



**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 \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
County \_\_\_\_\_  
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%. Include additional pages if more than three owners.

Name of Owner 1 \_\_\_\_\_  
Relationship with the Provider \_\_\_\_\_  
Percent of Ownership \_\_\_\_\_  
Owner DOB (mm/dd/yyyy) \_\_\_\_\_  
Primary Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
SSN (individual) and/or TIN \_\_\_\_\_  
PO 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*) \_\_\_\_\_

(Continued)

Name of Owner 2 \_\_\_\_\_  
Relationship with the Provider \_\_\_\_\_  
Percent of Ownership \_\_\_\_\_  
Owner DOB (mm/dd/yyyy) \_\_\_\_\_  
Primary Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
SSN (individual) and/or TIN \_\_\_\_\_  
PO 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*) \_\_\_\_\_

Name of Owner 3 \_\_\_\_\_  
Relationship with the Provider \_\_\_\_\_  
Percent of Ownership \_\_\_\_\_  
Owner DOB (mm/dd/yyyy) \_\_\_\_\_  
Primary Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
SSN (individual) and/or TIN \_\_\_\_\_  
PO 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*) \_\_\_\_\_

(Continued)

B. 42 C.F.R. §455.104(b)(4) requires disclosure of the name, address, date of birth, and Social Security Number of any managing employee(s) of the provider. Include additional pages as necessary.

Name 1 \_\_\_\_\_  
Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_

Name 2 \_\_\_\_\_  
Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_

C. 42 C.F.R. §455.104(b)(1)-(2) and the New Jersey Medicaid HMO Contract, Section 7.35.A.1-2, require providers to identify direct or indirect ownership interest of five percent or more in a subcontractor.

Does this provider have a direct or indirect ownership interest of five percent or more in a subcontractor?

- No
- Yes

If you selected “Yes,” provide the following information. Include additional pages as necessary.

Name of Subcontractor 1 \_\_\_\_\_  
Relationship with the Provider \_\_\_\_\_  
Percent of Ownership \_\_\_\_\_  
Subcontractor 1 Primary Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
SSN (individual) and/or TIN \_\_\_\_\_  
PO 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*) \_\_\_\_\_

(Continued)

Name of Subcontractor 2 \_\_\_\_\_  
 Relationship with the Provider \_\_\_\_\_  
 Percent of Ownership \_\_\_\_\_  
 Subcontractor 2 Primary Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 Zip Code \_\_\_\_\_  
 SSN (individual) and/or TIN \_\_\_\_\_  
 PO 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*) \_\_\_\_\_

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

Does a person with an ownership or control interest in this provider also have an ownership or control interest in another entity?

- No
- Yes

If you selected “Yes,” provide the following information to the extent you can obtain this information by requesting it in writing. Include additional pages as necessary.

Name of Owner 1 \_\_\_\_\_  
 Name of Other Entity \_\_\_\_\_  
 Primary Address of Other Entity \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 Zip Code \_\_\_\_\_  
 PO Box Address (if applicable) \_\_\_\_\_  
 Nature of Relationship with Other Entity \_\_\_\_\_

(Continued)

Name of Owner 2 \_\_\_\_\_

Name of Other Entity \_\_\_\_\_

Primary Address of Other Entity \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

PO Box Address (if applicable) \_\_\_\_\_

Nature of Relationship with Other Entity \_\_\_\_\_

Name of Owner 3 \_\_\_\_\_

Name of Other Entity \_\_\_\_\_

Primary Address of Other Entity \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

PO Box Address (if applicable) \_\_\_\_\_

Nature of Relationship with Other Entity \_\_\_\_\_

**III. Disclosure by Provider: Information Related to Business Transactions**

- A. 42 C.F.R. §455.105(b)(1) requires disclosure of the 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.

Has this provider had business transactions totaling more than \$25,000 in the past 12 months with a subcontractor?

No

Yes

If you selected “Yes,” provide the following information. Include additional pages as necessary.

Name of Subcontractor 1 \_\_\_\_\_

Address \_\_\_\_\_

Ownership \_\_\_\_\_

Name of Subcontractor 2 \_\_\_\_\_

Address \_\_\_\_\_

Ownership \_\_\_\_\_

*(Continued)*

- B. 42 C.F.R. §455.105(b)(2) requires disclosure of significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5 years. "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.

Has this provider had significant business transactions with a wholly owned supplier and/or a subcontractor during the past 5 years?

- No  
 Yes

If you selected "Yes," provide the following information. Include additional pages as necessary.

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 \_\_\_\_\_

#### IV. Disclosure of Information on Persons Convicted of Crimes

42 C.F.R. §455.106(a) requires identification of any person who has ownership or control interest in the provider, or is a director, officer, agent or managing employee of the provider; and who 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.

Has any person who has ownership or control interest in the provider, or is a director, officer, agent or managing employee of the provider 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?

- No  
 Yes

If you selected "Yes," provide the following information. Include additional pages as necessary.

Name 1 \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Tax Identification Number (TIN) \_\_\_\_\_

*(Continued)*

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 \_\_\_\_\_

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