Arizona Long Term Care System (ALTCS) RFP, YH12-0001
Letter of Intent (LOI)

The following LOI and information is provided as early notification for Offeror's benefit. Additional instructions regarding this Letter of Intent may be provided when the Arizona Long Term Care System (ALTCS) RFP is released. Only the instructions included in the RFP are considered official. Do not send completed Letters of Intent to AHCCCS unless requested.

Letter of Intent Instructions

The LOI is to be used to show a provider's intention to enter into a contract to provide Medicaid covered services with an Offeror for the ALTCS contract beginning 10/1/2011. No alterations or changes are permitted, except for shaded areas which identify the Offeror. The Offeror may print the form on its letterhead or insert its name or logo in the box at the top of the form. Completed LOIs or executed contracts will be acceptable evidence of an Offeror's proposed network.

If a representative signs an LOI on behalf of a provider, evidence of authority for the representative must be available upon request.

Offeror's
Name/Logo

SAMPLE LETTER OF INTENT

No alterations are permitted. The information provided is subject to verification by AHCCCS.

The provider signing below is willing to enter into contract negotiations with [Offeror's name] for provision of covered services to ALTCS members enrolled with [Offeror's name]. The undersigned provider intends to sign a contract with [Offeror's name] if [Offeror's name] is awarded an ALTCS contract beginning 10/1/2011 in the provider's service area and an acceptable agreement can be reached between the provider and [Offeror's name]. **Signing this letter of intent does not obligate the provider to sign a contract with [Offeror's name]. This is not a contract. The provider identified below understands that AHCCCS requires that all contracts include the Minimum Subcontract Provisions which can be found on the AHCCCS website (see AHCCCS Plans/Solicitations/Contract Amendments/ALTCS-EPD/2011 Contract Renewal – Section F, Attachment A).**

PROVIDER'S NAME: _____

PROVIDER'S ADDRESS(ES) (Sites where services will be provided):

_____
_____
_____
_____

COUNTY: _____
AHCCCS REGISTRATION ID #: _____
NATIONAL PROVIDER ID #: _____
PHONE: _____ FAX: _____

CHECK ALL THAT APPLY:

____	1	Adult Day Health	____	20	Homemaker
____	2	Adult Foster Care	____	21	Hospice
____	3	Assisted Living Center	____	22	Individual, Group, Family Counseling
____	4	Assisted Living Home	____	23	Inpatient Hospital
____	5	Attendant Care	____	24	Laboratory
____	6	Behavioral Health Day Program/Partial Care	____	25	Medical Imaging
____	7	Behavioral Health Emergency Care	____	26	Medication Monitoring
____	8	Behavioral Health Evaluation	____	27	Nursing Facility
____	9	Behavioral Health Inpatient Services	____	28	PCP
____	10	Behavioral Health Level II	____	29	Personal Care
____	11	Behavioral Health Level III	____	30	Pharmacy Services
____	12	DD Group Home	____	31	Physician Specialist
____	13	Dentist	____	32	Podiatrist
____	14	Durable Medical Equipment	____	33	Psychosocial Rehabilitation
____	15	Emergency Alert	____	34	Respite
____	16	Habilitation	____	35	Substance Abuse Transitional Agency
____	17	Home Delivered Meals	____	36	Therapies (PT, OT, ST)
____	18	Home Health Care	____	37	Transportation
____	19	Home Modifications			

AUTHORIZED SIGNATURE:_____

NAME OF SIGNER:_____ TITLE: _____

DATE SIGNED:_____

Note to Providers: This Letter of Intent will be used by AHCCCS in its bid evaluation and contract award process. Do not return this completed Letter of Intent to AHCCCS. The completed Letter of Intent must be returned to [Offeror's Name].