NJ DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. BOX 712
TRENTON, NJ 08625-0712

TO: Pamela Orton, RN, MSN
Director, Office of Delivery System Innovation

FROM: Organization Name: _____

Primary Contact Person: _____

Origination Address: _____

Phone: _____

FAX: _____

Email: _____

DATE: _____

RE: New Jersey Medicaid Accountable Care Organization Demonstration
Non-Binding Letter of Intent

Please accept this document as a non-binding intent to apply to the NJ Department of Human Services, Division of Medical Assistance and Health Services, for certification as an Accountable Care Organization for the Demonstration project as cited in NJ P.L. 2011, Chapter 114.

This form should be completed and faxed to the Office of Delivery System Innovation at 609-588-3354 no later than March 1, 2013. Please contact 609-588-4611 for inquiries.