**REVISION NUMBER:** 6

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	<b>GENERAL LIABILITY</b> <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC					EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$	
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$	
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE				EACH OCCURRENCE \$ AGGREGATE \$	
B	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N <input checked="" type="checkbox"/> N	N/A	RSC C48128865	01/01/2015	01/01/2016	X WC STATU-TORY LIMITS E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)  
EVIDENCE OF COVERAGE.

**CERTIFICATE HOLDER**
**CANCELLATION**

 PLANNED PARENTHOOD OF SOUTHERN NEW  
 ENGLAND, INC.  
 345 WHITNEY AVENUE  
 NEW HAVEN, CT 06511

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

 AUTHORIZED REPRESENTATIVE  
 of Marsh USA Inc.

Ricki Fitzsimmons

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## **ORGANIZATION CHART**

**Planned Parenthood of Southern New England, Inc.**

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### **BOARD OF DIRECTORS**

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**Planned Parenthood of Southern New England Inc.**

^

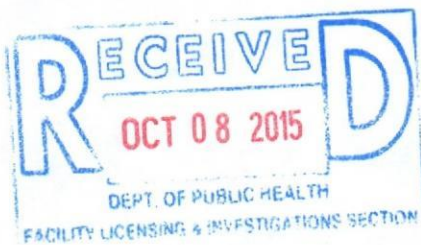
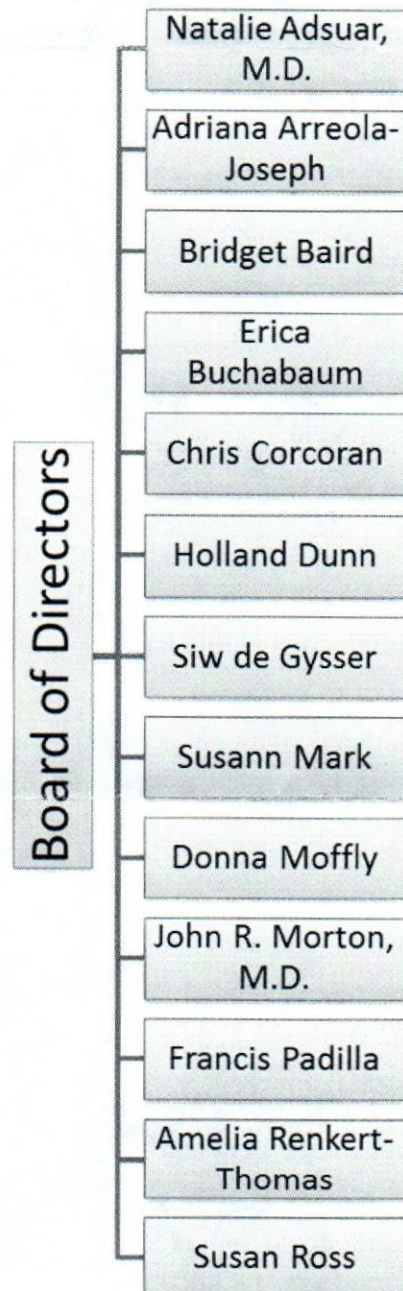
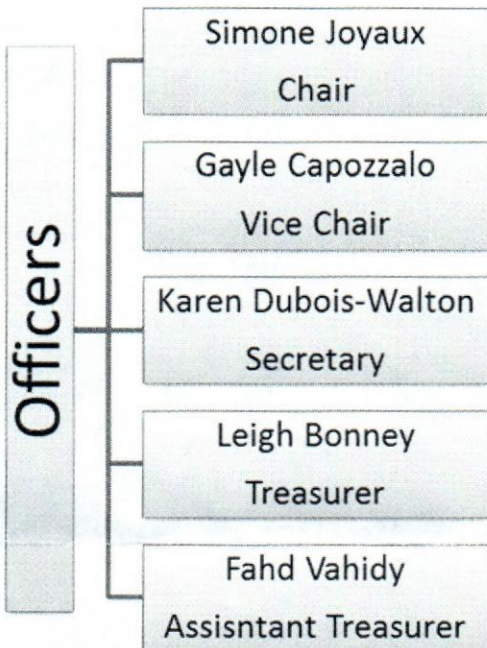
**Planned Parenthood of Southern New England Inc.**



Planned Parenthood of Southern New England  
d/b/a Planned Parenthood of Southern New England, Inc.

Organizational Chart

Board of Directors 2014-2015





STATE OF CONNECTICUT  
INSPECTION CERTIFICATE

On (date) 2/4/15, the (Town/City) Killingly Office of the Fire Marshal conducted an inspection of (name of facility) Planned Parenthood located at (address) 87 Westcott Road. in the City/Town of Killingly to determine the degree of compliance with the fire safety requirements of Connecticut General Statutes Chapter 541 as authorized by Section 29-305 of the statutes. This facility was evaluated as a (new/existing) existing (occupancy classification) B- group as classified by the CONNECTICUT STATE FIRE SAFETY CODE. As a result of this inspection, the following conditions were found:

- I. ☐ At the time of inspection, no code violations were identified. **Certificate of approval recommended.**
- II. ☒ At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. (See attached information) **Certificate of approval recommended** Exit sign corridor.  
Blocked Egress door with snow, corridor. OCT 04 2015
- III. ☐ At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approved plan of correction was submitted. (See attached information) **Certificate of approval NOT recommended**
- IV. ☐ Based on the extreme hazard to public safety discovered at the time of this inspection, this office is currently seeking an injunction from the court through our Town/City Attorney for the purpose of closing or restricting usage of this facility by the public. (See attached information) **Certificate of approval NOT recommended**

[Signature]  
Fire Marshal

2/4/15  
Date

City or Town: Killingly





# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
02/12/2015

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<b>PRODUCER</b> Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-948-1307		<b>CONTACT</b> NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL: ADDRESS:	
109210-NIPT-CAS-15-16 NEW, C PL		<b>INSURER(S) AFFORDING COVERAGE</b>	
<b>INSURED</b> PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC., AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511		<b>INSURER A:</b> N/A <b>INSURER B:</b> National Union Fire Ins. Co. of Pittsburgh, PA <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> N/A 19445	

## COVERAGES

CERTIFICATE NUMBER:

NYC-007010539-01

REVISION NUMBER: 0

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	<b>GENERAL LIABILITY</b> <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC					EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE  DED \$ RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A				WC STATUTORY LIMITS \$ OTHER \$ E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
B	<b>MEDICAL PROFESSIONAL</b> CLAIMS-MADE COVERAGE		6793286 'Program Retro Date: 11/1/76'	01/01/2015	01/01/2016	PER CLAIM \$1,000,000 AGGREGATE \$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

EVIDENCE OF COVERAGE FOR HEALTH CENTER

## CERTIFICATE HOLDER

## CANCELLATION

PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND 87 WESTCOTT ROAD DANIELSON, CT 06239	<b>SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.</b>  <b>AUTHORIZED REPRESENTATIVE</b> of Marsh USA Inc. Ricki Fitzsimmons
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STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
FACILITY LICENSING & INVESTIGATIONS SECTION

Attachment 3

FORM 3

FACILITY/AGENCY NAME: Planned Parenthood of Southern New England, Inc.

