

Disclosure Statement: Hospital and Ancillary Providers

Federal and State law require this form to be completed by any hospital or ancillary provider with a contractual arrangement with Horizon NJ Health relating to the managed Medicaid and NJ FamilyCare programs. Horizon must provide this form to DMAHS upon request. Please direct any questions regarding this form to your legal counsel and refer to the New Jersey Medicaid HMO Contract as well as 42 CFR 455.100, et seq.

I.	Identifying Information of the Provider
	Name of Disclosing Provider and D/B/A
	Street Address
	City
	County
	State
	Zip Code
	Telephone Number
	NJ Medicaid Provider Number
II.	Ownership and Control Interest
A.	Provide the following information for each individual or corporation with an ownership or control interest in the provider as required by 42 C.F.R. §455.104(b)(1)-(2). Ownership percentages must total 100%. Append additional pages if more than three owners.
	Owner 1
	Name of Owner
	Relationship with the Provider
	Percent of Ownership
	Owner DOB (mm/dd/yyyy)
	Primary Address
	City
	State
	Zip Code
	SSN (individual) and/or TIN
	P.O. Box address (for Corporations)
	IRS ID/Other Tax ID (for Corporations)
	All business location addresses (for Corporations)
	Relationship to other persons with ownership or control interests

Owner 2
Name of Owner
Relationship with the Provider
Percent of Ownership
Owner DOB (mm/dd/yyyy)
Primary Address
City
State
Zip Code
SSN (individual) and/or TIN
P.O. Box address (for Corporations)
IRS ID/Other Tax ID (for Corporations)
All business location addresses (for Corporations)
Relationship to other persons with ownership or control interests
Owner 3
Name of Owner
Relationship with the Provider
Percent of Ownership
Owner DOB (mm/dd/yyyy)
Primary Address
City
State
Zip Code
SSN (individual) and/or TIN
P.O. Box address (for Corporations)
IRS ID/Other Tax ID (for Corporations)
All business location addresses (for Corporations)
Relationship to other persons with ownership or control interests

provid subcor	extent the provider has a direct or indirect ownership interest of five percent or more in a subcontractor, the the following information for each individual or corporation with an ownership or control interest in that intractor, as required by 42 C.F.R. §455.104(b)(1)-(2) and the New Jersey Medicaid HMO Contract, and 7.35.A.1-2. Append additional pages if there are additional subcontractors and/or owners.
Subco	ntractor 1: Owner 1
Name	of Owner
	onship with the Provider
Percen	t of Ownership
	DOB (mm/dd/yyyy)
	y Address
State _	
Zip Co	ode
	ndividual) and/or TIN
P.O. B	ox address (for Corporations)
	O/Other Tax ID (for Corporations)
IRS II	siness location addresses (for Corporations)
IRS III All but	
All but Relation	onship to other persons with ownership or control interests
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All but Relation (identity) Subconname	onship to other persons with ownership or control interests fy whether parent, spouse, child, or sibling of other owner herein) ntractor 1: Owner 2
Relation (identity) Subconname Relation	onship to other persons with ownership or control interests fy whether parent, spouse, child, or sibling of other owner herein) ntractor 1: Owner 2 of Owner
All but Relation (identity) Subconname Relation Percent	siness location addresses (for Corporations) onship to other persons with ownership or control interests fy whether parent, spouse, child, or sibling of other owner herein) ntractor 1: Owner 2 of Owner onship with the Provider
Relation (identity) Subcon Name Relation Percent Owner of the subcon the sub	siness location addresses (for Corporations) onship to other persons with ownership or control interests fy whether parent, spouse, child, or sibling of other owner herein) ntractor 1: Owner 2 of Owner onship with the Provider t of Ownership t DOB (mm/dd/yyyy)
Relation (identity) Subcon Name Relation Percent Owner Primare	siness location addresses (for Corporations) onship to other persons with ownership or control interests fy whether parent, spouse, child, or sibling of other owner herein) ntractor 1: Owner 2 of Owner onship with the Provider t of Ownership
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Relation (identity) Subconname Relation Percent Owner Primar City State _ Zip Conname SSN (identity)	siness location addresses (for Corporations) onship to other persons with ownership or control interests fy whether parent, spouse, child, or sibling of other owner herein) intractor 1: Owner 2 of Owner onship with the Provider t of Ownership DOB (mm/dd/yyyy) y Address ode ndividual) and/or TIN
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Owner 1 Name of Owner	erest in the ent applies
Name of Other Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable) Nature of Relationship with Other Entity Owner 2 Name of Owner Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable) Nature of Relationship with Other Entity City State Zip Code P.O. Box Address (if applicable) Nature of Relationship with Other Entity Owner 3 Name of Owner Name of Other Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable)	
Primary Address of Other Entity	
Primary Address of Other Entity	
State	
Zip Code P.O. Box Address (if applicable) Nature of Relationship with Other Entity Owner 2 Name of Owner Name of Other Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable) Nature of Relationship with Other Entity Owner 3 Name of Owner Name of Other Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable) Nature of Relationship with Other Entity	
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P.O. Box Address (if applicable) Nature of Relationship with Other Entity Owner 2 Name of Owner Name of Other Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable) Nature of Relationship with Other Entity Owner 3 Name of Owner Name of Owner Name of Other Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable)	
Owner 2 Name of Owner	
Name of Owner	
Name of Other Entity	
Name of Other Entity	
Primary Address of Other Entity	
City	
State	
Zip Code P.O. Box Address (if applicable) Nature of Relationship with Other Entity Owner 3 Name of Owner Name of Other Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable)	
Nature of Relationship with Other Entity Owner 3 Name of Owner Name of Other Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable)	
Nature of Relationship with Other Entity Owner 3 Name of Owner Name of Other Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable)	
Name of Owner	
Name of Other Entity Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable)	
Name of Other Entity	
Primary Address of Other Entity City State Zip Code P.O. Box Address (if applicable)	
City State Zip Code P.O. Box Address (if applicable)	
State Zip Code P.O. Box Address (if applicable)	
Zip Code P.O. Box Address (if applicable)	
P.O. Box Address (if applicable)	
1 word of Relationship with other Entity	
(Con	(Continues)

	required by 42 C.F.R. §455.104(b)(4).
	Name 1
	Address
	Date of Birth
	Social Security Number
	Name 2
	Address
	Date of Birth
	Social Security Number
III.	Disclosure by Provider: Information Related to Business Transactions
A.	Please provide the following ownership information for any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request as required by 42 C.F.R. §455.105(b)(1).
	Name 1
	Address
	Ownership
	Name 2
	Address
	Ownership
В.	Please provide the following information for any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5 years as required by 42 C.F.R. §455.105(b)(2). "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 or 5 percent of a provider's total operating expenses.
	Name of parties to Transaction 1
	Amount of Transaction
	Date of Transaction
	Nature of Transaction
	Name of parties to Transaction 2
	Amount of Transaction
	Date of Transaction

D. The name, address, date of birth, and Social Security Number of any managing employee of the provider, as

IV. Disclosure of Information on Persons Convicted of Crimes

V.

As required by 42 C.F.R. §455.106(a), identify any person who:

- Has ownership or control interest in the provider, or is a director, officer, agent or managing employee of the provider; and
- Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs.

Name 1
Address
Date of Birth
Social Security Number
Tax Identification Number (TIN)
Name 2
Address
Date of Birth
Social Security Number
Tax Identification Number (TIN)
Attestation Whoever knowingly and willfully makes or causes to be made a false statement or representation on this Disclosure Statement may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the provider already participates, a termination of its agreement or contract with Horizon NJ Health, as appropriate.
Name of Authorized Representative
Title
Signature
Date

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