GreenMountainCare
A HEALTHIER STATE OF LIVING

VERMONT MEDICAID DISCLOSURE FORM

Federal law requires that Green Mountain Care have individuals and entities with ownership, control, management or a business relationship complete and submit a Vermont Medicaid Disclosure Form for each entity or person affiliated with the provider, as part of a complete application packet for enrollment, revalidation and to report a change in an entity or person, as defined below. For more information on federal disclosure requirements, see 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3.

Please refer to the Green Mountain Care Instructions for Enrollment and Revalidation for instructions.
*All *asterisked sections must be completed.*

I. *Provider Information

Applicant Name *(if individual, please format **LAST, FIRST MI, Title**. If group/institution, please format exactly as it appears on your license/professional certification)*

Provider/Group/Institution Name: _____

Legal Business Name *(as shown on W-9)*: _____

"Doing Business As" DBA Name: _____

Medicaid Provider Number(s) for address below *(if applicable)*: _____

Street: _____ **Suite:** _____

City: _____ **State:** _____ **Zip Code:** _____

Check One:

This form is to disclose a CHANGE in an entity or person affiliated with the above provider:

☐ Add ☐ Remove Entity/Person Name: _____

☐ Change in the % of ownership (*If change, you are required to complete the sections relevant to the entity)*

☐ This form is to disclose an entity or person not previously disclosed.

Check One: ☐ **Entity** ☐ **Person**

Select one:

☐ Direct owner 5% or more ☐ Indirect owner 5% or more

☐ Controlling interest 5% or more ☐ Corporate office/director/partner/shareholder

☐ Managing employee ☐ Subcontractor

% of Ownership: _____

2. *Entity Information

Tax ID number as shown of the W-9 IRS Form: _____

Legal business name as shown on W9: _____

Complete address as shown on W-9 IRS Form:

Street: _____ *Suite#:* _____

City: _____ *State:* _____ *Zip Code:* _____

2. *Entity Information *(Continued)*

Entity Type: *How is this Entity organized to conduct business activities (select one or specify other):*

☐ Sole proprietor (unincorporated) ☐ Limited partnership

☐ Professional association ☐ Limited liability partnership

☐ General partnership ☐ Limited liability company

☐ Corporation ☐ Nonprofit

☐ Governmental ☐ Other *(specify)*: ______________________________

Do you conduct business under an assumed name? ☐ Yes ☐ No

*If **Yes**, provide name*: ______________________________

"Doing Business As" DBA name: ______________________________

NPI *(if applicable)*: ____________________ **Medicare number** *(if applicable)*: ____________________

3. *Individual/Person Information

Last Name: ____________________ **First:** ____________________ **MI:** ________

Maiden Name *(if applicable)*: ______________________________

List any other alias, name or form of your name: ______________________________

Street: ______________________________ **Suite:** ____________

City: ____________________ **State:** ____________ **Zip Code:** ____________

Social Security Number: ____________________ **Federal Tax ID Number:** ____________________

NPI *(if applicable)*: ____________________ **Specialty of Practice** *(if applicable)*: ____________________

DOB *(mm/dd/yyyy)*: ______________________________ **Gender** *(M/F)*: ________

Medicare provider number *(if applicable)*: ____________________ **Issue date** *(mm/dd/yyyy)*: ____________

DEA number *(if applicable)*: ____________________ **Expiration date** *(mm/dd/yyyy)*: ____________

DEAX number *(if applicable)*: ____________________ **Expiration date** *(mm/dd/yyyy)*: ____________

CLIA number *(if applicable)*: ____________________ **Issue date** *(mm/dd/yyyy)*: ____________

Do you have one or more professional licenses, accreditations or certifications? ☐ Yes ☐ No

*If **Yes**, provide the following information. Copy additional pages as needed.*

Professional Licensing/Certification Board: ____________________ **Licensing State:** ____________

License Accreditation Certification Issuer: ____________________ **License Accreditation Number:** ____________

Date Issued: ____________________ **Expiration Date** *(mm/dd/yyyy)*: ____________________

Professional Licensing/Certification Board: ____________________ **Licensing State:** ____________

License Accreditation Certification Issuer: ____________________ **License Accreditation Number:** ____________

Date Issued: ____________________ **Expiration Date** *(mm/dd/yyyy)*: ____________________

Professional Licensing/Certification Board: ____________________ **Licensing State:** ____________

License Accreditation Certification Issuer: ____________________ **License Accreditation Number:** ____________

Date Issued: ____________________ **Expiration Date** *(mm/dd/yyyy)*: ____________________

4. *Contractual Relationships

Corporate Name: _____

Last Name: _____First Name: _____ MI:_____

Street Address: _____ Suite:_____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ **Federal Tax ID Number:** _____ **NPI** *(if applicable)*: _____

DEA Number *(if applicable):* _____ **Expiration Date** *(mm/dd/yyyy):* _____

DEAX Number *(if applicable):* _____ **Expiration Date** *(mm/dd/yyyy):* _____

CLIA Number *(if applicable):* _____ **Issue Date** *(mm/dd/yyyy):* _____

Title in the provider's or entity's organization: _____

Duties Performed in the provider's or entity's organization *(attach additional sheets as needed)*:

_____

Role in the provider's or entity's organization (for example: Accountant, Agency, *Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Government Official , Individual [Contracted], Individual [Fiscal Agent], Limited Partner, Managing Employee, Non-Limited Partner, Nurse, Official, Owner [Direct], Owner [Indirect] Parent, Recruiter, Representative, Shareholder, Subcontractor, or Unknown [attach additional sheets as needed])*: _____
Effective/start date of role (mm/dd/yyyy): _____

