Attachment Four-A
Maternity Care Program
Operational Manual
Effective 1.1.16

LETTER OF INTENT TO CONTRACT

The provider signing below is willing to enter into a contract with the __ (name of Primary Contractor) _____ as a subcontractor for the provision of covered services to Medicaid eligibles enrolled with the __(name of Primary Contractor)_____. This provider agrees to sign a contract with __ (name of Primary Contractor)_____, if said Primary Contractor is awarded a Medicaid contract beginning January 1, 2010 for __(district #)__ eligibles. Signing this letter of intent obligates the provider to sign a contract with __ (name of Primary Contractor)_____.

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 or, or be otherwise subjected to discrimination under any program of services.

The following information is furnished by the subcontracting provider:

1. Check all that apply: ____ DHCP ____ Prenatal Care Only
   ____ Other: specify: _____
2. Printed Name: _____ NPI: _____
3. Address: _____City _____ State _____ Zip _____
   (where services will be provided)
4. Telephone: _____ Fax: _____ Email: _____
5. Counties from which I will take patients: _____
6. If DHCP, hospital privileges held at: _____
7. Payment Arrangement: _____

_____ Provider Signature

_____ Date Signed

_____ Printed Name/Relation of Signer

_____ Office Contact