Form 3 must be completed if the facility/agency or Real Property Owner is owned/operated by a corporation (profit or non-profit). Please copy additional sheets if necessary.

For each stockholder with a 10% or greater ownership interest in the Licensee, provide the information requested below. If no owner owns 10% or more of the total shares, please indicate the two largest stockholders. Please complete a separate form for each legal entity listed below that is not an individual.

This information is for: ☐ Licensee Planned Parenthood of Southern New England, Inc.  
☐ Real Property Owner \_\_\_\_\_

1. Name: N/A non Profit organization without stockholders  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Stockholder's percentage of ownership: \_\_\_\_\_  
Stockholder's occupation with the owner: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Stockholder's percentage of ownership: \_\_\_\_\_  
Stockholder's occupation with the owner: \_\_\_\_\_
3. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Stockholder's percentage of ownership: \_\_\_\_\_  
Stockholder's occupation with the owner: \_\_\_\_\_
4. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Stockholder's percentage of ownership: \_\_\_\_\_  
Stockholder's occupation with the owner: \_\_\_\_\_







STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
FACILITY LICENSING & INVESTIGATIONS SECTION

LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

OUTPATIENT CLINICS, WELL CHILD CLINICS AND  
FAMILY PLANNING CLINICS

Please respond to all of the following questions:

1. Planned Parenthood of Southern New England, Inc.  
Facility "d/b/a" (doing business as) Name

87 Westcott Rd Daniels CT 06239 860-774-0533  
Business Address City State Zip Code Telephone

2. Check the appropriate box/boxes describing the services to be provided by the clinic:

<input type="checkbox"/> Primary Care	<input checked="" type="checkbox"/> Family Planning
<input type="checkbox"/> Well Child Clinic	<input type="checkbox"/> Abortion Procedures
<input type="checkbox"/> Dental	<input type="checkbox"/> Mental Health Services

Be advised that mental health services does NOT include Substance Abuse Services.

3. Jessica Stefanski  
Administrator (Your name needs to appear as it is shown on your Professional License).

4. Timothy Spurrell, MD  
Medical Director Dental Director (if applicable)  
(Your name needs to appear as it is shown on your Professional License).

5. Days & Hours of Operation: M: 10-6, T: 8-4, W: 1-8, Th: Closed, F: 8-4  
You MUST notify this agency when ANY change to the noted day/time changes. We accept email and fax.

6. Please provide a list of services that will be provided.

7. Business Fax Number: 860-724-2559

8. Business Email Address: Jessica.Stefanski@PPSNE.org

9. Business Cell Phone Number with Texting capabilities of the Administrator: N/A

Jessica Stefanski  
Signature of Administrator

8/4/15  
Date Signed

# HEALTH CENTER F - August 3, 2015

HEALTH CENTER - August 3, 2015						
CENTER MANAGER CLINICIAN	BRIDGEPORT	DANBURY	DANIELSON	ENFIELD	HARTFORD NORTH	MANCHESTER
	Isonia Cole Laurie Haydu Linda Magee	Antonietta Schaalman Gannon Ward Susan Ruehl, PD Joan Welch, PD	Jessica Stefanski Lindsay Delaire	Christy Beach Chris Bachand	Erin Livensparger Debbie Hamer Lucinda Canty, PD Laura Kattan, PD	Carlin Murphy Diane Libby-Ramage Jennifer Love Kris Sterling
RN						
LPN						
ENROLLMENT SPECIALIST						
CA	Omar Jehaludi Nikole Moya Gina Porto Tenisa Paulding, PD Evelyn Cuevas*	Mayce Torres Dana Almonte Anntreen Lamar	Carissa Croff Richard Morrow Sheri Saddlemyre	Monique Grala Claudia Valderrama	Rosa Rodriguez Nina Daugherty (Float)	Bridget Tomczak Samantha DeAngelis Fernanda Formel Brianna Johnson
ADVANCED CA	Lori Gall Aida Ortega*	Jennifer Tomasini	Jacklyn Michalski, PD	Nathan Dorian Jennifer Bouley, PD	Jenny Martorelli Jennifer Messenger Yolanda Young	Stephanie Colon Normar Neves Nicolette Laune, PD
REGIONAL DIRECTOR	Amber Bachman, PD Shira Revzen	Fedra Sanchez	Fedra Sanchez	Fedra Sanchez	Fedra Sanchez	Fedra Sanchez
CENTER MANAGER CLINICIAN	MERIDEN/NEW BRIT	NEW HAVEN	NEW LONDON	NORWICH	OLD SAYBROOK	PROVIDENCE
	Samantha Dobson Loren Fields Samantha Hyacinth* Jenna LoGiudice, PD	Jody Clark Carrie Ferrigno Janet Gunner Diana Kavanagh Gina Novick, PD Leslie Robinson, PD	Lauren Pereira Sarah Whalen Edie Morren-Morrison, PD	Janeen Ortiz* Kathy Bryson Stephanie Malla, PD	Sara Culver Elizabeth Fabrizio Christina Fantoni	Danna Friedman-Shara Stacy Ramsey Jessica Wilder Willa Carter, PD Constance Chang, PD Megan Gaynor Charette*, PD Kristina Shepherd, PD
RN						
LPN						
ENROLLMENT SPECIALIST						
CA	Daiva Morales* Madeline Martinez Jade Hughes Stephanie Proietto	Salina Amara Amanda Bradley Hector Cotto Chelsea Epps Kaitlin Sohn, PD	Dominique Soldato Tylisha Wrighten	Stephen Polach Hannah Carey, PD	Nicole Abbott Susan Schlachter	Emily Clinton Jacklyn Dos Reis Cassey Mederos Kayla Murphy Tara Patterson Pam Shaw Harriet Singer Jasmyan Sullivan Sarah Bramblet, PD Jessa Goldstein*, PD Adina Riggins, PD Nindi Tiemo, PD Brianna Jolaoso Amber Newmann Antigone Reyes Eni Valerio*
ADVANCED CA	Viviana Hernandez* Tina St. Germain Casandra Lehr, PD	Victoria Burch Omara de la Cruz* Candice Langley Tiffany Martin Esther Pellet Mercy Plant Carmen Trochez*	Bernadette DeShields Damaris Hernandez* Esperanza DeJesus-Santana* Veronica Sohn	Donna Bonanno Jessica Davila* Emily O'Hearn		
REGIONAL DIRECTOR	Shira Revzen	Shira Revzen	Fedra Sanchez	Shira Revzen	Fedra Sanchez	Shira Revzen
CENTER MANAGER CLINICIAN	STAMFORD	TORRINGTON	WATERBURY	WEST HARTFORD	WILLIMANTIC	
	Doris Walden Salma Mody Susan Kissel, PD Ines Riera, PD	Tammy Hrehu Claudette Bari Barla Bishop, PD	Alicia Caban Ronnie Dubrowin* Karen Parkhurst, PD	Jane Yousman Mark Pierce Chloe Quinn Emily Cole, PD Raeanne DePasquale, PD Kate Sivel* Lily Shield, PD Samantha Tamulis, PD Morayma Rodriguez	Beth Murana Jaime Hill Lisa Marie Griffiths, PD	
RN						
CA	Lauren Narbey, PD Clara Thomas-Barnett, PD	Jennifer Helt	Nicole Perez Claudia Waller*	Isabel Caban Shailyn O'Connell, PD		
ADVANCED CA	Laitsha Ervin Digna Guadalupe Devlynn Hresko Melinda Rankine Nasia Frataroli, PD	Heather Keyes Jasmine Osorio*	Karina Santos Ivelisse Vasquez*	Madeline Alvarez Mary Cruz Geizena Neves Brenda Samuels	Lindsey Jones (Float) Lillian Morales* Franceska Vega	
REGIONAL DIRECTOR	Shira Revzen	Fedra Sanchez	Fedra Sanchez	Shira Revzen	Fedra Sanchez	

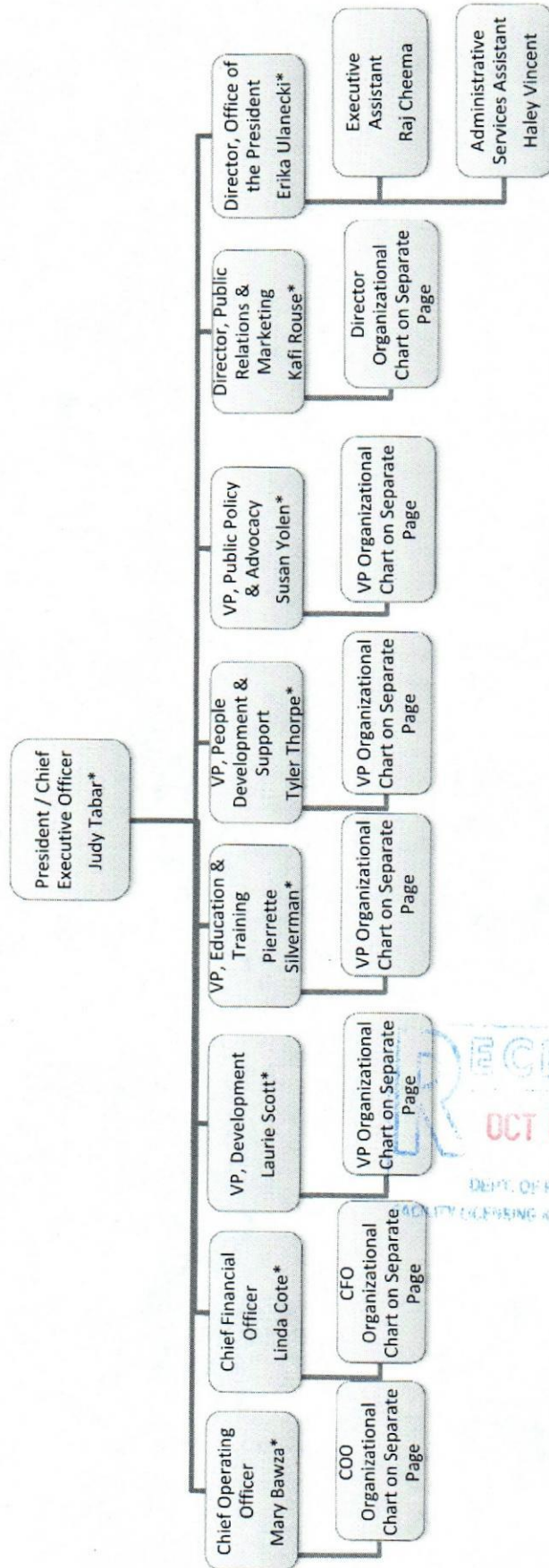
\*Bilingual English/Spanish \*\*Bilingual English/French PD = Per Diem



# Planned Parenthood of Southern New England

## President & CEO

### August 2015

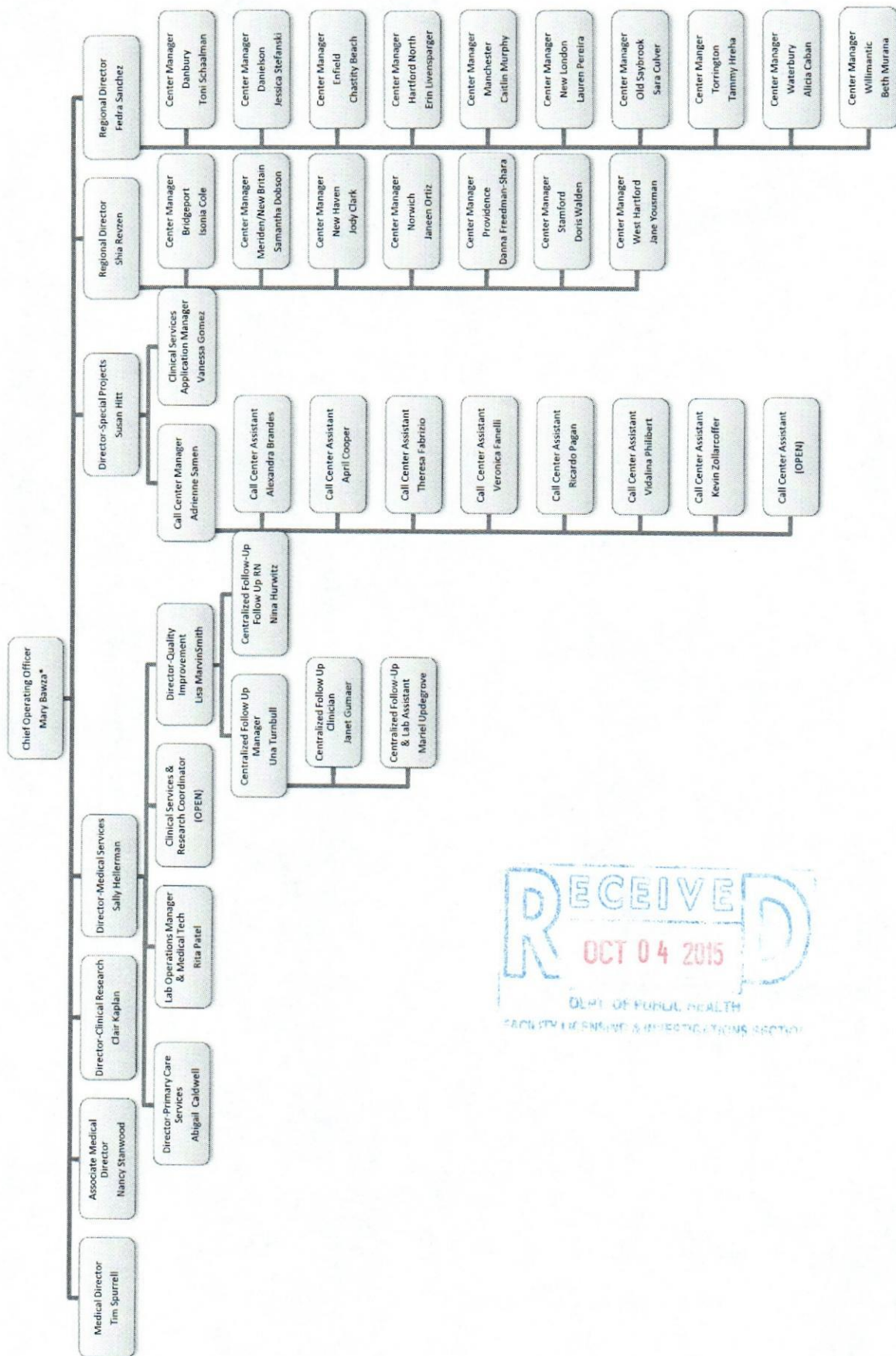


RECEIVED  
OCT 04 2015  
DEPT. OF PUBLIC HEALTH  
QUALITY IMPROVING & INVESTIGATIONS SECTION

# Planned Parenthood of Southern New England

## Chief Operating Officer

### August 2015



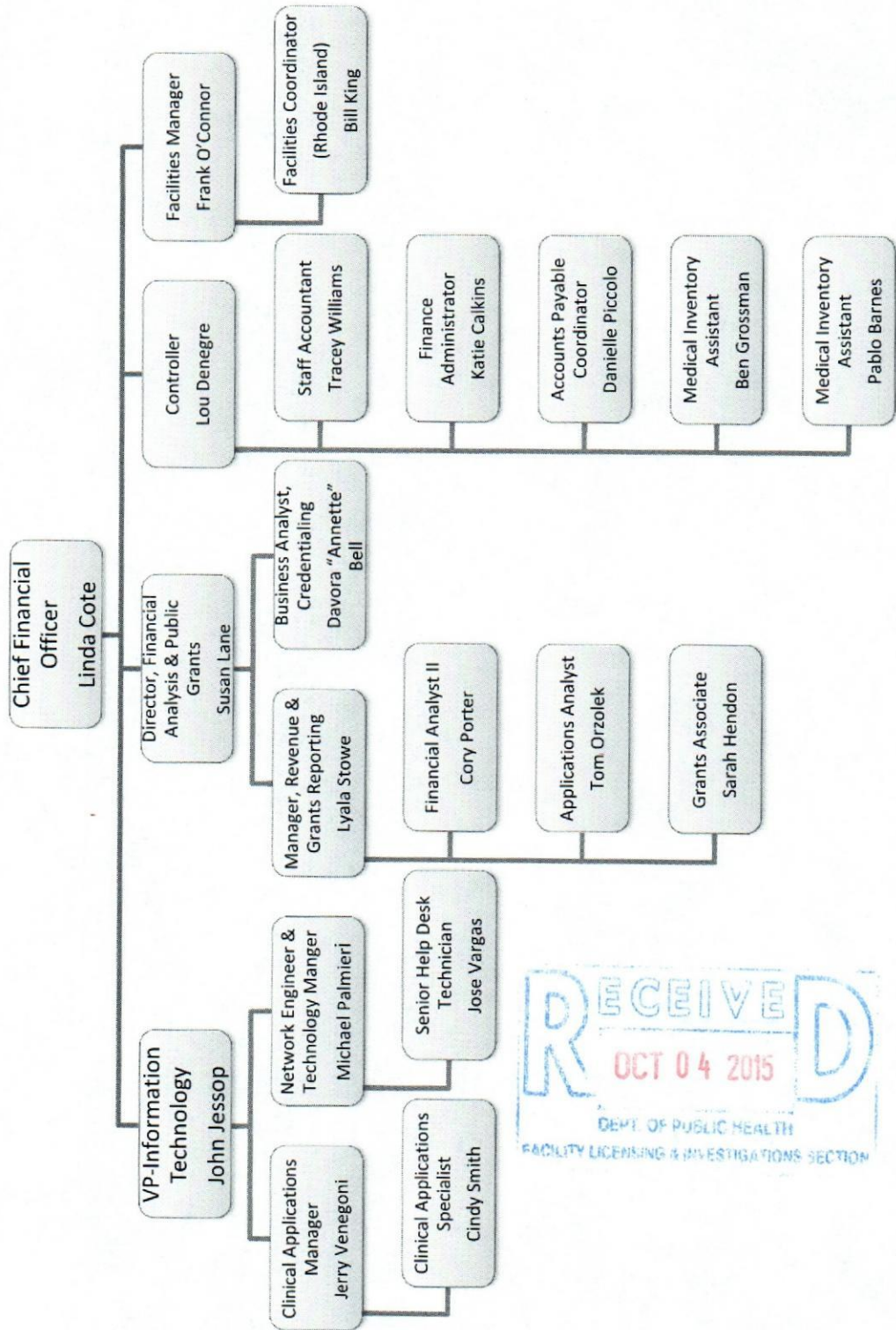
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DEPT. OF PUBLIC HEALTH  
FACILITY PLANNING & INVESTIGATIONS SECTION



# Planned Parenthood of Southern New England

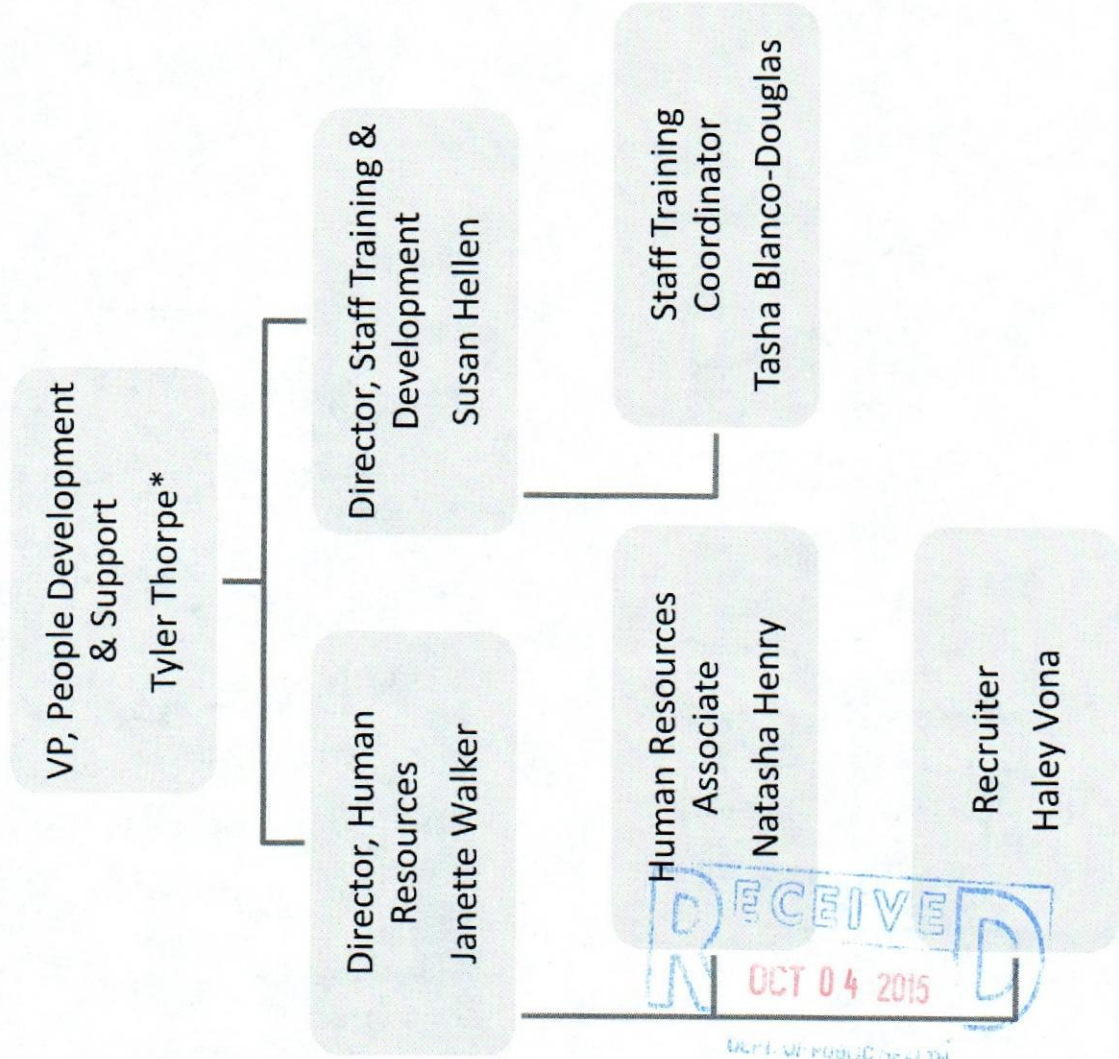
## Chief Financial Officer

August 2015



# Planned Parenthood of Southern New England Vice President, People Development & Support

August 2015



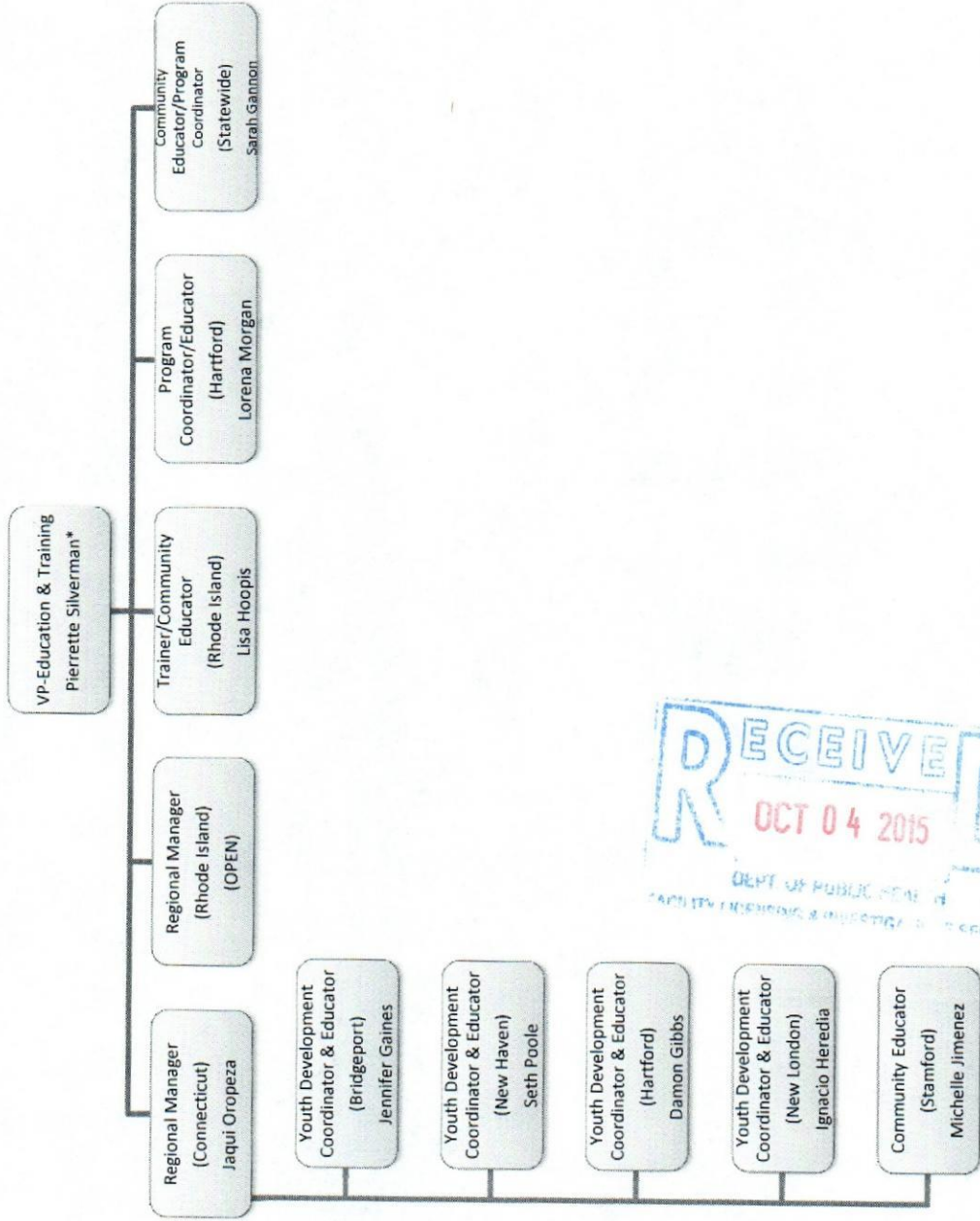
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DEPT. OF PUBLIC HEALTH



# Planned Parenthood of Southern New England Vice President, Education & Training

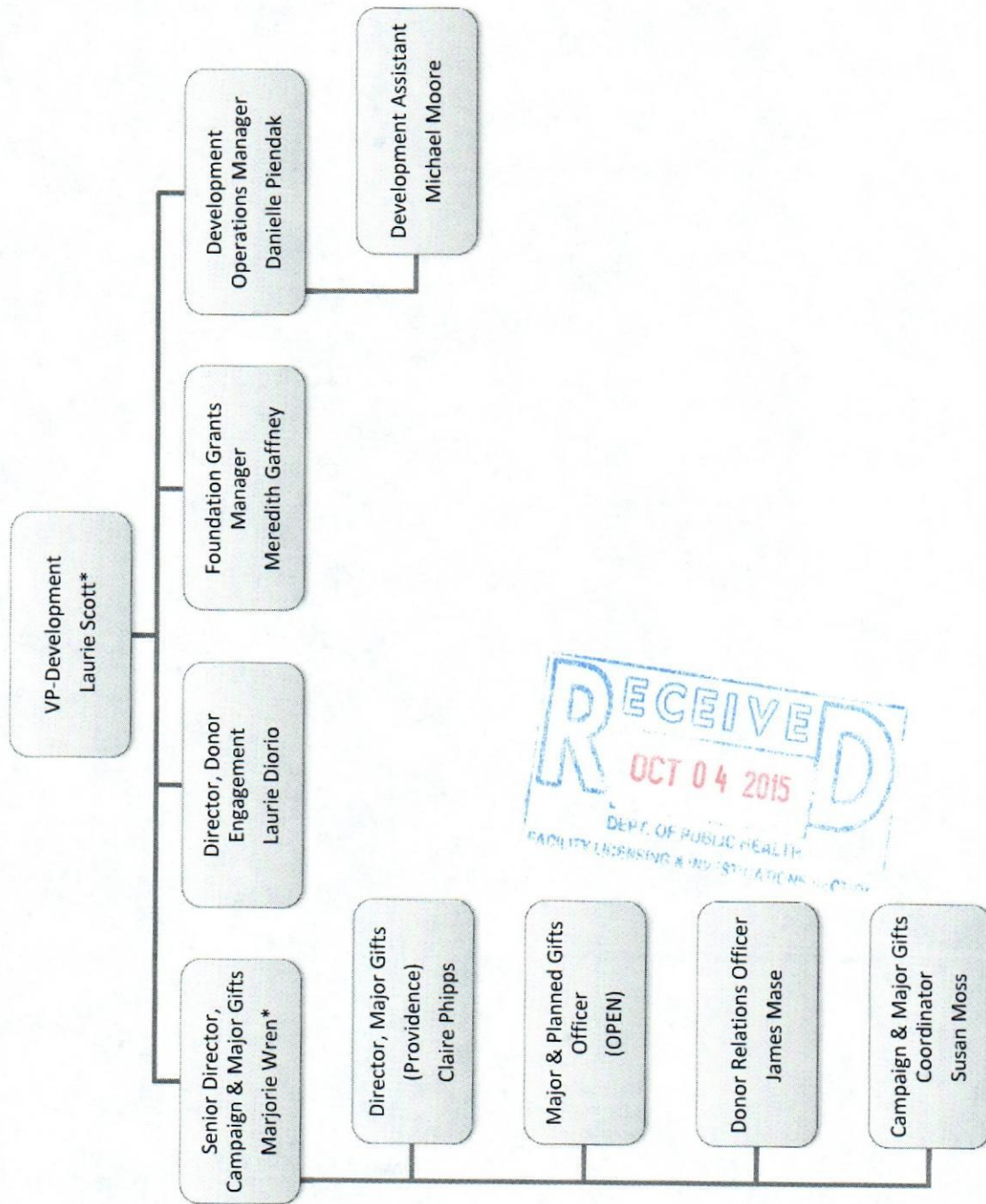
August 2015



# Planned Parenthood of Southern New England

## Vice President, Development

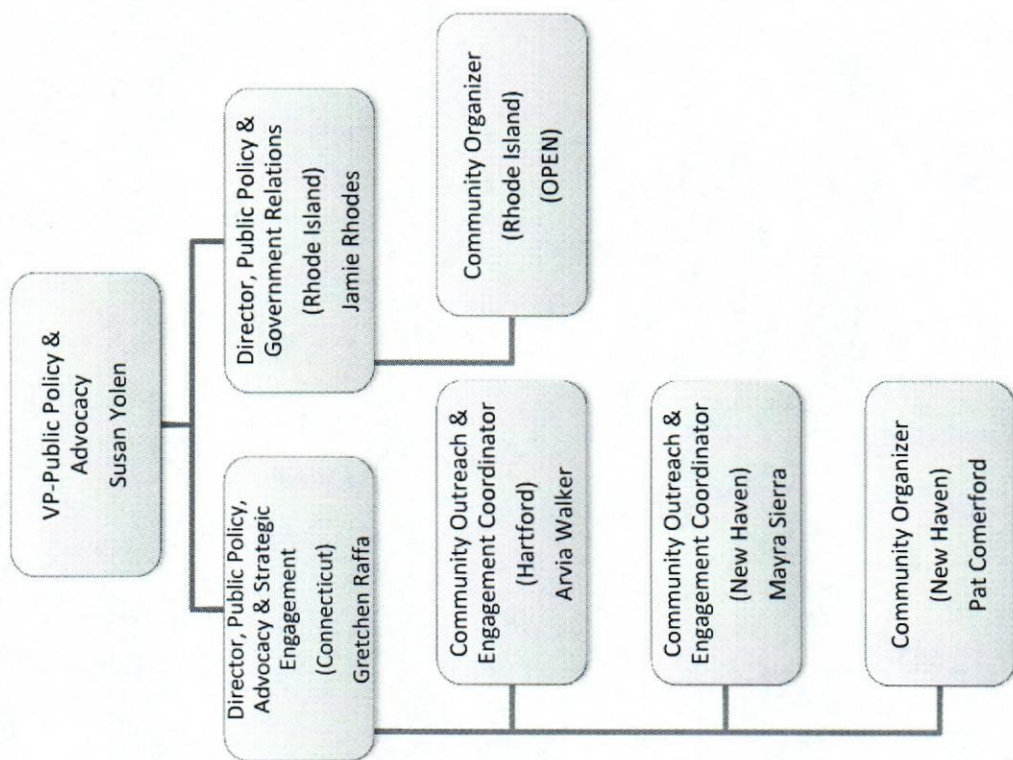
### August 2015





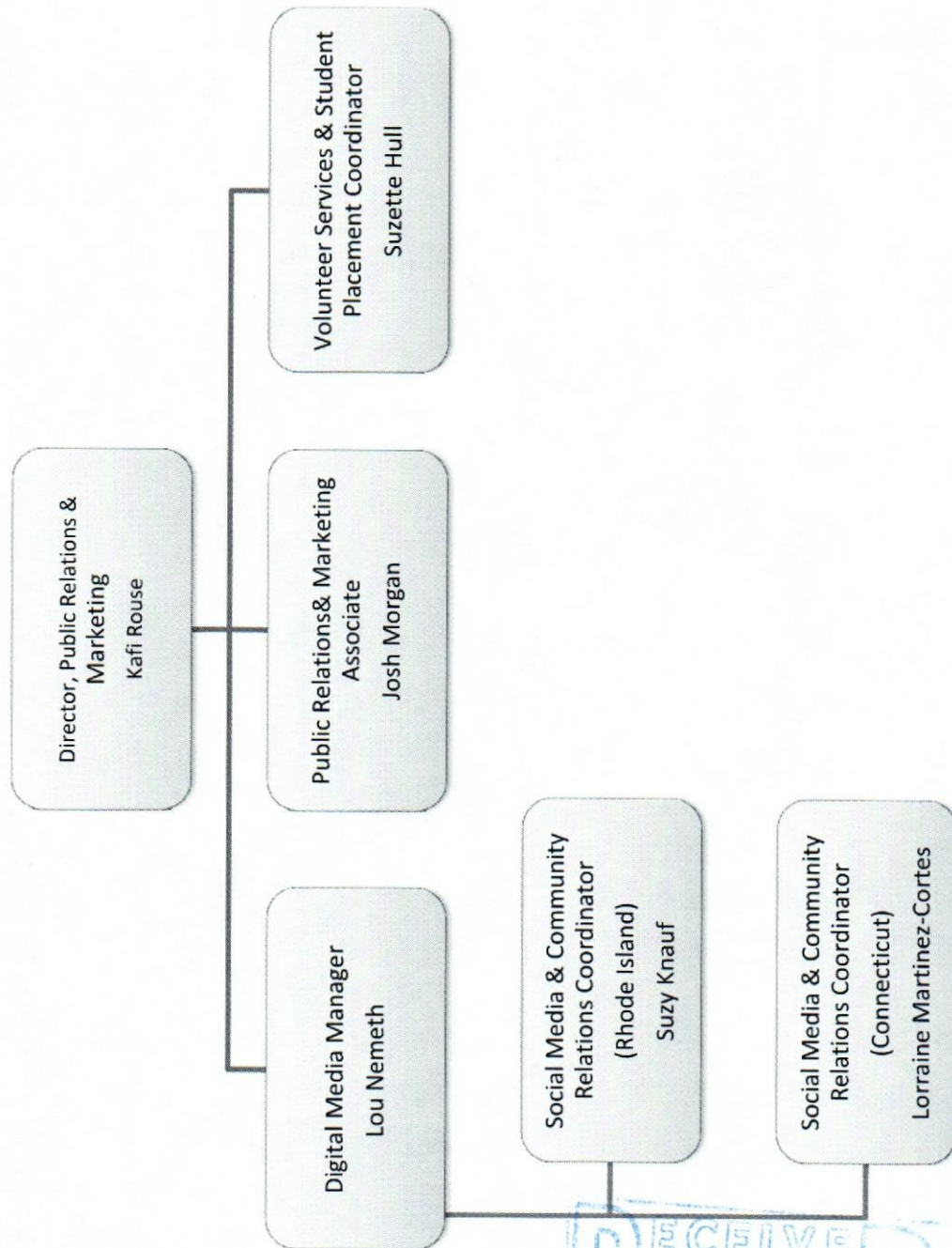
# Planned Parenthood of Southern New England Vice President, Public Policy & Advocacy

