RESET

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 _____
(identify whether parent, spouse, child, or sibling of other owner herein)

(*Continues*)

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 _____
(identify whether parent, spouse, child, or sibling of other owner herein)

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 _____
(identify whether parent, spouse, child, or sibling of other owner herein)

(*Continues*)

B. To the extent the provider has a direct or indirect ownership interest of five percent or more in a subcontractor, provide the following information for each individual or corporation with an ownership or control interest in that subcontractor, as required by 42 C.F.R. §455.104(b)(1)-(2) and the New Jersey Medicaid HMO Contract, Section 7.35.A.1-2. Append additional pages if there are additional subcontractors and/or owners.

Subcontractor 1: 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 _____
(identify whether parent, spouse, child, or sibling of other owner herein)

Subcontractor 1: 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 _____
(identify whether parent, spouse, child, or sibling of other owner herein)

(*Continues*)

C. Provide the following information for any other entity in which a person with an ownership or control interest in the provider also has an ownership or control interest as required by 42 C.F.R. §455.104(b)(3). This requirement applies to the extent that the provider can obtain this information by requesting it in writing from the person.

Owner 1

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 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 _____

(*Continues*)

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

B. 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 _____

Nature of Transaction _____

(*Continues*)

IV. Disclosure of Information on Persons Convicted of Crimes

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) _____

V. 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 _____