Is the entity or person related to any other entity or person that has an interest in the applicant or provider, as defined in this document?
☐ Yes ☐ No

*If **Yes**, specify relationship (for example: child, spouse, parent, sibling, etc):* _____

Specify Name of Individual: _____

Does the entity or person have a relationship/agreement/affiliation with another Vermont health care provider?: ☐ Yes ☐ No

List all Vermont Medicaid providers and medical entities with whom the entity or person has a contractual relationship. If known, provide the NPI and Medicaid provider number of each provider or entity *(attach additional sheets as needed)*:

Name: _____ **Social Security Number**: _____

DOB *(mm/dd/yyyy):* _____ **Federal Tax ID***:* _____ **NPI***:* _____

Street: _____ **Suite**: _____

City: _____ **State**:_____ **Zip code**:_____

DEA Number: _____ **Expiration Date** *(mm/dd/yyyy):* _____

DEAX Number: _____ **Expiration Date** *(mm/dd/yyyy):* _____

CLIA Number: _____ **Expiration Date** *(mm/dd/yyyy):* _____

Medicaid Number: _____ **Medicare Number**: _____

Specialty of Practice: _____

Name: _____ **Social Security Number**: _____

DOB *(mm/dd/yyyy):* _____ **Federal Tax ID***:* _____ **NPI***:* _____

Street: _____ **Suite**: _____

City: _____ **State**:_____ **Zip code**:_____

DEA Number: _____ **Expiration Date** *(mm/dd/yyyy):* _____

DEAX Number: _____ **Expiration Date** *(mm/dd/yyyy):* _____

CLIA Number: _____ **Expiration Date** *(mm/dd/yyyy):* _____

Medicaid Number: _____ **Medicare Number**: _____

Specialty of Practice: _____

5. * Entity or Person Professional Licensing/Sanctions/Convictions

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.

Has the entity/person ever been sanctioned (as defined above) in any state or federal program? ☐ Yes ☐ No

*If **Yes**, fully explain the details and include any applicable documentation:*

_____

_____

Is your professional license/certification currently revoked, suspended or otherwise restricted? ☐ Yes ☐ No

Have you ever had your professional license or certification revoked, suspended, or otherwise restricted? ☐ Yes ☐ No

Are you currently, or have you ever been, subject to a licensing or certification board order? ☐ Yes ☐ No

Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action? ☐ Yes ☐ No

(All disclosed entities/persons are subject to a license or certification verification/status check with your licensing or certification board)

*If **Yes** was answered to any of the above questions, fully explain details and include applicable documentation (attach additional sheets as needed)*:

_____

"Convicted" means that:

(a) A judgment of conviction has been entered against an individual or entity by a federal, state or local court, regardless of whether:

(1) There is a post-trial motion or an appeal pending, or

(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(b) A Federal, State or local court has made a finding of guilt against an individual or entity;

(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or

(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? ☐ Yes ☐ No

To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. All entities/persons are screened per the requirements 42 CFR 455.434.

Have you been arrested for a crime but not yet charged? ☐ Yes ☐ No

Is there an outstanding warrant for your arrest? ☐ Yes ☐ No

*If **Yes**, fully explain the details and include applicable documentation (attach additional sheets if necessary)*:

_____

Within ten years of the date of this statement, has the entity or person been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No

*If **Yes**, provide the date of the conviction (mm/dd/yyyy)*: _____ Details: _____

Within ten years of the date of this statement, has the entity or person been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No

*If **Yes**, provide the date of the conviction (mm/dd/yyyy)*: _____ Details: _____

Within ten years of the date of this statement, has the entity or person entered into a settlement in lieu of conviction for fraud or abuse involving a government program? ☐ Yes ☐ No

*If **Yes**, provide the date of the conviction (mm/dd/yyyy)*: _____ Details: _____

Does the entity or person currently participated, or have they ever participated, as a provider in the Vermont Medicaid program or in another state's Medicaid program? ☐ Yes ☐ No

*If **Yes, State:*** _____ ***Name(s)*** (*Legal & DBA): _____
NPI** and/or **Provider Number(s): _____

6. *Declaration & Signature Page

I have read the contents of this application. I declare under penalty of perjury under the laws of the State of Vermont that the information in this application and any attachments are true, accurate and complete to the best of my knowledge and belief. My signature legally and financially binds this entity or person to the laws, regulations, and program instructions of the Vermont Medicaid program and state/federal assisted healthcare programs**.** I declare that I have the authority to legally bind the listed entity or person(s) listed or I am the listed entity or person noted on this Application.

If I become aware that any information in this application is not true, correct or complete, I agree to notify Gainwell of this fact immediately (within 30 days of change) 800.925.1706.

Name of Entity or Person on This Application:	
Printed Name of Person Signing This Declaration:	*Title of Person Signing This Declaration:*
Original Signature of the Person, Entity or Person with the Authority to Legally Bind the Disclosed Entity or Individual (must be made in blue ink):	

Contact Person	*Title of Contact Person:*
Contact Number:	*Contact Fax Number:*
Email:	

All signatures must be original and signed in blue ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures are not accepted.

Return all completed forms to:

Gainwell Technologies, Attn: Enrollment Unit , P.O. BOX 888, Williston, VT 05495

If confirmation of delivery is requested, please return to:

Gainwell Technologies, 28 Walnut Street, Suite 245 Building C
Maple Tree Place Shopping Center, Williston, VT 05495