GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES
Division of Developmental Disabilities

LETTER OF INTENT TO PROVIDE SERVICES FORM

SERVICE SITE

(Legal name and address must be registered with the Georgia Secretary of State's office)

Legal Name:			
Tax ID #:			
Corporate Street Address:			
City:	County:	State:	Zip Code:
Service Site Name:			
Service Site Address:			
City:	County:	State:	Zip Code:
Mailing Address (if different):			
City:	County:	State:	Zip Code:
Owner:			
Telephone:		Fax:	
Email Address:		Website:	
Director:			
Telephone:		Fax:	
Email Address:		Website:	
Nurse:			
Telephone:		Fax:	
Email Address:		Website:	
Developmental Disabilities Professional:			
Telephone:		Fax:	
Email Address:		Website:	

EMAIL ADDRESSES MUST BE CURRENT AND CORRECT AS ALL FUTURE CORRESPONDENCE FROM DBHDD WILL BE CONDUCTED VIA EMAIL. IT IS THE RESPONSIBILITY OF THE POTENTIAL PROVIDER TO ENSURE THAT EMAILS FROM DBHDD ARE ACCEPTED BY YOUR EMAIL SYSTEM AND DO NOT GO TO THE "SPAM" MAILBOX.

List below the Waiver Services that you are applying to provide and the number of individuals to be served in each Service.

Waiver Service *Such as CRA, CLS, SE etc.*	Number of Individuals to be Served In Each Service	County of Service Provision	Region of Service Provision	Licensed Service Y/N?

In accordance with Department of Community Health (DCH) Healthcare Facility Regulation Division (HFR) [which was formerly known as Office of Regulatory Services or ORS], please indicate all applicable license(s) that you possess:

❒ Child Placing Agency (CPA) license
❒ Community Living Arrangement (CLA) license
❒ Home Health Agency (HHA) license
❒ Personal Care Home (PCH) license
❒ Private Home Care (PHC) license

Please list any services that the organization has delivered to citizens with developmental disabilities within the past five years.

Name of Service	Location of Service	Length Of Service

Please list any previous Contracts, Letters of Agreement (LOA) or Provider Agreements (PA) issued to the organization within the last five years by any of the following:

- the Department of Human Resources (DHR), Division of Mental Health, Developmental Disabilities & Addictive Diseases (DMHDDAD) – currently known as the Department of Behavioral Health and Developmental Disabilities (DBHDD)
- the Department of Human Resources (DHR), Division of Aging – currently known as the Department of Human Services (DHS), Division of Aging
- Department of Community Health (DCH)

List Agency Name Used On Contract or LOA	**List all Key Personnel Names** **Such as** CEO/President Key Management Staff, Relative or Board of Directors	**Contact Phone Number And E-Mail Address of each Key Personnel Name Listed**	**Department Issuing Contract**	**Service Provided Such as Aging, ICWP, Source etc.**

With this *Letter of Intent to Provide Services Form,* your organization must also submit all pre-qualifiers listed within the **Recruitment and Application to Become a Provider of Developmental Disabilities Services Policy**. Any incomplete *Letter of Intent to Provide Services Form*, and/or incomplete or deficient pre-qualifier will result in no invitation to move forward to the application process.

Under applicable state and federal laws, I do hereby affirm that I am the authorized agent to complete this document and that the information contained herein this document is complete, true, and correct.

_____ _____

Name of Organization (please print) Owner / Title (please print)

_____ _____

Signature of Owner/ Title Date