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| CMHPSM Organizational Disclosure StatementCommunity Mental Health Partnership of Southeast Michigan 3005 Boardwalk Dr. Ste. 200, Ann Arbor MI 48108Contact: Christina Biddle biddlec@cmhpsm.org Phone: 734-645-8734 Fax: 734-222-3844 |

The CMHPSM must comply with federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 CFR §455.104–106. The CMHPSM and its partner CMHSPs are required to collect disclosure of ownership, controlling interest and management information from providers that participate in federally funded service provision. More information can be found within CMHPSM policies located at [www.cmhpsm.org/policies](http://www.cmhpsm.org/policies) or within [42 CFR Part 455](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=44553fb82b58dcd2e16a62408a3d8247&mc=true&n=sp42.4.455.b&r=SUBPART&ty=HTML#se42.4.455_1106).

Completion and submission of an Organizational Disclosure Statement is a condition of participation in the Medicaid managed care network and is a contractual obligation with the CMHPSM or its partner CMHSPs for services to members under Medicaid benefit plans. Failure to submit the requested information may result in denial of claim payments, a refusal to enter into a provider contract, or termination of existing provider contracts.

Contracted Organizational Providers must complete the Organizational Disclosure Statement including all information for individuals affiliated with the organization. Affiliated individuals include: individuals with an ownership share of 5% or more, individuals with a controlling interest, individuals on the organization’s Board of Directors, individuals that work as managing employees for the organization. All affiliated individuals identified within sections C, D or E of this Organizational Disclosure Statement need to complete the CMHPSM Individual Disclosure Statement form.

Individual Providers do not need to complete this Organizational Disclosure Statement but must complete the CMHPSM Individual Disclosure Statement form.

# Contracted Provider Entity Information

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| [ ] New Provider (New Contract or Provider Network Status)[ ] Renewal of Contract or Re-Credentialing of Provider Network Status[ ] Provider Information Update or Other (Change of ownership, new information, etc.) |

Section A: Please provide the following organizational information of the disclosing entity:

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| Organization’s Legal Name:      |
| Other Business Name(s), Doing Business As (DBA) Name(s):      |
| Primary Business Address:      |
| City:      | State:      | ZIP+4:      -      |
| Please List Additional Business Addresses (Include City, ST, ZIP):      |
| Federal ID Number (EIN/TIN):       |
| Medicaid Identification Number:      |
| National Provider Identification Number:      |

Section B: Contact Information for Individual Completing this Disclosure Statement:

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| Name:      |
| Title:      |
| Phone:      |
| Fax:      |
| Email:      |

Section C: Provider Entity Ownership and/or Board of Directors:

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| Are there individuals or organizations with a Direct or Indirect Ownership or Controlling Interest of 5% or more in the Provider Entity? [ ] Yes [ ] NoIf yes, list the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Controlling Interest in the Provider Entity of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership or Controlling Interest of 5% or greater. (42 CFR §455.104) |
| Type:Ind. or Org | Name of Owner: | Complete Address: | Ind.: SSNOrg: EIN/TIN | Ind. Only:Date of Birth (mm/dd/yyyy) | % Interest of Entity |
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| Does the provider entity have a Board of Directors? [ ] Yes [ ] NoIf yes, list the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person on the Organization’s Board of Directors. (42 CFR §455.104) |
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| First Name | Last Name | Address: | Date of Birth | Soc Sec # |
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Section D: Provider Entity Ownership in Other Providers Entities

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| Does the disclosing provider entity identified in Section A or any owner of the entity identified in Section C have a direct or indirect ownership or controlling interest in any provider entity contracted with the CMHPSM or its partner CMHSPs? [ ] Yes [ ] NoIf yes, list the disclosing entity’s name or the individual owner listed in Section C, the name of the provider the preceding has an ownership in and that provider’s TIN/EIN: (42 CFR §455.104) |
| Disclosing entity or name from Section C : | Name of subcontractor or other provider entity: | Subcontractor or provider entity TIN/EIN: |
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Section E: Provider Entity Ownership in Subcontractors

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| Are any of the individuals listed within Sections C, D or E related to each other? [ ] Yes [ ] NoIf yes, list each of the individual’s full names and their relationship to each other: (42 CFR §455.104) |
| Individual from Section C,D,E: | Type of Relationship: | Individual from Section C,D,E: |
|       | [ ] Spouse[ ] Sibling[ ] Parent/Child [ ] Step or Adoptive Parent/ Child[ ] Aunt or Uncle/Niece or Nephew [ ] Grandparent/Grandchild[ ] Cousins |       |
|       | [ ] Spouse[ ] Sibling[ ] Parent/Child [ ] Step or Adoptive Parent/ Child[ ] Aunt or Uncle/Niece or Nephew [ ] Grandparent/Grandchild[ ] Cousins |       |
|       | [ ] Spouse[ ] Sibling[ ] Parent/Child [ ] Step or Adoptive Parent/ Child[ ] Aunt or Uncle/Niece or Nephew [ ] Grandparent/Grandchild[ ] Cousins |       |
|       | [ ] Spouse[ ] Sibling[ ] Parent/Child [ ] Step or Adoptive Parent/ Child[ ] Aunt or Uncle/Niece or Nephew [ ] Grandparent/Grandchild[ ] Cousins |       |

Section F: Managing Employees and Agents:

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| Does your organization have any agents or managing employees? [ ] Yes [ ] NoIf yes, provide the name, address, date of birth and social security number of the applicable individuals.Agent means any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR 1001.1001).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. |
| Full Name | Agent or Job Title: | Address: | Date of Birth | Soc Sec # |
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Section G: Sanctions/Exclusions Disclosure

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| Does the disclosing entity itself as an organization, or any persons (individual or entity) with an ownership or control interest in the provider/disclosing entity, or an agent, managing employee, officer, consultant, director, co-partner, board member of the provider/disclosing entity who is excluded, suspended, terminated, sanctioned, or debarred, or any adverse legal action taken by the United States Department of Health and Human Services or by any state from participation in any program established under Title XVIII (Medicare), XIX (Medicaid programs), XX (Social Services Block Grants), XXI (State Children’s Health Insurance Program), Title V (Maternal & Child Health Services Block Grant), or any other government-funded program since the inception of these programs? [ ] Yes [ ] No If no skip Section G. If yes, list the name, position (if individual), offense and date of action. |
| Full Name or Entity Name | Position | Offense | Date of Action |
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Section H: Criminal Offense Disclosure

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| Has the provider/disclosing entity, or any person (individual or entity) with an ownership or control interest in the provider/disclosing entity, or is an agent or managing employee, officer, consultant, director, co-partner, board member, or shareholder of the provider/disclosing entity ever been convicted of a criminal offense related to that person’s involvement in any program established under Titles XIX (Medicaid), XVIII (Medicare), Title XX programs (Social Services Block Grants), Title V (Maternal & Child Health Services Block Grant), or XXI (State Children’s Health Insurance Program) of the Social Security Act since the inception of those programs (42 CFR 455.106)? [ ] Yes [ ] No If no skip Section H. If yes, list the name, position (if individual), offense and date of action. |
| Full Name or Entity Name | Position | Offense | Date of Action |
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Section I: Other Offense Disclosure

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| Including you the provider/disclosing entity, are there any persons (individual or entity) with an ownership or control interest in the provider/disclosing entity, or is an officer, consultant, director, co-partner, board member, shareholder, agent or managing employee of the provider/disclosing entity, who is presently indicted for, or otherwise criminally (felony and/or misdemeanor) or civilly charged by a governmental entity or who has been found guilty, or pled guilty or nolo contendere, or assessed fines or penalties for any of the offenses listed below, under any federal law or in any state, in connection with the delivery of a health care item or service, or with respect to any act or omission in a health care program operated by or financed in whole or in part by any Federal, State, or local government agency? [ ] Yes [ ] No If no skip Section I. If yes, list the name, position (if individual), offense and date of action. |
| Full Name or Entity Name | Position | Offense | Date of Action |
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Provider Entity Attestation

My signature below is my certification that the information in this form is complete and accurate. I will notify the CMHPSM immediately if any information entered into this form changes. I hereby give consent to the CMHPSM to utilize this information to meet its obligations as a pre-paid inpatient health plan within the State of Michigan. I understand that misleading, inaccurate or incomplete data may result in denial or termination of network participation or contractual relationship with the CMHPSM.

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| Full Name:      | Title:       |
| Signature: | Date:       |