

PROVIDER DISCLOSURE STATEMENT

Completion and submission of this form is a state and federal requirement (42 CFR 455.100,.104,.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.

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)

STOP: If payments are made to an **INDIVIDUAL**, skip to page 3 and sign the form. If payments are made to a **BUSINESS**, complete the remainder of this form. (attach additional pages as necessary)

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

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: