

**LETTER OF AGREEMENT
ASSESSMENTS**

This Letter of Agreement, effective / / is entered by and between **Capitated Health Care Services, Inc.** (referred to herein as "CHCS") and _____
_____ (referred to herein as "Provider.") This Letter of Agreement is entered in order for the Provider to commence providing services.

The Provider, by signing this Letter of Agreement, hereby agrees to:

1. Maintain all appropriate licenses required to provide services in accordance with the laws and regulations of the State of _____.
2. Accept as payment in full the amounts specified below for services rendered.
3. Obtain and maintain reasonably adequate policies of insurance for general business operations and professional negligence for itself and its employees, agents and representatives.
4. Listing in a directory of providers published by CHCS or an insurance company contracted with CHCS.

CHCS, by signing this Letter of Agreement, hereby agrees to:

1. Guarantee payment in full, subject to policy provisions, from the insurance company of the policyholder for home care services pre-authorized by CHCS. Appropriate documentation must be submitted and bill rates must be as stated below.

Each party, by signing this letter of Agreement, hereby agrees to:

1. Either party may terminate this Letter of Agreement without cause by giving 60 days prior written notice of termination to the other party.
2. In the event of termination of this letter of understanding, payment to provider shall continue under the terms listed above.

Rates:

Benefit Determination Assessment	\$60.00
Re-assessment	\$50.00
Underwriting Assessment	\$50.00

Note: A Registered Nurse must do all assessments.

Provider:

Signature

Print name

Title

Date

CHCS:

Signature
Steven Turner

Print name
National Director, Provider Management

Title

Date