Form Approved
OMB Exempt

BUNDLED PAYMENTS FOR CARE IMPROVEMENT LETTER OF INTENT MODEL 2 - 4

This form shall serve as the letter of intent for organizations interested in submitting applications for Model 2, 3, and/or 4 of the Bundled Payments for Care Improvement initiative. Letters of intent will be used for planning purposes only, and will not be binding. Applications from organizations that do not submit a timely letter of intent will not be considered. Potential applicants interested in participating in two or more of Models 2, 3, and 4 may submit a single letter of intent but must submit separate applications to participate in multiple models.

For the purposes of this letter of intent, "Bundled Payment participating organizations" is used to mean all other providers or suppliers with whom the potential applicant plans to partner, e.g., physician group practices, hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies.

CMS considers all information submitted in the Letter of Intent and Application as exempt under the Freedom of Information Act. Therefore, CMS will not release this information to the general public. If you are selected to participate in the Bundled Payments, CMS may release publicly available demographic information (e.g. name, location, etc.) for informational purposes.

Please submit this form, a completed Data Use Agreement, and a Research Request Packet as appropriate by email to: BundledPayments@cms.hhs.gov. All forms must be submitted in a searchable digital format (e.g., searchable PDF) with attachments encrypted. Encryption must be compliant with AES 256 encryption guidelines. A decryption key must be sent in a separate email from these forms. In place of a written signature, please use a digital signature with a third-party certificate. All digital signatures must be third-party certified for verification purposes. A scanned written signature pasted into the signature box will not be accepted. If you cannot provide a digital signature with a third-party certificate, please attach a scanned copy of the signed LOI in addition to the searchable digital copy.

All letters of intent for Models 2, 3, and 4 must be received by 5:00 pm EDT November 4, 2011. Letters of intent and other forms will only be accepted via email.

Any questions regarding the Bundled Payments for Care Improvement initiative, the letter of intent, data use agreement, research request packet, or application process should be submitted by email to: BundledPayments@cms.hhs.gov. Responses to questions will be shared publicly to ensure that all applicants have access to clarifying information regarding the initiative and the application process. Questions and answers will be posted on the Bundled Payments for Care Improvement website, http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html

Name of Contact at Applicant Organization:

Applicant Organization Name:

Street Address:

Address Line 2:

Contact Phone:

Contact Email Address:

City:	State:	Zipcode:

Dear Innovation Center Staff,

This is to inform you that _____ intends to submit an application for

☐ Model 2 ☐ Model 3 ☐ Model 4

of the Bundled Payments for Care Improvement initiative. Below is the information requested by CMS:

Type of Applicant organization *(check only one)*

- ☐ Acute care hospital
- ☐ Hospital system(s)
- ☐ Physician group practice
- ☐ Network of individual practices (e.g., IPA)
- ☐ Partnership of hospital system(s) and medical practices
- ☐ Integrated delivery system
- ☐ Skilled Nursing Facility
- ☐ Inpatient Rehabilitation Facility
- ☐ Long-Term Care Hospital
- ☐ Home Health Agency
- ☐ Convener of health care providers (please describe)
- ☐ Other, please describe

Please list the name, address, and CMS Certification Number (CCN) for your organization and each Bundled Payment participating organization you expect to be involved in your application. *(This list is non-binding and for CMS planning purposes only.)*

Name	Street Address	Street Address 2	City	State	Zip	CCN

Has your organization or any anticipated Bundled Payment participating organization applied to participate in Model 1 of the Bundled Payments for Care Improvement initiative?

☐ Yes ☐ No

If yes, name of Model 1 applicant organization: _____

If yes, name of Model 1 applicant contact person: _____

If you have any other comments, please include them here.

_____

Sincerely,

_____
CEO/President/Executive Director Name:

_____
Potential applicant organization name:

_____
CEO/President/Executive Director Digital Signature:

_____
Date:

_____