Sample Letter of Intent Form

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Care Transformation Collaborative of Rhode Island:

Please accept the following letter, as an intent to apply for the 2019 CTC-RI Multi-Payer PCMH-Kids Pediatric Expansion by the deadline of October 31, 2018 on behalf of \_\_\_\_ (practice name) \_\_\_\_\_\_\_\_\_.

**Practice Name/Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Champion:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Application Key Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email address:** [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](mailto:Barringtonfamilymed@gmail.com)

**Phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person completing letter of intent:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact information if different from above: email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if practice site is applying as a single site\_\_\_\_ or multi-site \_\_\_

If practice is part of a multi-site organization, indicate other practice sites that are applying:

If other practice sites that are applying, please include above information for each of the practice sites: