New York State Medicaid Disclosure Form

Thank you for updating your provider records with the Medicaid Program. As a Medicaid provider, you have agreed to comply with the rules, regulations and official directives of the NYS Department of Health including, but not limited to, Part 504 of 18 NYCRR (i.e., Title 18). Title 18 can be found by choosing the Laws and Regulations link of the Department of Health's website, www.health.ny.gov.

This form must be completed when your organization has a change in managing employee(s) or a change in those with a control interest. If your organization has experienced an ownership change, please use Form EMEDNY-436701.

New York State's Personal Privacy Protection Law requires us to inform every person from whom we request personal information why we are requesting information and how we will use it. The information requested will permit proper payments to you as a Medicaid provider, according to the provisions of applicable State and Federal Law and Regulations. Collection of this information is authorized by Section 367-b of the Social Services Law. This information will be used as one element of various reviews before payment is made for the goods or services furnished and/or for any post payment audits required by the State or Federal authorities. This information will also be used to satisfy the reporting requirement imposed upon us by State and Federal Regulations (e.g., by IRS for payment information reporting purposes). Failure to provide us with the information will prevent establishing the records necessary to enroll you as a Medicaid provider. The information will be maintained by the New York State Department of Health, Office of Health Insurance Programs, Division of OHIP Operations, Bureau of Provider Enrollment, Albany New York.

NOTE: Refer back to this page when identifying managing employees and those with a control interest:

Association Types: Enter the letter (B, F, H, I, M, P, U or J) which best corresponds to the individual's role. *Note: ALL lifestyle coaches providing NDPP services for your organization must be listed in Section 5 of the application as a I-Employee/Lifestyle Coach*

B: Board of Directors Member	F: Facility Administrator	H: Compliance Officer	I: Employee/Lifestyle Coach
M: Managing Employee	P: Supervising Pharmacist	U: Laboratory Director	J: Employee/Leader

NY MEDICAID DISCLOSURE FORM for **BUSINESSES**			Mail to: eMedNY PO Box 4610 Rensselaer, NY 12144
Effective Date of Change:	FEIN:		NPI (unless exempt):
Provider Name		NY Medicaid ID (if known):	

Completion is required by 18NYCRR, Section 502.5(b) ***Failure to provide the information requested may impact your enrollment***. **Visit www.health.ny.gov to review definitions and policy found at 18NYCRR, Section 504.1 before completing this form.** .

Agents, Managing Employees & Those with a Control Interest – Including, but not necessarily limited to, the following: Facility Administrator, all Members of the Board of Directors, Compliance Officer, Laboratory Director, Supervising Pharmacist, Employee/Lifestyle Coach, Employee/Leader, and Managing Employees (includes general, business and office managers; all persons who exercise operational or managerial control of a provider; all persons who directly or indirectly conduct the day-to-day operations of a provider).

Name (Last, First, Middle)		Association Type (see page 1)	
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth	Leave this Space Blank	
Name (Last, First, Middle)		Association Type (see page 1)	
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth	Leave this Space Blank	
Name (Last, First, Middle)		Association Type (see page 1)	
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth	Leave this Space Blank	
Name (Last, First, Middle)		Association Type (see page 1)	
Home Address	City & State		Zip Code (9 digit)
SSN	Date of Birth	Leave this Space Blank	

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Respond to these questions on behalf of the Provider, the Owners, and Managing Employees and those with a Control Interest:

1. Have any of these individuals/entities been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in New York or in any other State, Medicare, or any other governmental or private medical insurance program?

   ☐ Yes ☐ No

2. Have any of these individuals/entities ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?

   ☐ Yes ☐ No

3. Have any of these individuals/entities ever had their business or professional license or certification, or the license of an entity in which they had an ownership interest over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State?

☐ Yes ☐ No

4. Is there currently pending any proceedings that could result in the above stated sanctions for these individuals/entities?

☐ Yes ☐ No

NOTE: All questions must be answered. If you answered "Yes" to any of the questions above, you must complete and submit the "Prior Conduct Questionnaire" available at www.emedny.org.
Please continue and Answer Question 5.

5. Does the Provider have any unpaid balances owed to the NY Medicaid Program related to this Business or another entity owned by the Applicant? ☐ Yes ☐ No

- If yes, indicate amount $_____
- If yes, has payment been arranged? ☐ Yes ☐ No If yes, attach verification of arrangement.
  If no, this enrollment will be reviewed by the OMIG

By signing this form, the Provider understands and agrees to the following:

- As a Medicaid Provider you agree to comply with the rules, regulations and official directives of the Department including, but not limited to Part 504 of 18NYCRR which can be found at the Department of Health's website, www.health.ny.gov
- In addition, pursuant to 42 CFR, Part 455.105, by enrolling in the Medicaid Program you agree to disclose the following regarding business transactions within the next 35 days upon request of the Department or the Secretary of Health and Human Services.
  (1) Information about 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.
- As a Medicaid Provider you agree to abide by all applicable Federal and State laws as well as the rules and regulations of other New York State agencies particular to the type of program covered by this enrollment application.
- For those providers for whom the Mandatory Compliance Law applies (https://omig.ny.gov/compliance/compliance), the Provider has certified via the CERTIFICATION STATEMENT FOR PROVIDER BILLING MEDICAID that the provider adopted, and implemented, where applicable, an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York Code, Rules and Regulations, Part 521.
- Unannounced site visits by Medicaid, CMS or their agents/designated contractors may be a condition of initial and continued enrollment. In addition, the provider and/or owners (defined as at least a 5 % interest) may be required to consent to criminal background checks including fingerprinting.
- As a Medicaid Provider you agree to notify this Department immediately of any changes supplied in this disclosure document as well as impending ownership changes or any other changes.
- The Department may deny or terminate enrollment as a provider in the Medicaid program if it is determined that executive compensation, bonuses, incentives and costs of administration exceed reasonable levels.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS 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 ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR SECRETARY, AS APPROPRIATE.

__________________________________ _______________
Provider's Signature (original; no stamps) Date