Carolina Family Health Centers, Inc.

Ownership and Control Disclosure Statement

As mandated by various federal and state granting entities, third party payers, and other insurers, CFHC, Inc. is required to gather, maintain, and provide certain information. Specifically, the federal regulations set forth in *42 CFR 455.104-106* require all providers who are entering into or renewing a provider agreement ("disclosing entities") to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: (1) the identities of all owners with a control interest of 5% or greater, (2) all agents or managing employees of the disclosing entity, (3) details of certain familial relationships between owners or owners of subcontractors owned by the disclosing entity, and (4) the identities of any excluded individual or entity with an ownership or control interest in the disclosing entity.

Completion and submission of this Statement is a condition of CFHC, Inc.'s participation in certain state and federal programs. Failure of CFHC, Inc. to submit the requested information may result in denial of a claim, a refusal to enter into a provider contract, or termination of existing provider contracts. Failure of the individual completing this form to provide accurate information or timely updates to this information shall result in disciplinary action, up to and including termination.

Check one that most closely describes you: ☐Board Member ☐Employee ☐Independent Contractor ☐Other:_____
Name:
Other Names Used (maiden names, etc.):
Date of Birth: **Place of Birth (City, State; Country):**
Address:
Social Security Number or Tax Identification Number:
Health Care Practitioners **Medicare I.D. number:** **NPI number:**

Please complete questions 1-17 below. For any question with a "yes" response, you must provide supporting documentation.

1. Have you ever been convicted of a federal or state felony, had adjudication withheld on a felony, pled no contest to a felony, or entered into a pre-trial agreement for a felony?

   ☐Yes ☐No

2. Have you ever had disciplinary action taken against any business or professional license held in this or any other state, or has your license to practice ever been restricted, reduced, or revoked in this or any other state or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?

   ☐ Yes ☐ No

3. Have you ever been denied enrollment, been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state, or been employed by a corporation, business, or professional association that has ever been suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state?

   ☐ Yes ☐ No

4. Have you ever had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state?

   ☐ Yes ☐ No

5. Have you ever had civil monetary penalties levied by Medicare, Medicaid, or other State or Federal Agencies or Programs, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full?

   ☐ Yes ☐ No

6. Do you owe money to Medicare or Medicaid that has not been paid?

   ☐ Yes ☐ No

7. Have you ever been convicted under federal or state law of a criminal offense related to the delivery of an item or service under Medicare or a State health care program or neglect or abuse of a patient in connection with the delivery of any health care item or services?

   ☐ Yes ☐ No

8. Have you ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?

   ☐ Yes ☐ No

9. Have you ever been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service?

☐ Yes ☐ No

10. Have you ever been convicted under federal or state law relating to the interference with or obstruction of any investigation into any federal or state criminal offense relating to the delivery of a health care item or service, offense relating to patient neglect or abuse; a felony criminal health care fraud offense, or a felony offense relating to a controlled substance.

☐ Yes ☐ No

11. Have you ever been found to have violated federal or state laws, rules, or regulations governing North Carolina's Medicaid program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program and been sanctioned accordingly?

☐ Yes ☐ No

12. Have you ever been convicted of an offense against the law other than a minor traffic violation?

☐ Yes ☐ No

13. Have you ever been debarred or suspended from participating in government contracts, subcontracts, loans, grants, or other government assistance programs?

☐ Yes ☐ No

14. Have you ever had any liability insurance carrier cancel, refuse coverage, or rate up because of unusual risk or have any procedures been excluded from coverage?

☐ Yes ☐ No

15. Have you ever practiced or worked without liability coverage?

☐ Yes ☐ No

16. Have your privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending?

☐ Yes ☐ No

17. Have you had a professional liability claim assessed against you in the past five years or are there any professional liability cases pending against you?

☐ Yes ☐ No

By signing below, I agree to immediately report to the Chief Executive Officer of Carolina Family Health Centers, Inc. (or to the President of the Board of Directors, if a board member) any occurrence or event that subsequently results in a change of my status related to any of the information contained above. Additionally, I certify that the answers to the questions (and any supporting documentation) are true to the best of my knowledge. My signature is also my consent to the use of this information, including my name and other personally identifiable information, for purposes related to the governance and operations of Carolina Family Health Centers, Inc.

Return this completed, signed form and any supporting documentation to the Director of Human Resources or to the Executive Assistant (for board members).

_____ _____

Date Signature

_____

Printed Name

_____

Title/Position