STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

MEDICAID APPLICATION / CHANGE REQUEST FORM

(PART A)

☐ Group
☐ Individual

Provider is currently credentialed with:

CHIP FROM ANOTHER STATE: State Abbreviation ____ (Y / N) ***MEDICARE: (Y / N)***	***MEDICAID FROM ANOTHER STATE: State Abbreviation ____ (Y / N)*** ***Attach credentialing documents***

Medicaid Application type:

1) NEW (Y / N)	***2.) 5 –YEAR RE-VALIDATION (Y / N)***	***3) CHANGE REQUEST (Y / N)***

If application type #1 or #2, check box to confirm enclosed $500 money order ☐

SHADED FIELDS FOR MED-QUEST PROVIDER REGISTRATION STAFF ONLY ***Please Type or Print in Ink***

SECTION I

1) **N**ATIONAL **P**ROVIDER **I**DENTIFIER NUMBER *(Enter your 10-digit number, if applicable)* — — — — — — — — — —	2) PROVIDER NAME *(Last Name/First Name/Middle Initial)*	
3) PROVIDER'S REGISTERED BUSINESS NAME / DOING BUSINESS AS (d.b.a.) NAME		☐ SOLE PROPRIETORSHIP ☐ CORPORATION ☐ OTHER _____
4) SOCIAL SECURITY NUMBER - -	5) SPECIALTY / DEGREE *(Attach Board Certificate or Letter)*	**DHS USE ONLY** PROVIDER MEDICAID ID NUMBER:
6) GENDER	7) DATE OF BIRTH Month ___ Day ___ Year ___	8) FIRST DATE OF SERVICE FOR WHICH A CLAIM WILL BE SUBMITTED Month ____ Day ____ Year ____

SECTION II ADDRESS INFORMATION

☐ INITIAL SERVICE ADDRESS *(IF NEW APPLICANT)*

☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

CORRESPONDENCE ADDRESS (C)

9) ATTENTION TO: _____
10) STREET LINE 1: _____
11) STREET LINE 2: _____
12) CITY/STATE/ZIP: _____
13) BUSINESS PHONE: ( ) – 14) FAX NUMBER: ( ) –
15) E-MAIL ADDRESS:

SERVICE ADDRESS (S) **DHS USE ONLY**

16) ATTENTION TO: _____
17) STREET LINE 1: _____
18) STREET LINE 2: _____
19) CITY/STATE/ZIP: _____
20) BUSINESS PHONE: ( ) – 21) FAX NUMBER: ( ) –
22) BEGIN DATE: / / 23) END DATE: / /
24) CLIA NUMBER: *If Applicable* 25) NABP/NCPDP NO.: *If Applicable*

DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO

PAY TO ADDRESS (P) **DHS USE ONLY**

26) ATTENTION TO: _____
27) STREET LINE 1: _____
28) STREET LINE 2: _____
29) CITY/STATE/ZIP: _____
30) BUSINESS PHONE: ( ) – 31) FAX NUMBER: ( ) –
32) BEGIN DATE: / / 33) END DATE: / /
34) FEDERAL TAX ID NUMBER: 35) GENERAL EXCISE TAX NUMBER:

DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

SERVICE ADDRESS (S)				**DHS USE ONLY**
16) ATTENTION TO:				
17) STREET LINE 1:				
18) STREET LINE 2:				
19) CITY/STATE/ZIP:				____
20) BUSINESS PHONE:	( ) –	21) FAX NUMBER:	( ) –	
22) BEGIN DATE:	/ /	23) END DATE:	/ /	
24) CLIA NUMBER: *If Applicable*		25) NABP/NCPDP NO.: *If Applicable*		
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO				

PAY TO ADDRESS (P)				DHS USE **ONLY**
26) ATTENTION TO:				
27) STREET LINE 1:				
28) STREET LINE 2:				
29) CITY/STATE/ZIP:				____
30) BUSINESS PHONE:	( ) –	31) FAX NUMBER:	( ) –	
32) BEGIN DATE:	/ /	33) END DATE:	/ /	
34) FEDERAL TAX ID NUMBER:		35) GENERAL EXCISE TAX NUMBER:		
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO				

☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

SERVICE ADDRESS (S)				**DHS USE ONLY**
16) ATTENTION TO:				
17) STREET LINE 1:				
18) STREET LINE 2:				
19) CITY/STATE/ZIP:				____
20) BUSINESS PHONE:	( ) –	21) FAX NUMBER:	( ) –	
22) BEGIN DATE:	/ /	23) END DATE:	/ /	
24) CLIA NUMBER: *If Applicable*		25) NABP/NCPDP NO.: *If Applicable*		
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO				

PAY TO ADDRESS (P)				**DHS USE ONLY**
26) ATTENTION TO:				
27) STREET LINE 1:				
28) STREET LINE 2:				
29) CITY/STATE/ZIP:				____
30) BUSINESS PHONE:	( ) –	31) FAX NUMBER:	( ) –	
32) BEGIN DATE:	/ /	33) END DATE:	/ /	
34) FEDERAL TAX ID NUMBER:		35) GENERAL EXCISE TAX NUMBER:		
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO				

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SECTION III ADDITIONAL INFORMATION

LICENSING AND CERTIFICATION

35) LICENSE / CERTIFICATE NUMBER	36) LICENSING / CERTIFYING AGENCY	37) ISSUE DATE (MM/DD/YYYY)	38) EXPIRATION DATE (MM/DD/YYYY)

* A **COPY** OF THE LICENSE AND/OR CERTIFICATION **MUST BE ATTACHED**

AUTHORIZED AGENTS

39) AGENT SIGNATURE	40) PRINT NAME	41) BEGIN DATE (MM/DD/YYYY)	42) END DATE (MM/DD/YYYY)

NOTE: THAT ALL SIGNATURES MUST BE ORIGINAL. ATTACHED A SEPARATE SHEET IF NEEDED.

GROUP BILLING AUTHORIZATION

43) GROUP NAME	44) ASSOCIATION BEGIN DATE (MM/DD/YYYY)	45) ASSOCIATION END DATE (MM/DD/YYYY)

MEDICARE INFORMATION *(Mandatory for all providers. If not a Medicare provider indicate by placing N/A in block #46)*

46) MEDICARE ID NUMBER	[redacted]

I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.

47) PROVIDER SIGNATURE *(ONLY)*

48) DATE

49) PROVIDER NAME *(PLEASE TYPE OR PRINT)*

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
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FOR DHS USE ONLY - DETERMINATION

APPROVAL / DENIAL:

FEE-FOR-SERVICE Provider QMB ONLY Provider *(Medicare Co-Payment / Deductible ONLY)*

NEGOTIATED Provider *(Rates and/or Procedure Codes Attached)*

APPROVED _____ (MM DD YY) DENIED _____ (MM DD YY) *REASON FOR DENIAL NOTATED BELOW*

REASON: _____

_____
MQD AUTHORIZED SIGNATURE

_____
DATE

FOR DHS USE ONLY - VALIDATION

PROVIDER TYPE:		ENROLLMENT BEGIN DATE:				DATE COS ENTERED: *Per Attached*			
	CODE		MM	DD	YY		MM	DD	YY

_____
MQD AUTHORIZED SIGNATURE

_____
DATE

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Health Care Services Branch
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PART B AND PART C

Read through the Provider Agreement and Condition of Participation.

HAWAII STATE MEDICAID PROGRAM
PROVIDER AGREEMENT AND CONDITION OF PARTICIPATION (PART B)

I/We, _____, hereby apply to become a provider under the Hawaii State Medicaid Program and agree to the following terms and conditions if accepted:

1. I/We agree to abide by the applicable provisions of the Hawaii State Medicaid Program set forth in the Hawaii Administrative Rules, Title 17, Subtitle 12, and applicable provisions set forth in the Code of Federal Regulations (C.F.R.) related to the Medical Assistance Program. Upon certification by the Hawaii State Medicaid Program, I/We also agree to abide by the policies and procedures contained in the Hawaii State Medicaid Manual. If I/We are a provider for the 1915© waiver for participants with Developmental Disabilities (DD) or Intellectual Disabilities (ID), I/We agree to abide by the policies and procedures contained in the Medicaid Waiver Provider Standards Manual.

2. I/We agree to comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Age Discrimination Act of 1975 (P.L. 94-135), and all the requirements issued pursuant to the respective title, section and/or act, as promulgated by the regulations of the Department of Health and Human Services and hereby give assurance that I/We will immediately take any measures necessary to enact this agreement, to the effect that no person shall on the grounds of the applicable categories such as race, color, national origin, sex, age or handicap, be excluded from participation in, or be denied the benefits of, or be otherwise subjected to discrimination under any program and/or activity of the service provider that is funded in its entirety or in part directly or indirectly by Federal Financial Assistance.

3. I/We agree to keep all such records necessary to disclose fully, upon request, the extent of care and/or services provided by me/we to eligible Medicaid beneficiaries and to furnish the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division, such information from those records regarding any payments that have been claimed by me/we under the program as the Hawaii State Department of Human Services may, from time to time, require as authorized by 42 C.F.R. §431.107(b)(2).

4. I/We agree to disclose full and complete information regarding ownership information as described in 42 C.F.R. §455 Subpart B. This includes but is not limited to disclosure of information on ownership and control (42 C.F.R. §455.104), information related to business transactions (42 C.F.R. §455.105), and information on persons convicted of crimes (42 C.F.R. §455.106) upon execution of this provider agreement during re-validation of the enrollment process, within thirty-five (35) days of any change in ownership of the disclosing entity and at the request of the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division in the Department of Attorney General.

5. I/We understand that the Hawaii State Medicaid Program may refuse to enter into or renew an agreement with me/we if any person, who has an ownership or control interest in the provider, or who is an agency or managing employee, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare and Medicaid Program (Title XIX) as stipulated in 42 C.F.R. §455.106.

6. I/We agree to accept, as payment in full, the applicable amount or amounts established by the Hawaii State Medicaid Program in Chapter 1739, Hawaii Administrative Rules, plus any deductible, coinsurance, or copayment required by the Hawaii State Medicaid Program to be paid by the Medicaid recipient as stipulated in 42 C.F.R. §447.15. I/We am aware that it is violation of Federal law to accept or require additional payments over and beyond those established by the Hawaii State Department of Human Services for services rendered under the Hawaii State Medicaid Program. I/We understand the reimbursement rates shall be in accordance with payment methodologies pursuant to Chapter 1739, Hawaii Administrative Rules.

7. I/We understand that when changes in Hawaii State Department of Human Services and Hawaii State Medicaid Program policies and procedures become necessary due to changes in State or Federal laws or regulations, that such change will take effect within thirty (30) days of receipt of written notice from the Hawaii State Department of Human Services or the Hawaii State Medicaid Program to me/we.

8. I/We understand that (1) Any information provided by the Hawaii State Department of Human Services and the Hawaii State Medicaid Program to a provider and by a provider to the Department or Medicaid Program, shall be treated confidentially and shall not be released to other agencies or persons without the written consent of the recipient except in accordance with Subtitle 12, Chapter 17-1702 of the Hawaii Administrative Rules; (2) Any information about Medicaid Providers and recipients shall be confidential and shall not be disclosed except in accordance with Subtitle 12, Chapter 1702-5 of the Hawaii Administrative Rules. Such confidential information includes, but is not limited to the names and addresses of individuals, social and economic circumstances of an individual, evaluations, and medical, psychological or psychiatric information about the individual; (3) The records of any person, including all communications or specific medical or epidemiological information contained therein, that indicates that a person has or has been tested for HIV/AIDS shall be strictly confidential and shall only be released in accordance with Chapter 325-101, Hawaii Revised Statutes; (4) Information regarding an individual's records and reports with respect to mental health and substance abuse services are confidential and may only be disclosed in accordance with Chapter 334-5, Hawaii Revised Statutes; (5) Any information pertaining to the provision of services related to pregnancy, family planning or venereal disease shall be treated as confidential and may be released in accordance with Chapter 577A-3, Hawaii Revised Statutes.

9. I/We shall comply with the provisions of the Federal Drug Free Act of 1988 (P.L. 100-690), Title V Subtitle D, which requires that the provider maintain a drug-free workplace.

