



**Department
of Health**

**Office for People With
Developmental Disabilities**

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner of Health, DOH

KERRY A. DELANEY, J.D.
Acting Commissioner, OPWDD

ATTACHMENT B- Letter of Interest Form

Letter of Interest – Submission of Health Home Application to Serve Individuals with Intellectual and/or Developmental Disabilities

Please submit this Letter of Interest Form on or before August 4, 2017, via email to: HHIDD@health.ny.gov and indicate Letter of Interest in the Subject Line

JoAnn Lamphere
Deputy Commissioner
Division of Person Centered Supports
Office for People With Developmental Disabilities

Lana I. Earle
Deputy Director
Office of Health Insurance Programs
Department of Health

This Letter of Interest is being submitted by:

Name of Organization/Agency: _____

Address of Organization/Agency: _____

Phone of Primary Contact at Organization/Agency: _____

Email of Primary Contact at Organization/Agency: _____

The submission of this Letter of Interest is optional and not binding. Failure to submit a Letter of Interest will not preclude entities from submitting an Application. To facilitate discussions amongst potential Applicants, network partners and care managers, including providers that are now Medicaid Service Coordinators (MSC), Letters of Interest will be posted to:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_IDD

Interested Applicants are encouraged to read the Draft Health Home Application to Serve Individuals with Intellectual and/or Developmental Disabilities in its entirety, including information regarding who can apply to be a CCO/HH.

In the space below please define the anticipated governance structure (e.g., anticipated ownership entity or entities, network providers, including MSCs) of your proposed CCO/HH and any other information you would like to provide the State.

The State’s goal is to provide CCO/HH services statewide, including a choice of CCO/HH in a region wherever possible. Please identify the OPWDD region or regions you anticipate your CCO/HH intends to serve. Note that preference will be given to Applicants that are applying for designation in all counties in an OPWDD Region. Please see the Draft Application for additional details.

Area: Region 1 – ALL

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|----------|-------------|------------|---------|----------|---------|------------|
| Allegany | Cattaraugus | Chautauqua | Chemung | Erie | Genesee | Livingston |
| Monroe | Niagara | Ontario | Orleans | Schuyler | Seneca | Steuben |
| Wayne | Wyoming | Yates | | | | |

Region 2 – ALL

| | | | | | | |
|----------|----------|----------|-------------|----------|----------|--------|
| Broome | Cayuga | Chenango | Clinton | Cortland | Delaware | Essex |
| Franklin | Hamilton | Herkimer | Jefferson | Lewis | Madison | Oneida |
| Onondaga | Oswego | Otsego | St.Lawrence | Tioga | Tompkins | |

Region 3 – ALL

| | | | | | | |
|--------|------------|------------|-------------|-------------|------------|----------|
| Albany | Columbia | Dutchess | Fulton | Greene | Montgomery | Orange |
| Putnam | Rensselaer | Rockland | Saratoga | Schenectady | Schoharie | Sullivan |
| Ulster | Warren | Washington | Westchester | | | |

Region 4 – ALL

| | | | | |
|-------|-------|----------|--------|----------|
| Bronx | Kings | New York | Queens | Richmond |
|-------|-------|----------|--------|----------|

Region 5 – ALL

| | |
|--------|---------|
| Nassau | Suffolk |
|--------|---------|

Name, title and telephone number of authorized contact person for matters related to the application:

Name: _____

Title: _____

Telephone number: _____

Signature: _____

Date: _____