
BUNDLED PAYMENTS FOR CARE IMPROVEMENT LETTER OF INTENT MODEL 1

This form shall serve as the letter of intent for organizations interested in submitting applications for Model 1 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.

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 by email to: BundledPayments@cms.hhs.gov. Please submit this letter of intent 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 submitted in a separate email from this form. 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 Model 1 must be received by 5:00 pm EDT October 6, 2011. Letters of intent will only be accepted via email.

Any questions regarding the Bundled Payments for Care Improvement initiative, the letter of intent, or the 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:

Zip code:

Dear Innovation Center Staff,

This is to inform you that _____ intends to submit an application for Model 1 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, e.g., Physician-Hospital Organizations
- Integrated delivery system
- Convener of health care providers, please describe
- Other, please describe

Please list the name, address, and CMS Certification Number (CCN) for each hospital 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

Please indicate any other model(s) of the Bundled Payments for Care Improvement initiative for which you intend to apply. *(This indication is non-binding and for CMS planning purposes only. Potential applicants interested in applying for Model 1 and any other model must submit separate letters of intent.)*

Model 2

Model 3

Model 4

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:
