STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

AUTISM SPECTRUM DISORDER (ASD) TREATMENT PROVIDER

The Enrollment Packet consists of:

1. Application Cover Letter
2. Notice to Enrollee(s)
3. **Request for National Provider Identifier (NPI) (required)**
4. Signature Authorization Form
5. Provider Start Date Form
6. Provider Application - FD-20
7. Provider Agreement - FD-62
8. Disclosure of Ownership and Control Interest Statement
9. W-9 Tax Form (required)
10. **Notice to Enrollee (documentation required)**
11. Affirmative Action Survey (optional)
12. **Authorization for Automatic Payments & Deposits (required)**
13. Agreement of Understanding
14. **Proof of Completed Background Checks and Meeting Fingerprinting Requirements**
15. **ASD Treatment Provider Experience Attestation**

In order to be approved as a provider of autism services, a completed application package must be submitted including the following:

1. If you are an entity, you are required to submit a copy of your 147C Letter from the IRS or a copy of the IRS CP-575 form. If a Social Security Number is the primary means of identity, you are required to submit a copy of your Social Security Card.

2. Written documentation indicating the successful completion of criminal background checks and meeting fingerprinting requirements for all employees having direct contact with children.

The enclosed W-9 Tax Form is required for all enrollments. Please indicate the name of the entity as registered with the IRS.

If all components are present and complete, a provider of autism services may be approved for participation in the NJ FamilyCare/Medicaid Fee-For-Service Program by DXC Technology.

The effective date of approval will be either the date of the Provider Agreement or the date on the Provider Start Date Form, whichever date is earlier.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Dear Provider:

Your request for a Provider Specific Enrollment Packet has been received and documented. We are mailing you the packet of forms needed to meet enrollment requirements for your provider type. Please complete the forms and make sure all questions are answered; where not applicable, just enter N/A. Otherwise, there will be a delay in the enrollment process.

Other attachments required for your provider type are listed on the preceding page.

Your promptly completed enrollment packet will ensure a speedy enrollment process. If you have not received any correspondence with a month, please write to:

Provider Enrollment
DXC Technology
P.O. Box 4804
Trenton, NJ 08650

Provider Enrollment Unit
609-588-6036

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

CAROLE JOHNSON
Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

Notice to Enrollee(s)

In an effort to properly set-up the identity of an individual or an entity as a NJ FamilyCare Medicaid provider, the Division requires that when a Social Security Number is the primary means of identity, you are required to submit a copy of your Social Security Card.

If you are an entity, you are required to submit a copy of your 147C Letter from the IRS or copy of the IRS CP-575 Form.

PLEASE BE ADVISED THAT YOUR APPLICATION TO BECOME A NJ FAMILYCARE MEDICAID PROVIDER CANNOT BE COMPLETED UNTIL WE HAVE RECEIVED A COPY OF THESE DOCUMENTS.

Request for National Provider Identifier (NPI)
Provider Enrollment Application Insert

You must have an NPI number to bill electronically. Please provide us with the information requested in the boxes below and return this form along with your completed enrollment application. Failure to do so will slow the enrollment process.

The NPI shall replace the billing and servicing provider number previously used to bill Medicare, NJ FamilyCare (NJFC)/Medicaid, and other health care payers.

All health care providers can apply for an NPI by:

- Using the web-based application https://nppes.cms.hhs.gov; or
- Sending a paper application to the Centers for Medicare & Medicaid Services' (CMS') NPI Enumerator, Fox Systems. A copy of the application can be downloaded at https://nppes.cms.hhs.gov. A health care provider can also contact the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.

Name	Address	NPI Number
1)		
2)		
3)		

For DXC Technology Internal Use Only			
Provider Name: _____		Provider ID# _____	
Doc Type: **CHNGREQ**	Provider Type: _____	Provider Specialty: _____	

DXC.technology

SIGNATURE AUTHORIZATION FORM

Date:

Dear Provider:

If anyone other than the practitioner is authorized to sign and certify NJFC Medicaid claims and supporting documents, the signature of that person must appear on the claim form as indicated below (**NOT THE PRACTITIONER'S NAME).** If the authorized individual is the NJFC Medicaid Provider, he/she must sign the Authorization Form.

In addition to the above, an authorized representative(s) who is an employee of your office should **only** complete this Form. Should your office utilize a billing firm or agency, a letter signed by yourself must be submitted indicating the name(s) of those individuals you have authorized to sign. The name(s) should be printed and then the actual signature affixed by that individual. The letter should contain the name of the billing firm or agency which has been approved to provide your billing.

If your application is for the group please provide the GROUP NAME in the Provider Name field. If the application is for an individual please provide the Individual Provider name in the Provider Name field.

Note: Only Originals. No Faxes or Copies are accepted.

Provider Name:		
Provider ID #:		NPI#:
Address:		
City:	State:	Zip:

Please Print or Type	
Full Name	**Actual Signature(s)**

RETURN TO:

DXC Technology
Attn: Provider Enrollment Unit
P.O. Box 4804
Trenton, NJ 08650-4804

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Provider Start Date Form

HAVE YOU ALREADY RENDERED SERVICES TO A NEW JERSEY MEDICAID BENEFICIARY? IF SO, GIVE DATE OF SERVICE _____.

Take Note:

The above date you indicate will be the effective date of your Medicaid Provider Enrollment for claims submission. If this form is not completed, your effective date will reflect the date signed on your provider agreement.

ALSO, ATTACH A COPY OF THE PROVIDER'S LICENSE THAT SUPPORTS THE ABOVE DATE OF SERVICE. (IF APPLICABLE)

PLEASE TAKE NOTE: It is a New Jersey Medicaid Requirement (NJAC 10:49-7.2 Timeliness of Claim Submission and Inquiry) that the New Jersey Medicaid Fiscal Agent, DXC Technology, receive a provider's claim submittal within one (1) year from:

1. The date of discharge for institutional claims, or,
2. The date of service or dispensing date for non-institutional claims.

Please also refer to the billing manual you will receive from the Fiscal Agent when a provider number is assigned for further claim submittal instructions.

For DXC Technology Internal Use Only

Provider Name: _____

Doc Type: _____ Provider Type: _____ Provider Specialty: _____

Tax ID: _____ Social Security: _____

Provider Number: _____

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

AUTISM SPECTRUM DISORDER (ASD) TREATMENT PROVIDER

1a. Is this application a transfer of ownership: Yes___ No___ If yes, provide previous owners' seven digit provider # and tax id: Provider # Tax ID:	1b. Legal Name of Provider: 2. Provider Type

2A. Type of Business or Facility ☐ Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other (Specify)

3. Business Name, if Different from Above

4. Employer/Tax ID Number/Social Security Number

5. Office Telephone Number/Ext. 5a. Billing Phone # 6. Length of time at Practice address in New Jersey

7. Name, Birth Date, Social Security #s of any administrators, agents and employees in managing positions: (use separate sheet if necessary)
a)
b)
c)

8. **Billing Provider Address** (Do not use PO Box)

Street

City State County Zip

9. **Pay To Address** (for Checks/Remittance Advice)

Street

City State Zip

10. **Mail To Address** (for Newsletters/Correspondence)

Street

City State Zip

11. E-mail Address 12. Fax #

13. Indicate NJ Charity Care Provider _____Yes _____No (Questions 14-17 are for NJ acute care hospitals only)

14. **Charity Care Pay To Address** (Remittance Advice)

Street

City State Zip

15. Charity Care Telephone Number/Extension 16. Charity Care Fax #

17. Charity Care E-mail Address

18. Indicate legal status of your organization: Profit _____ Non-Profit_____ Private_____ Public_____
If other, please specify_____

19. List the specific service(s) for which you are requesting approval for reimbursement under the programs administered in whole or in part by the Division of Medical Assistance and Health Services

20. Do you operate from more than one location? _____Yes _____No. If yes, list name, service address and Medicaid Provider Number or Tax Id if applicable.

a. _____

b. _____

c. _____

Please attach additional sheet if necessary.

21. Is the applicant a member of a chain organization. Yes____ No ____ If yes, indicate name:_____

22. Are you required from the New Jersey Department of Health to receive a Certificate of Need under the Health Facilities Planning Act? _____Yes _____ No. If yes, attach a copy of the Certificate of Need.

23. If your business or facility requires a current license/permit, indicate type _____ and number _____
Please attach a copy of the current license/permit, e.g., Independent Laboratory Certification.

24. CERTIFICATION, ACCREDITATION OR APPROVAL: Specify type and attach copy, for example, Behavior Analyst Certification Board (BACB) Certificate, JCAHO (hospitals); New Jersey Department of Human Services (clinics); Division of Mental Health Services (mental health clinics); State Board of Dentistry (dental clinics); State Board of Pharmacy (providers offering pharmaceutical services); American Board for Certification in Prosthetics and Orthotics (Prosthetist and/or Orthotist).

25. Approved by Medicare? _____Yes _____No. If yes, what is your Medicare provider number _____, and also attach copy of your Medicare approval.

26. NPI number: _____

26A. Please report a bed count for your facility_____.

27. If Out-of-State Provider: Are you approved as a Medicaid provider in your State? _____ Yes _____ No. If yes, attach a copy of the approval letter from your state's Medicaid agency and your state's Medicaid Provider Number_____.

28. List the names, SSA Number, Date of Birth, National Provider Identifier (NPI), License, Certification Agency and Number and Degree(s) for all ASD treatment staff in the organization directly involved with the delivery of Medicaid services and/or the processing of claims. If more space is needed, attach additional sheets.

	Name	SSA Number	Date of Birth	NPI	License #/State	Certification Number	Degree
a.							
b.							
c.							
d.							
e.							

29. Have any of the individuals or entities named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees:

a. Ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? Yes____ No____ If Yes, list type of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s).

b. Ever been the subject of any past or pending license suspension, revocation, or other adverse action by any licensing authority including but not limited to any fine, penalty, reprimand, disciplinary action or probationary period (even if paid and/or resolved) imposed by any licensing authority (excluding motor vehicle violations), in this state or any other jurisdiction? Yes ____ No ____. If yes, explain:

c. Ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime or disorderly persons offense in this State or any other jurisdiction (even if this resulted in pre-trial intervention)? Yes ____ No ____. If yes, explain:

d. Ever been the subject of any past or pending suspensions, debarments, disqualifications or recovery action or criminal convictions involving Medicaid, Medicare, any other federally or state-funded health care program, any private or non-profit health insurance plan or program in this state or any other jurisdiction, or any other programs administered in whole or in part by DMAHS? Yes ____ No ____. If yes, explain, and indicate current status of action:

e. Ever owned or had any financial interest in any other provider participating in the New Jersey Medicaid Program of any other state or jurisdiction? Yes ____ No ___. If Yes, list provider name and nature of relationship.

30. Do you charge for goods and/or services? TO ALL _____ or TO CERTAIN GROUPS ONLY _____.
If you charge to all or only certain groups, please explain your arrangement.
(Attach a copy of your fee schedule)

31. List days and hours of operation.

32. NOTE: There are federal and state statutes and regulations governing kickbacks and referral practices which may apply to the applicant and to those individuals and entities listed in this application. These statutes and regulations include, but are not limited to: The Federal Medicare and Medicaid Anti-Kickback Statute (42 USC 1320a-7b(b)); the Federal Safe Harbor Regulations (42 CFR 1001:952); the Stark Laws (42 USC 1395nn, 42 USC 1396b(s) and implementing regulations); the State Medicaid Anti-Kickback Statute (NJS 30:4D-17(c)); and the Codey Law (NJS 45:9-22.4 et. seq.) and its implementing regulations (NJAC 13:35-6.17)). Applicants should carefully review and understand these legal requirements and prohibitions, because signing this Agreement is a representation that there is full compliance with all these statutes and regulations.

33. FOR THE PURPOSE OF ESTABLISHING ELIGIBILITY TO RECEIVE DIRECT PAYMENT FOR SERVICES TO BENEFICIARIES UNDER THE NEW JERSEY MEDICAID (TITLE XIX) PROGRAM AND THE OTHER PROGRAMS ADMINISTERED IN WHOLE OR IN PART BY THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS), I CERTIFY ON BEHALF OF THE APPLICANT THAT THE INFORMATION FURNISHED IN THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE. I AM AWARE, AND BY SIGNING THIS APPLICATION GIVE CONSENT ON BEHALF OF THE APPLICANT THAT I REPRESENT, THAT DMAHS AND/OR THE MEDICAID FRAUD DIVISION (MFD) OF THE OFFICE OF THE STATE COMPTROLLER MAY VERIFY THE ACCURACY OF ANY AND ALL INFORMATION AND DOCUMENTATION SUBMITTED IN CONNECTION WITH THIS APPLICATION, INCLUDING, BUT NOT LIMITED TO, CONDUCTING A CIVIL AND/OR CRIMINAL BACKGROUND INVESTIGATION RELATING TO ANY OF THE INDIVIDUALS OR ENTITIES MENTIONED IN THIS APPLICATION OR IN ANY SUPPORTING DOCUMENTS.

I AM AWARE THAT ALL EMPLOYEES HAVING DIRECT CONTACT WITH AND/OR RENDERING BEHAVIORAL ASSISTANCE SERVICES DIRECTLY TO THE BENEFICIARIES SHALL BE REQUIRED TO SUCCESSFULLY COMPLETE CRIMINAL BACKGROUND CHECKS, IN ACCORDANCE WITH N.J.A.C. 10:77-4.9(g) AND THE PROVIDER MUST MAINTAIN VERIFIED WRITTEN DOCUMENTATION OF SUCCESSFUL COMPLETION OF A CRIMINAL BACKGROUND CHECK CONDUCTED BY A RECOGNIZED AND REPUTABLE SEARCH ORGANIZATION FOR ALL STAFF HAVING DIRECT CONTACT WITH CHILDREN, IN ACCORDANCE WITH N.J.A.C. 10:77-4.14(d).

I AM ALSO AWARE THAT IF ANY OF THE STATEMENTS MADE BY ME IN THIS APPLICATION ARE FALSE OR FRAUDULENT, OR IF THE RESULTS OF THE BACKGROUND INVESTIGATION ARE UNSATISFACTORY, THIS APPLICATION MAY BE DENIED, AND **I** AND THE APPLICANT ARE SUBJECT TO PUNISHMENT, INCLUDING BUT NOT LIMITED TO: CRIMINAL PROSECUTION UNDER APPLICABLE STATUTES, INCLUDING N.J.S. 30:4D-17 AND N.J.S. 2C:28-3; SUSPENSION, DEBARMENT OR DISQUALIFICATION FROM THE NEW JERSEY MEDICAID PROGRAM AND ALL OTHER PROGRAMS ADMINISTERED IN WHOLE OR IN PART BY DMAHS IN ACCORDANCE WITH N.J.A.C. 10:49-11.1(d)22; TERMINATION OF ANY PROVIDER AGREEMENT UNDER N.J.A.C. 10:49-3.2(f); AND RECOVERY UNDER APPLICABLE STATUTES AND REGULATIONS INCLUDING N.J.S. 30:4D-7.h AND N.J.S. 30:4D-17. I ALSO UNDERSTAND THAT ALL OF THE QUESTIONS IN THIS APPLICATION MUST BE ANSWERED, AND THAT FAILURE TO DO SO MAY RESULT IN DENIAL OF THIS APPLICATION. I FURTHER UNDERSTAND THAT IF THIS APPLICATION IS DENIED, A NEW APPLICATION CANNOT BE RESUBMITTED FOR A PERIOD OF ONE YEAR FROM THE DATE OF THE DENIAL. I AGREE TO NOTIFY (IN WRITING) THE FISCAL AGENT'S PROVIDER ENROLLMENT UNIT IMMEDIATELY OF ANY UPDATES OR CHANGES TO ANY OF THE INFORMATION THAT ARE BEING PROVIDED IN THIS APPLICATION AND IN ANY SUPPORTING DOCUMENTS.

Signature of Provider Representative | Print Name and Title | Date

FOR DIVISION AND OR FISCAL AGENT USE ONLY

[ ] Approve [ ] Disapprove [ ] Other Initial_____ Date_____

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CONFIRMATION OF ASD TREATMENT PROVIDER QUALIFICATIONS

ASD Treatment Provider Qualification/Credentialing Requirements are Listed Below

Provider Specialty	Education Qualifications	Credentialing Requirements (Copy of BACB Certificate Required)	Attestation Requirement (Completion of the Attached Attestation Form is Required)
Board Certified Behavior Analyst - Doctoral (BCBA-D)	Doctorate degree in psychology, special education, guidance and counseling, social work or a related field	Behavior Analyst Certification Board (BACB) Certificate, doctoral level	At least one year of experience in developing and implementing behavior support plans for individuals who have intellectual/developmental disabilities
Board Certified Behavior Analyst (BCBA)*	Master level degree in psychology, special education, guidance and counseling, social work or a related field.	Behavior Analyst Certification Board (BACB) Certificate, graduate level	At least one (1) year of experience in developing and implementing behavior support plans for individuals who have intellectual/developmental disabilities
Board Certified Assistant Behavior Analyst (BCaBA)	Bachelor's level degree in psychology, special education, guidance and counseling, or social work.	Behavior Analyst Certification Board (BACB) Certificate, undergraduate level	At least one (1) year of post-graduate experience in developing and implementing behavior support plans for individuals who have intellectual/developmental disabilities.
Behavior Technician (BT) or Registered Behavior Technician (RBT)	Bachelor's degree in psychology, special education, guidance and counseling, social work or a related field; or a high school diploma or GED; or be an RBT.	Behavior Analyst Certification Board (BACB) Certificate (if applicable)	For a bachelor's degree, at least one (1) year of supervised experience in implementing behavior support plans for individuals who have intellectual/developmental disabilities. For a high school diploma or GED, at least three (3) years of supervised experience in implementing behavior support plans for individuals who have an intellectual/developmental disabilities. Or be a Registered Behavior Technician (RBT) certified by the Behavior Analyst Certification Board (BACB).

*Also psychologists with training in applied behavior analysis

In order to be approved with one of the provider specialties indicated above, a completed application package must be submitted including the following:

- A copy of an individual's Behavior Analyst Certification Board (BCBA) Certificate for his/her provider specialty if applicable.

- A completed ASD Treatment Provider Experience Attestation (See Attachment) **must** be completed by each staff person delivering services to individuals diagnosed with an ASD.

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ASD Treatment Provider Experience Attestation

I {_____} on behalf of our agency, {_____ _____}, on this date {_____} attest that staff identified below in this Attestation have the experience* required to qualify and practice as a Board Certified Behavior Analyst Doctoral (BCBA-D), Board Certified Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst (BCaBA), Registered Behavior Technician (RBT) or Behavior Technician (BT) to provide Autism Spectrum Disorder (ASD) Treatment for the NJ FamilyCare/Medicaid program and shall comply with all federal and State statutes and regulations applicable to a provider serving NJ FamilyCare/Medicaid beneficiaries. I fully understand the consequences for non-compliance which may result in adverse consequences including but not limited to denial and recovery of claims or other penalties being assessed by the New Jersey Division of Medical Assistance and Health Services or other authorities.

* See "Confirmation of ASD Treatment Provider Qualifications" page within this application.

Name	DOB	Provider Specialty (e.g. BCBA-D, BCBA, BCaBA, RBT, BT)

_____ _____

Print Name **Signature**

_____ _____

Title **Date**

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

_____

PROVIDER NAME

PROVIDER AGREES:

1. To comply with all applicable State and Federal laws, policies, rules and regulations promulgated pursuant thereto;

2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the programs administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS), and to provide any authorized DMAHS employee or agent with copies of requested records free of all copy fees and related duplication charges;

3. To furnish the DMAHS, the Secretary of the U.S. Department of Health and Human Services and the Medicaid Fraud Section of the Division of Criminal Justice with such information as may be requested from time to time, regarding any payments claimed for providing services under the programs administered in whole or in part by DMAHS;

4. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 2428 which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/ agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended).

5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106.

6. To accept Title XIX payments as payment in full, and not institute collection activities, including but limited to, billing, balance billing and litigation, against Title XIX beneficiaries for the payment of claims that have been denied in whole or in part by DMAHS or its fiscal agent, except as permitted by NJSA 30:4D-6.c., or otherwise permitted or required by State or Federal Law.

The provider or DMAHS may, on 60 days written notice to the other party, terminate this Agreement without cause.

_____ _____

DATE SIGNATURE OF PROVIDER

_____

PRINT NAME AND TITLE

INSTRUCTIONS FOR COMPLETING DMAHS DISCLOSURE OF **OWNERSHIP AND CONTROL INTEREST STATEMENT**

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS), or as a condition of approval or renewal of a provider agreement between the disclosing entity and DMAHS. A full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal of DMAHS to enter into an agreement or contract with a provider or can lead to the termination of existing agreements.

General Instructions
Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks section on page 3, referencing the item number to be continued. If additional space is needed use an attached sheet. Return the original to DMAHS and keep a copy for your files. This form may be required to be completed annually. Any substantial delay in completing the form will be reported to the State survey agency.

Definitions:
“Disclosing entity” means a provider (including a managed care entity, but not including an individual practitioner or group of practitioners) or a fiscal agent under any of the programs administered in whole or in part by DMAHS.

“Indirect ownership interest” means an ownership interest in an entity that has an ownership interest in the disclosing entity. This includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A’s interest equates to an 8 percent indirect ownership in the disclosing entity and must be reported.

“Ownership interest” means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

“Person with an ownership or control interest” includes an individual or entity that:
1. Has an ownership interest totaling 5 percent or more in a disclosing entity;
2. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
3. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
4. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
5. Is an officer or director of a disclosing entity that is organized as a for-profit or not-for-profit corporation;
6. Is a partner in a disclosing entity that is organized as a partnership.

Detailed Instructions:
These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory. It is essential that all applicable questions be answered accurately and that all information is current.

Item I — Under identifying information, specify the trade name and D/B/A of the disclosing entity.

Item II and III — Self-explanatory.

Item IV-VIII — See below.

Changes in ownership or control would include, but not be limited to, the following: a new officer; a change in the composition of the owning partnership even though, under applicable State law, a change in the composition of the owning partnership is not considered a change in ownership; the hiring or dismissing of any employees with 5 percent or more financial interest in the entity or parent company; or any other change of ownership.

For Items IV-VIII, if the" yes" box is checked, list additional information requested in the Remarks section on page 3. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership or control within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V- If the answer is yes, list the name of the management firm and employer identification number (EIN), or other tax identification number, or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the business.

Item VI, VII and VIII-Self-explanatory

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a). Name of Disclosing Entity	Trade Name and D/B/A	Provider No.	EIN or Other Tax ID	Telephone No.
Business Street Address		City, County, State		Zip Code

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or entities, and supporting details, under Remarks on page 3. Identify each item number to be continued.

(a) Are there any individuals or entities having a direct or indirect ownership or control interest of 5 percent or more in the disclosing entity that have been charged with or convicted of a state or federal criminal offense related to the involvement of such persons or entities in any of the programs administered in whole or in part by DMAHS, or any of the programs established in New Jersey or any other State, or by the federal government, under titles XVIII, XIX, XX or XXI of the Social Security Act? Yes ☐ No ☐

(b) Are there any directors, officers, agents, or managing employees of the disclosing entity who have ever been charged with or convicted of a state or federal criminal offense related to their involvement in the programs administered in whole or in part by DMAHS, or any of the programs established in New Jersey or any other State, or by the federal government, under titles XVIII, XIX, XX or XXI of the Social Security Act? Yes ☐ No ☐

(c) Are there any individuals currently employed by the disclosing entity in a managerial, accounting, auditing, or similar capacity who were employed by the disclosing entity's Medicare fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only) Yes ☐ No ☐

III. (a) In accordance with 42 CFR 455.104(b)(1)(i), list the name and address of any individual or entity with an ownership of control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(b) In accordance with 42 CFR 455.104(b)(1)(ii), for each individual, list the date of birth and Social Security Number.

(c) In accordance with 42 CFR 455.104(b)(1)(iii), for corporations or other entities with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a 5 percent or more interest, list any other tax identification number.

(d) In accordance with 42 CFR 455.104(b)(2), list whether any individual or entity with an ownership or control interest in the disclosing entity is related to another individual with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether any individual or entity with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest is related to another individual with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling.

(e) In accordance with 42 CFR 455.104(b)(3), list the name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

(f) In accordance with 42 CFR 455.104(b)(4), list the name, address, date of birth, and Social Security Number of any managing employee or agent(s) of the disclosing entity.

(g) In accordance with 42 CFR 455.105(b)(1) and (2), submit full and complete information about the following: (1) The ownership of any subcontractor with whom the disclosing entity has had business transactions totaling more than $25,000 during the previous 12 months; and (2) Any significant business transactions between the disclosing entity and any wholly owned supplier, or between the disclosing entity and any subcontractor, during the previous 5 years.

USE THE REMARKS SECTION ON PAGE 3 IF YOU NEED ANY ADDITIONAL SPACE					
Name	Address	Ownership %	Social Security #	Other Tax ID #	Date of Birth

(h) Nature of Disclosing Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated Associations ☐ Other (Specify)

(i) If the disclosing entity is a corporation or a non-profit, list the names, addresses, social security #s and date of birth of the officers and directors and EINs for corporations under Remarks on page 3.

(j) Do any persons with an ownership or control interest in the disclosing entity also have an ownership or control interest in a health care provider participating in a program administered in whole or in part by DMAHS? If yes, list names, addresses, and provider numbers. Use page 3 if you need additional space. Yes ☐ No ☐

Name	Home Address	Provider Number

IV. (a) Has there been a change in ownership or control within the last year? Yes ☐ No ☐
If yes, give date _____

(b) Do you anticipate any change of ownership or control within the next year? Yes ☐ No ☐
If yes, when? _____

(c) Is there a possibility that the disclosing entity will be filing for bankruptcy within the next year? Yes ☐ No ☐
If yes, when? _____

V. Is the disclosing entity operated by a management company, or leased in whole or part by another organization? Yes ☐ No ☐
If yes, provide us with the name, address, and tax ID# of the management company or other organization.

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? Yes ☐ No ☐

VII. (a) Is the disclosing entity a subsidiary of a parent company? Yes ☐ No ☐ (If yes, list name, address, and its EIN or other tax ID)
Name: EIN or other Tax ID:

Address:

VII. (b) If the answer to Question VII.a. is no, was the disclosing entity ever affiliated with a parent company? Yes ☐ NO ☐
(If yes, list name, address, and EIN or other tax ID of the chain)
Name: EIN or other Tax ID:

Address:

VIII. Has the disclosing entity increased its bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?
Yes ☐ No ☐

If yes, give year of change _____
Current beds _____ LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION IN THIS DOCUMENT 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 DISCLOSING ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY, AS APPROPRIATE. BY SIGNING THIS DISCLOSURE FORM, THE DISCLOSING ENTITY ALSO CONSENTS TO A CIVIL AND CRIMINAL BACKGROUND CHECK BY DMAHS AND/OR BY THE MEDICAID FRAUD DIVISION OF THE OFFICE OF THE STATE COMPTROLLER. THE DISCLOSING ENTITY FURTHER UNDERSTANDS THAT IF THE RESULTS OF THIS BACKGROUND CHECK ARE UNSATISFACTORY, DMAHS MAY REFUSE TO ENTER INTO OR MAY TERMINATE AN AGREEMENT WITH THE DISCLOSING ENTITY.

Name of Authorized Representative of Disclosing Entity (Typed or Printed)	Title

Signature _____ Date _____

Print Signature
_____

Remarks:

Form **W-9**
(Rev. December 2000)

Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Please print or type

Name (See **Specific Instructions** on page 2.)

Business name, if different from above. (See **Specific Instructions** on page 2.)

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▸ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number

or

Employer identification number

List account number(s) here (optional)

Part II

For U.S. Payees Exempt from Backup Withholding (See the Instructions on page 2.)

▸

Part III Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here **Signature of U.S. person** ▸ **Date** ▸

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Corporations.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to back up withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willingly falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal Law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Part I - Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are **LLC** that is **disregarded as an entity** separate from its owner (see ***Limited liability company (LLC)*** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Care, from your local Social Security Administration office. Get **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at **www.irs.gov**.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other type of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN* ***or*** *that you intend to apply for one soon.*

Part II-For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are **not** exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Part III-Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items.1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole Proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

AFFIRMATIVE ACTION SURVEY (OPTIONAL)

Dear Provider:

The Department of Human Services, Division of Medical Assistance and Health Services, which administers the New Jersey Medicaid Program, is conducting an Affirmative Action Survey of its participating providers.

This survey is being used as a tool to better understand the diversity of our provider network and the needs of our clients. The completion of this survey is voluntary. The statistical data from this survey will be used for Affirmative Action purposes only and will be maintained separately from all other types of information.

Please refer to definitions below and check or fill in appropriate responses in space indicated:

From N.J.A.C. 4A:7-1.1(D):

"White, Not of Hispanic Origin"	Means persons having origins in any of the original Peoples of Europe, North Africa or the Middle East
"Black, not of Hispanic Origin"	Means persons having origins in any of the Black Racial Groups of Africa
"Hispanic"	Means persons of Mexican, Puerto Rican, Cuban, Central or South America or other Spanish Culture or origin, regardless of race.
"American Indian or Alaskan Native"	Means persons having origins in any of the original Peoples of North America, and who Maintain cultural identification through Tribal Affiliation Community Recognition.
"Asian or Pacific Islander"	Means persons having origins in any of the original Peoples of the Far East, Southeast Asia, the Indian Subcontinent, or Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

1. How many direct service providers are of the following racial or ethnic background?

_____White _____Black _____Hispanic _____American Indian

_____Asian

2. How many of your support staff are of the following racial or ethnic background?

_____White _____Black _____Hispanic _____American Indian

_____Asian

3. How many of service provider(s) speak the following languages?

_____English _____Spanish Please list language & numbers

_____ _____

_____ _____

_____ _____

4. How many of the support staff speak the following languages?

_____English _____Spanish Please list language & numbers

_____ _____

_____ _____

_____ _____

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS/DEPOSITS

I (we) hereby authorize DXC Technology, acting as Fiscal Agent for the State of New Jersey, Division of Medical Assistance and Health Services, to initiate credit entries to my (our) checking account and the depository bank indicated below, hereinafter called Depository, to credit the same to such account.

DEPOSITORY NAME _____ **BRANCH** _____

CITY _____ **STATE** _____ **ZIP** _____

BANK TRANSIT/ABA NO _____ **ACCOUNT NO.** _____

This authority is to remain in effect until the Fiscal Agent has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the Fiscal Agent a reasonable opportunity to act on it.

BANK ACCOUNT NAME _____
(Print account name exactly as it appears on your statement)

PROVIDER NAME _____

PROVIDER NO. _____ **TELEPHONE NO.** _____

NPI # _____

ADDRESS _____

_____

_____ _____ **DATE** / /
Printed Name Signature

_____ _____ **DATE** / /
Printed Name Signature

REMARKS _____

_____

NOTES:

1. To insure accuracy of the bank account numbers, it is imperative that you attach a **BLANK, VOIDED CHECK** verifying the above bank ABA and account numbers.
2. If a joint account, both owners must sign request form.
3. New Jersey Medicaid payments are deposited to your account each Friday at 9:00 a.m.
4. Once DXC Technology has received a **completed** authorization for payments/deposits, it will take approximately 4 weeks before the first deposit is completed electronically to your account. To verify this information, please call your bank and specifically ask for the **ACH Department**.
5. For those providers who previously had Direct Deposit, you will now receive paper checks until the new information is processed.
6. Please make a copy of this before mailing to DXC Technology.

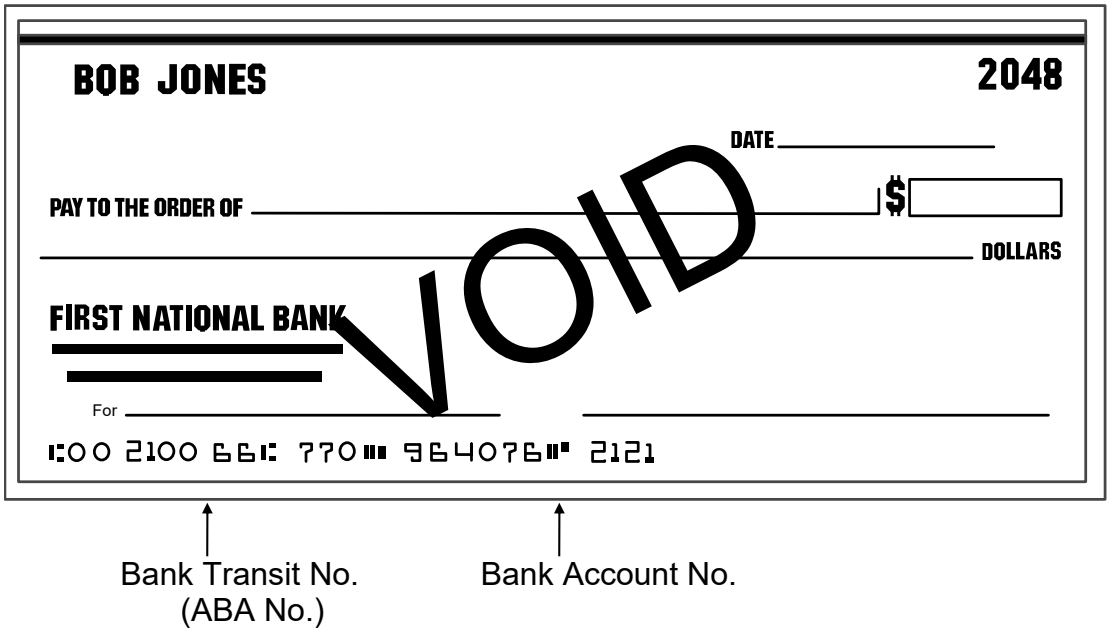
PROVIDER INSTRUCTIONS FOR COMPLETING AUTHORIZATION AGREEMENT FORM

1.	DEPOSITORY NAME	Name of bank servicing your checking account.
2.	BRANCH	Name of bank branch.
3.	CITY	City or town location of bank branch.
4.	STATE	State location of bank branch.
5.	ZIP	Zip code of bank branch.
6.	BANK TRANSIT/ABA NUMBER	Bank routing number (see below, voided check example).
7.	BANK ACCOUNT NUMBER	Checking account number (see below, voided check example).
8.	BANK ACCOUNT NAME	Actual account name per your bank's records.
9.	PROVIDER INFORMATION	Provider name, Medicaid/NJ FamilyCare Provider No., telephone No., address, date prepared and signature.

MAIL THE COMPLETED AUTHORIZATION AGREEMENT AND VOIDED CHECK TO:

Provider Enrollment Unit
DXC Technology
P.O. Box 4804
Trenton, NJ 08650-4804

NOTE: Attach blank, voided check per below sample.



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

CAROLE JOHNSON
Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

*Agreement of Understanding

To the Person Submitting this Enrollment Packet:

I understand that upon receipt of this enrollment packet to DXC Technology, it becomes property of the State of New Jersey. The enrollment packet and any documents that are generated as result of the submission of this application, such as but not limited to, an enrollment letter or a denial letter are subjected to the Open Public Records Act (OPRA see NJSA Section 47:1A).

Before any documents are sent to someone requesting this information, all personal information such as tax Id and social security numbers would be redacted.

It is the responsibility of the person signing this Agreement of Understanding to convey this information to all of individuals who are named in this application to become a New Jersey Medicaid provider. Although the request for enrollment information is uncommon, it does fall under the Open Public Records Act.

I have read this Agreement of Understanding and acknowledge that once I submit these documents for processing that they will become property of the State of New Jersey.

Sign

Print

_____

Date

*A signed Agreement of Understanding is required before an application can be processed.

08/29/2019

REQUEST FOR PAPER UPDATES

DIRECTIONS: Enter the requested information below, sign your name, and send the completed form to the address at the bottom of this form.

Provider Name: _____ Provider Number: _____

Contact Name: _____ Telephone Number: _____

FAX Number: _____

Mail To Address: _____

_____

_____

I would like to receive printed (paper) copies of updates and distributions.

_____

Provider/Authorized Representative Signature

_____

Date

MAIL THIS COMPLETED FORM TO:

Provider Enrollment
DXC Technology
P.O. Box 4804
Trenton, NJ 08650

OR FAX THIS COMPLETED FORM TO DXC TECHNOLOGY PROVIDER RELATIONS AT:

Fax Number: (609) 584-1192

Federal Regulations on Disclosure of Information by Providers

42 CFR 455.100

§ 455.100 Purpose.

This subpart implements sections 1124, 1126, 1902(a)(38), 1903(i)(2), and 1903(n) of the Social Security Act. It sets forth State plan requirements regarding--

(a) Disclosure by providers and fiscal agents of ownership and control information; and

(b) Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services program.

The subpart also specifies conditions under which the Administrator will deny Federal financial participation for services furnished by providers or fiscal agents who fail to comply with the disclosure requirements.

42 CFR 455.101

§ 455.101 Definitions.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that--

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $ 25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means--

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

42 CFR 455.102

§ 455.102 Determination of ownership or control percentages.

(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

42 CFR 455.103

§ 455.103 State plan requirement.

A State plan must provide that the requirements of §§ 455.104 through 455.106 are met.

42 CFR 455.104

§ 455.104 Disclosure by providers and fiscal agents: Information on ownership and control.

(a) Information that must be disclosed. The Medicaid agency must require each disclosing entity to disclose the following information in accordance with paragraph (b) of this section:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;

(2) Whether any of the persons named, in compliance with paragraph (a)(1) of this section, is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must--

(i) Keep copies of all these requests and the responses to them;

(ii) Make them available to the Secretary or the Medicaid agency upon request; and

(iii) Advise the Medicaid agency when there is no response to a request.

(b) Time and manner of disclosure. (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. The survey agency must promptly furnish the information to the Secretary and the Medicaid agency.

(2) Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified in paragraph (a) of this section to the Secretary within the prior 12-month period, must submit the information to the Medicaid agency before entering into a contract or agreement to participate in the program. The Medicaid agency must promptly furnish the information to the Secretary.

(3) Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or contract renewals, within 35 days of a written request.

(c) Provider agreements and fiscal agent contracts. A Medicaid agency shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.

(d) Denial of Federal financial participation (FFP). FFP is not available in payments made to a provider or fiscal agent that fails to disclose ownership or control information as required by this section.

42 CFR 455.105

§ 455.105 Disclosure by providers: Information related to business transactions.

(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about--

(1) The ownership of 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; and

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) Denial of Federal financial participation (FFP). (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).

(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

42 CFR 455.106

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) Notification to Inspector General. (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) Denial or termination of provider participation. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

APPLICABLE STATE STATUTE

N.J. Stat. § 30:4D-6.c.

c. Payments for the foregoing services, goods, and supplies furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto and, where applicable, subject to the agreement of insurance provided for under this act. The payments shall constitute payment in full to the provider on behalf of the recipient. Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, the recipient's family, the recipient's representative or others on the recipient's behalf for the services, goods, and supplies furnished pursuant to this act.

No provider whose claim for payment pursuant to this act has been denied because the services, goods, or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on his behalf for such services, goods, and supplies provided pursuant to this act; provided, however, a provider may seek reimbursement from a recipient for services, goods or supplies not authorized by this act, if the recipient elected to receive the services, goods, or supplies with the knowledge that they were not authorized.