August 2015



# Planned Parenthood of Southern New England Director, Public Relations & Marketing

August 2015





**Planned Parenthood of Southern New England  
d/b/a Planned Parenthood of Southern New England**

**Organizational Chart**

**Board of Directors 2014-2015**

**Officers:**

Simone Joyaux, Chair  
Gayle Capozzalo, Vice Chair  
Karen Dubois Walton, Secretary  
Leigh Bonney, Treasurer  
Fahd Vahidy, Assistant Treasurer

**Board of Directors:**

Natalie Adsuar, M.D.  
Adriana Arreola-Joseph  
Bridget Baird  
Erica Buchsbaum  
Chris Corcoran  
Holland Dunn  
Siw de Gysser  
Susann Mark  
Donna Moffly  
John R. Morton, M.D.  
Francis Padilla  
Amelia Renkert-Thomas  
Susan Ross



Planned Parenthood of Southern New England, Inc.

Services available at PPSNE health centers:

- Sexually Transmitted Infections (STI) Testing & Treatment
- Birth Control Services
- Emergency Contraception (morning after pill) Services
- Pregnancy Testing & Pregnancy Services
- HIV Testing
- Hepatitis Vaccine and HPV Vaccine Services
- Lesbian, Gay, Bisexual, & Transgender Services
- Abortion Services & Abortion Referrals
- Patient Education
- Preconception Care
- Well-Women's Health Care
- Well-Men's Health Care

Updated 8/2/10





FOR OFFICE USE ONLY

CHECK # \_\_\_\_\_

AMOUNT \$ \_\_\_\_\_

DATE RECEIVED \_\_\_\_\_

INITIALS \_\_\_\_\_

\*\*\*\*\*

13. Annual Fire Marshal's Certificate of Inspection Form (attached) must be completed by the Local Fire Marshal. **NOTE: Hospitals must have a separate Fire Marshal's Certificate of Inspection completed for each building on the hospital's campus and each satellite listed on the hospital's license. Additional forms may be copied if necessary. Each completed Fire Marshal's Certificate of Inspection that is submitted must have an original signature. (Not applicable for Homemaker Home Health and Home Health Agencies).**

14. Affidavit of Owner:

I attest that the information provided within this application is true and accurate and that any changes in the information submitted will be reported to the Department as required by law.

Judy Tabak  
Signature

9/30/15  
Date Signed

Check one as applicable:

- ☐ Individual/Sole Proprietor  
☐ General/Managing Partner  
☐ President of Corporation  
☐ Secretary of Corporation  
☐ Municipal Officer  
☐ Trustee  
☐ Member of the LLC

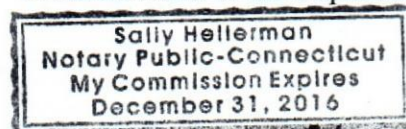
State of Connecticut )

County of New Haven ) ss 9/30 2015

Personally appeared before me the above named Judy Tabak and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

Sally Hellerman  
 Notary Public [x]  
 Justice of the Peace [ ]  
 Town Clerk [ ]  
 Commissioner of the Superior Court [ ]

My Commission Expires:  
(If Notary Public)



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF HEALTH SYSTEMS REGULATION

DHSR #13a

Page 1 of \_\_\_\_\_

**LICENSING INSPECTION REPORT**

Name and Address of Entity

Signature of DHSR Staff

PPHE Danulson  
87 Westcott Rd  
Danulson CT

[Signature]

Licensure Category :

Family Planning of Center

Licensed Capacity : \_\_\_\_\_

Census : \_\_\_\_\_

Licensed Capacity : \_\_\_\_\_

Census : \_\_\_\_\_

Date(s) of Onsite Inspection : 10/27/15

Date(s) Additional Information Obtained: \_\_\_\_\_

Personnel Contacted : Jessie Stephens - HEMINGER

**REVIEW/FINDINGS/PROCESS** (complete all applicable)

- ☒ Licensing Inspection: [ ] Initial [ ☒ ] Renewal [ ] Other: \_\_\_\_\_
- [ ] Revisit for the Purpose of \_\_\_\_\_
- [ ] See Complaint Investigation # \_\_\_\_\_
- [ ] See Reportable Event Investigation # \_\_\_\_\_
- [ ] See Certification file.
- [ ] Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were identified at the time of this inspection.  
See violation letter dated \_\_\_\_\_
- [ ] Citation # \_\_\_\_\_ was issued to this facility as a result of this inspection.
- ☒ Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were not identified at the time of this inspection.
- [ ] Citation # \_\_\_\_\_ was verified as corrected. \_\_\_\_\_ was notified that the licensee was no longer required to post Citation (see narrative).
- [ ] Citation # \_\_\_\_\_ was not corrected (see narrative).
- [ ] Narrative Report / Additional Information Attached.
- [ ] Referral(s) to: \_\_\_\_\_

REPORT SUBMITTED BY

[Signature]

DATE OF REPORT

11/9/15  
10/27/15

[ ] Approval for Issuance of License granted by :

Joan Drouyen  
Supervisor / Title

Date

11-9-15





FACILITY: PAVE Danulson

DATE(S) of VISIT: 10/27/15 Page 2 of 2

OUTPATIENT CLINICS OPERATED BY CORPORATIONS/MUNICIPALITIES  
LICENSING INSPECTION NARRATIVE REPORT  
(P.H.C. Section 19-13-D45)

I. An unannounced visit was made to the above facility, by a representative of the Division of Health Systems Regulation, for the purpose of conducting a licensing inspection.

II. An entrance conference was held.

III. The following was conducted:

- a. Facility inspection ✓
- b. Observation of patient care ✓
- c. Personnel files review ✓
- d. Quality assurance program (audits) review ✓
- e. Fire drill log/disaster plan review ✓
- f. New or revised agency policies and procedures review ✓
- g. Clinical record review ✓
- h. In-service training/staff meeting documentation ✓ *in service and person*
- i. CLIA certificate/waiver ✓

IV. An exit conference was provided.

V. Violations of the Public Health Code of the State of Connecticut were/were not identified as a result of this inspection. not

SIGNATURE: 