10. I/We shall comply with the provisions of HIPAA. In this Agreement "HIPAA" means the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, Pub L. No. 104-191. PROVIDER is a "health care provider" under HIPAA. A "covered entity" is a health care provider that transmits information in a standard electronic transaction under 45 C.F.R. Parts 160 and 162. If PROVIDER is or becomes a "covered entity", then PROVIDER must comply with all of the rules adopted to implement HIPAA, including rules for privacy of individually identifiable information, security of electronic protected health information, transactions, and code sets, and national employer and provider identifiers. Refer to 45 C.F.R. Parts 160, 162 and 164.

11. I/We agree to have criminal history record check(s) conducted on myself/my employees consistent with State and Federal law and DHS Standards.

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
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(PART C)

I/We understand that I/We may be suspended or terminated from participation in the Hawaii State Medicaid Program for non-adherence to any of the preceding program requirements and for violation of any of the provisions of H.A.R. Subtitle 12, Chapter 17-1704 (Provider Fraud) and Chapter 17-1736 (Provider Provisions) which includes but is not limited to the following:

(1) Any provider's practice which is deemed harmful to public health, safety and welfare of Medicaid beneficiaries; (2) Not providing full and accurate disclosure of the identify of any person or persons who has been convicted of a criminal offense relating to Medicaid or Medicare; (3) Fraud against the Hawaii State Medicaid Program including, but not limited to, the claiming and receipt of payment or payments for services not rendered, submission of a duplicate claim to the Medicaid program with intent to defraud and acceptance of payments for services already paid, or deliberate preparation of a claim in a manner which causes higher payment than the amount entitled to; (4) Requiring and/or accepting any payment from a Medicaid beneficiary for services paid for by the Hawaii State Medicaid Program, except in cases where the Hawaii State Department of Human Services has identified a cost share to be paid by the beneficiary and where the beneficiary remits an amount equal to his or her cost share; (5) Requiring and receiving payment from a beneficiary to make up for the difference between the Hawaii State Department of Human Services' applicable fee schedule or rate and the provider's charges; (6) Revocation of the provider's license by the Hawaii State Department of Commerce and Consumer Affairs; (7) Withdrawal, expiration or termination of facility certification by the Hawaii State Department of Health; (8) Action taken by the provider's professional group or organization disapproving the provider's methods of treatment or care or a determination that care/services rendered by the provider are not in accordance with accepted practices of the profession or harmful to a beneficiary's health and safety; (9) Violation of the non-discrimination provisions; and (10) Notification from the Secretary of Health and Human Services, or person designated by him/her that an individual, hospital or nursing facility has withdrawn from participation in Medicare without refunding money it owes to Medicare or when the provider agreement has been terminated for defrauding Medicare.

IN THE CASE OF PROVIDERS WHO ARE INDIVIDUALS:

I agree that all services for which I make a claim against the Hawaii State Medicaid Program (Title XIX) will be personally rendered by me. Services such as administration of injections, immunizations, minimal dressings, and drawing of blood samples may be rendered by qualified support nursing staff.

I agree and understand that a qualified licensed psychiatrist or psychologist must provide all psychotherapeutic services, and qualified licensed clinical social worker or advance practice registered nurse shall be limited to behavioral health services.

IN THE CASE OF PROVIDERS WHICH ARE BUSINESSES, GROUPS, HOSPITALS, CORPORATIONS OR OTHER ENTITIES:

(1) I/We and each of us agree that all services for which our organization makes a claim against the Hawaii State Medicaid Program (Title XIX) shall be only for services rendered by persons who are properly licensed and/or qualified for the service they provide for which the claims are submitted; (2) If any real property or structure thereon is provided or improved either directly or indirectly by Federal

Financial Assistance from the Department of Health and Human Services, this Assurance shall obligate the service provider, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal Financial Assistance is extended or for another purpose involving the provision of similar services and/or benefits. If any personal property is so provided, this Assurance shall obligate the service provider for the period during which it retains ownership or possession of the property. In all other cases this Assurance shall obligate the service provider for the period during which the Federal Financial Assistance is extended to it either directly or indirectly by the Department of Health and Human Services; (3) This Assurance is given by the service provider in consideration of and for the purpose of receiving or benefiting from either directly or indirectly any or all Federal Financial Assistance that is extended after the date hereof by the Department of Health and Human Services, through the Hawaii State Department of Human Services. The service provider recognizes and agrees that such Federal Financial Assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States and/or the State of Hawaii shall have the right to seek judicial enforcement of the Assurance. This Assurance is binding on the service provider, its successors, transferees, and assignees, and to the person authorized to sign this Assurance on behalf of the service provider whose signatures appear below.

RETROACTIVE CERTIFICATION:

I/We agree that retroactive provider certification shall be limited to no more than twelve (12) months back to the date on which the application was received in the Hawaii State Department of Human Services/Med-QUEST Division/Health Care Services Branch office subject to the discretion of the Med-QUEST Division Administration. The month in which the application was received shall be counted as the first month.

I/We have read all of the Provider Agreement and Condition of Participation in the Hawaii State Medicaid Program and fully understand and agree to its terms.

_____
Print Name of Provider / Authorized Business Agent

_____
Signature of Provider / Authorized Business Agent

_____
Date of Signature

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
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(PART D)

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROVIDER AGREEMENT

I, as a Primary Care Provider (PCP) agree to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in accordance with Title 17, Chapter 1737, Subchapter 6, Section 53 to 62 of the Hawaii Administrative Rules.

I HAVE READ AND UNDERSTAND PART D OF THE AGREEMENT:

_____ _____
(Full Signature of Provider) (Date)

(Leave Blank if New Provider)

_____ _____
(Print Provider's Name in Full) (Medicaid Provider No.)

EFFECTIVE DATE REQUESTED:

_____

FOR DHS OFFICIAL USE ONLY

APPROVED: _____ _____
Provider Data Technician Date

EFFECTIVE DATE OF PROVIDER PARTICIPATION: _____
MONTH/DAY/YEAR

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
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(PART E)

DISCLOSURE INFORMATION (DI)

As required by the Affordable Care Act (42 CFR §455 Subpart B) and Hawaii Administrative Rules (§17-1736-20 & §17-1736-21) the following information must be submitted to the Med-QUEST Division prior to certification or renewal as a *provider* under Medicaid. For provider groups or sole proprietors, failure to provide accurate and complete disclosure information will render this application incomplete. THIS FORM IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR §455.101, §455.105 and §455.106 and HAR §17-1736-19). Note: See the instructions of this form for definitions of underlined terms according to 42 CFR §455.101, §455.104, §455.105, and HAR §17-1736-19. ***All attachments must be labeled and reference to the question the attachment pertains.***

1.	Entity Name that this DI pertains to:		
2.	Enter current NPI/Medicaid Provider number combination that this DI is in reference to, if applicable. NPI: _____ Provider number: _____ Provider number (Enter only if you are not required to have a NPI/Taxonomy Code for billing purposes): _____ ☐ *Check here for Not Applicable (N/A)*		
3.	If there has been a change in ownership, change of tax ID number (FEIN), or change in Medicaid Provider Number for a previously enrolled Hawaii Medicaid provider, enter the previous provider number(s) and their effective date(s): ☐ *Check here for N/A*		
	Previous Medicaid Provider #:	Start Date:	End Date:
4.	If you completed item #3, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) corporate boards of disclosing provider and previous Medicaid owner; i.e. board members and ownership or control interest (c) disenrollment circumstances. (Attach extra page if necessary.)		
	a.		
	b.		
	c.		
5.	If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. ☐ *Check here for N/A*		
	Date:	Change:	
6.	If you anticipate filing for bankruptcy within the year, enter anticipated date of filing. ☐ *Check here for N/A*		
7.	If this facility is a subsidiary of a parent corporation, enter corporate FEIN#: ☐ *Check here for N/A*		
	Name:		
	Address:		
	City:	State:	Zip Code:

Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

8.	List name, date of birth, SSN#/FEIN#, and address of each person or entity that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider. (Attach extra pages if necessary.) *Comple item #9 with the officer's and board members' information of the owning entities.*		
Name / Business Name:			SSN:
Business Address:		FEIN:	DOB:
City:		State:	Zip Code:
** If a corporate entity is disclosed in item #8 above, all business location(s) of this corporate entity must be disclosed. Please attach a sheet to disclose this information.			
9.	List officers' and board members' information of owning entities. However, if no one owns 5% or more direct or indirect ownership, please list the officers' and board members' information. (Attach extra sheet if necessary listing same details below.) ☐ *Check here for N/A*		
Name (a)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip Code:
Name (b)		Title:	
Address:		DOB:	SSN:
City:		State	Zip Code:
10.	If any individuals listed in items #8 and #9 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name (a)			SSN:
Relationship:			FEIN:
Name (b)			SSN:
Relationship:			FEIN:
11.	If this facility or organization employs a management company, please provide the following information: ☐ *Check here for N/A*		
Name:			
Address:			
City:		State:	Zip Code:

12.	List the names of any <u>other disclosing entity</u> in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities. ☐ *Check here for N/A*		
Name:		Provider #, if applicable:	
Address:			
City:		State:	Zip Code:
13.	List the names and addresses of all other Hawaii Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name:			
Address:			
City:		State:	Zip Code:
14.	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year periods. (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name:			
Address:			
City:		State:	Zip Code:
15.	List the name, SSN, and address of any immediate family member who is authorized under Hawaii Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment. ☐ *Check here for N/A*		
Name: (a)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip Code:
Name (b)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip Code:
16.	List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a Hawaii Medicaid provider number (s), please indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name (a) / Hawaii Medicaid Provider Number (s), if applicable:			
Name (b) / Hawaii Medicaid Provider Number (s), if applicable:			

17.	List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a Hawaii Medicaid provider number(s), indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name (a)/Hawaii Medicaid Provider Number(s), if applicable:			
Name (b)/Hawaii Medicaid Provider Number(s), if applicable:			
18.	List the name, title, FEIN / SSN, and business address of all managing employees below as defined in 42 CFR §455.101. (Attach extra page if necessary listing same details below.) ☐ *Check here for N/A*		
Name (a)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip Code
Name (b)		Title:	
Address:		DOB:	SSN:
City:		State:	Zip Code:
19.	List the name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name:			SSN:
Address:			FEIN:
City:		State:	Zip Code:
Name			SSN:
Address:			FEIN:
City:		State:	Zip Code:
20.	If you keep medical records on an electronic database, you hereby certify by your initials in the space provided that electronic records are confidential and patient privacy is protected. Every health care provider or organization, regardless of size, who creates or maintains individual protected health information in any form (written, oral, or electronic) for the purpose of treatment, payment, or operation is a covered entity and must comply with HIPAA Privacy and Security Rules. **Initials** _____		

STATE OF HAWAII
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Med-QUEST Division
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21.	Contact Information – This information is used only for questions regarding the information on this form	
	Contact Name:	Contact Telephone:
	E-mail address:	
22.	I certify that all the Information I have provided on this DHS, Med-QUEST Division Disclosure of Ownership Form is accurate. Failure to provide accurate information could result in termination from the Medicaid program.	
	Signature	Date Signed:
	Printed Name:	
	Title:	
23.	DHS will report all monies paid to you to theirs. Please indicate which number you use for tax reporting. If enrolled as an individual and you do not own a FEIN, please complete SSN only.	
	Report DHS payment to my FEIN:	
	Report DHS payment to my SSN:	
Please attach copy of your IRS verification letter OR a copy of your Social Security Card verifying FEIN/SSN above.		
24.	**FOR DHS USE ONLY:**	
	Signature:	Date Signed:
	Printed Name:	
	Title:	

EPLS/SAM:	OIG/HHS:	SSA Death Master File:

I/We hereby attest that the information contained in the Disclosure Statement is current, complete and accurate to the best of my knowledge. I/We understand that if I knowingly or willfully make or cause to make a false statement or representation on the statement, I/We may be prosecuted under applicable 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 in the Medicaid Program.

Further, the Provider shall, upon discovery of any information required by federal and state regulations, immediately notify the Med-QUEST Division in writing of the information required to be provided.

_____ _____

Date Signed | Print Name of Provider / Authorized Business Agent

_____

Signature of Provider / Authorized Business Agent