ATTACHMENT D:

Letter of Intent to Apply for HCBS Transportation Funding & Conditional IHCP Approval

From: {Company Name]

To: Indiana FSSA, Office of Medicaid Policy and Planning

CEO or CFO Name:

FEIN Number: [XXXXXXXXXX}

Indiana Headquarters Address:

Date:

RE: Wheelchair Van and Lift Grant Program Letter of Intent

To Whom it May Concern,

[XX Organization] requests conditional IHCP provider enrollment approval in order to apply for the active HCBS Wheelchair Van and Lift Grant Program. We understand and agree to the following:

- We must start the IHCP enrollment process and submit this letter with other enrollment paperwork as well as submit an official grant request.
- We may need to seek and receive temporary or permanent Indiana Department of Revenue Motor Carrier certification prior enrolling with IHCP.
- Submission of the letter of intent and conditional approval does not guarantee funding and if we are not award a grant our conditional IHCP enrollment will be ended.
- Conditional IHCP enrollment postpones, but does not waive, inspection requirements.
- Operation as an IHCP transportation provider cannot begin until our IHCP status is fully activated and we have a signed agreement with the state's NEMT Broker, Southeastrans, INC.
- Failure to comply with the requirements of the grant may result in recoupment of funds.

(Signature and Date)

CEO or CFO Name:

Phone Number:

E-mail Address: