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.
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].