



APPENDIX F

TRANSMITTAL COVER FORM LETTER – Addendum #1

Denise Sherburne, Procurement Coordinator  
NH Department of Health and Human Services  
Contracts & Procurement Unit  
129 Pleasant Street  
Concord, NH 03301

Dear Denise:

By providing the requested information below, and signing, dating and submitting this Transmittal Cover Form Letter to you, we attest that:

- We have reviewed and agree to be bound by all application terms and conditions. Please place a checkmark (multiple checkmarks for more than one core medical services) in the applicable services from the following list:

	<b>Appendix G – Mental Health &amp; Substance Use Disorder Counseling and Treatment Services, RFA-2019-DPHS-04-NHCAR</b>
	<b>Appendix H – Oral Health Care Services, RFA-2019-DPHS-04-NHCAR</b>
	<b>Appendix I – Outpatient/Ambulatory Health &amp; TBFA Services, RFA-2019-DPHS-04-NHCAR</b>
	<b>Appendix J – Home and Community Based Health &amp; TBFA Services, RFA-2019-DPHS-04-NHCAR</b>

Including, but not limited to the Appendix A – Exceptions to the Terms and Conditions, the Appendix B – Contract Minimum Requirement, and the Appendix C – CLAS Requirements.

- We understand that the Appendix B shall form the basis of any Contract resulting from this RFA.
- We understand and agree to provide proof of, and maintain for the term of any Contract resulting from this RFA, the following insurance coverages:
  - Comprehensive General Liability or Professional Liability, and
  - Workers' Compensation coverage, if applicable.
- We/I are/am not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntary excluded from covered transactions by any Federal department or agency under 45 CFR Part 76; and have the ability to become a vendor with the State of New Hampshire.



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- The following documents are completed, signed, dated and attached to this Transmittal Cover Letter:
  - Signed and dated Appendix A – Exceptions to the Terms and Conditions;
  - Completed, signed and dated Applicant Step #2 – Required Questions Relating to Language Assistance Measures in the Appendix C – CLAS Requirements;
  - Curriculum Vitae or resume of each individual performing functions identified in the RFA;
  - Medical Licenses, Credentials and/or Certificates; and
  - Completed, signed and dated Management Questionnaire in Appendix D – Contract Monitoring Provisions.
- The point of contact from my office is:
  - Name/Title: \_\_\_\_\_
  - Telephone Number: \_\_\_\_\_
  - Email Address: \_\_\_\_\_
- The individual from my office that is authorized to contractually obligate the practice is:
  - Name/Title: \_\_\_\_\_
  - Telephone Number: \_\_\_\_\_
  - Email Address: \_\_\_\_\_
- Subrecipients of the Contracted provider may be reimbursed at Medicaid rates. List Provider(s) and/or Agency(s) that have an existing MOU, MOA, Contract, and/or other form of agreement with your practice/agency providing ancillary services. Subrecipients of the Contracted provider are eligible for reimbursement. List any subrecipients that will be utilized for services  
\_\_\_\_\_  
\_\_\_\_\_

I look forward to working with the NH Department of Health and Human Services on Core Medical Services contract.

Sincerely,

Signed: \_\_\_\_\_

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

Name: \_\_\_\_\_

Title: \_\_\_\_\_