PROVIDER DISCLOSURE STATEMENT

Completion and submission of this form is a state and federal requirement (42 CFR §455.100 - 106) and a condition of participation in the North Country Community Mental Health (NCCMH) provider network. This form **must also be submitted within 35 days of any changes of ownership, managing employees or controlling interests**.

Federal statutes and regulations prohibit states from paying for goods and services provided by excluded parties and require states to search exclusions databases. The disclosure information you provide below is used only for the purpose of determining whether individuals and entities are federally excluded parties.

Providing Social Security Numbers and FEIN (as applicable) are required under 42 CFR §455.100

DISCLOSING ENTITY – please fill in the following information about the provider that receives payment from NCCMH.			
NAME (individual or business) **and PRIMARY ADDRESS**	**FEIN** (**business**)	**SSN** (individual)	**Date of Birth** (individual)

BUSINESS LOCATION(S) - List each additional business location address including PO Box as applicable	
Name	**Street, PO Box, City, State, Zip**

OWNERSHIP: List each individual or business entity having ownership interest of 5% or more of the Disclosing Entity and relationship if they are related (spouse, parent, child, sibling) to another owner.			
Name and Address	**Relationship**	**FEIN/SSN**	**Date of Birth** (individual)

MANAGING EMPLOYEES & CONTROLLING INTERESTS: List all managing employees (e.g. general manager, business manager, administrator, director) and other controlling interests (e.g. members of the board of directors or corporate officer) of the Disclosing Entity and if any individual listed is related (spouse, parent, child, sibling) to another managing employee or controlling interest of the Disclosing Entity

Name and Address	**Relationship**	**FEIN/SSN**	**Date of Birth** (individual)

OTHER OWNERSHIP: List any fiscal agent or managed care entity (Medicare/Medicaid provider) in which any owner or controlling interest of the Disclosing Entity has ownership or controlling interest of 5% or more

Name and Address	**FEIN**

SUBCONTRACTORS: List any subcontractors of the Disclosing Entity in which Disclosing Entity has ownership or controlling interest of 5% or more

Name and Address	**FEIN/SSN**	**Date of Birth** (individual)

List any owner or controlling interest of any subcontractor listed above that is related (spouse, parent, child, sibling) to an owner, managing employee or controlling interest of the Disclosing Entity

Name and Address	**Relationship**	**FEIN/SSN**	**Date of Birth** (individual)

SUSPENSION or DEBARMENT: List any individual noted above that 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

BUSINESS TRANSACTIONS - SUBCONTRACTORS: list any business transactions totaling more than $25,000 during the 12-month period ending on the date of this request	
Subcontractor Name and Address	**FEIN**

BUSINESS TRANSACTIONS – WHOLLY OWNED SUPPLIERS: 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.	
Supplier Name and Address	**FEIN**

By my signature, I certify that I have read the contents of this form, and that the information contained herein is true, correct, and complete to the best of my knowledge.

Name of Authorized Representative (printed or typed):	**Title:**
Signature:	**Date:**

Attestation Confirming Debarment, Suspension, and Exclusion

My signature below is my certification that I have never been convicted of or had a civil judgement rendered against me for commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or preforming a public (federal, state, or local) transaction or contract under public transaction; violation of federal or state antitrust statutes, or destruction of records, making false statements, or receiving stolen property; have never had a professional license revoked or suspended and have never been sanctioned, whether personally or through an entity, by State of Michigan Medicaid or other Healthcare program. I am not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in Federally Funded Health Care Programs.

I also understand that I am under obligation to report to NCCMH, within 35 days, any convictions of or civil judgement rendered against me for any of the above offenses.

By: _____ Date: _____

Printed Name: _____

Title: _____