Letter of Intent to Contract

By signing below, the provider is expressing his or her interest in contracting with *My Care Alabama* as a subcontractor for the provision of covered services to Medicaid eligible enrollees for the following programs:

- Health Home Services, if *My Care Alabama* is awarded a Health Home contract and/or;
- Regional Care Organizations, if *My Care Alabama* is awarded full certification as a Regional Care Organization and enters into a full-risk contract with the Alabama Medicaid Agency

All subcontractors shall comply with Title VI of the Civil Rights Act of 1964 (42 USC §2000d, et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 USC §6101, et seq.), the Americans with Disabilities Act of 1990 (42 USC §2101, et seq.), and the regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84 and 90). No individual shall, on the ground of race, sex, color, creed, national origin, age or disability be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program of services.

In accordance with Section 22-6-153 (c) of the Alabama Code and Medicaid Administrative Rule No. 560-X-62-.10, the minimum fee- for--service reimbursement rates that a Regional Care Organization shall pay providers for applicable Medicaid services provided to a Medicaid beneficiary shall be the prevailing Medicaid fee-for-service schedule, unless otherwise jointly agreed to by a provider and a Regional Care Organization through a contract or mandated by federal law.

By signing below, the provider is not obligated to sign a contract with My Care Alabama upon review of the terms of any proposed contract.

The following information is furnished by the provider:

1. Printed Name: _____

2. NPI: _____ MAID: _____

3. Provider Type or Specialty: _____

4. Are you planning to be a PMP or a Core Specialist? _____

5. Counties from which the provider will take patients:_____

6. Address: _____ City: _____ State: _____ Zip: _____
(where services will be provided)

7. Telephone: _____ Fax: _____ Email: _____

8. Program Intent (check all that apply): ☐ Health Home ☐ RCO Program

_____ _____

Provider Signature Date Signed

_____ _____

Printed Name/Title Office Contact

Attachment A: Group Attestation if submitting a Letter Of Intent on behalf of multiple providers

Name	NPI	MAID	Type or Specialty	PMP or Specialist