



PROVIDER CREDENTIALING APPLICATION

Thank you for your interest in contracting with AlohaCare to serve our AlohaCare Quest Integration and AlohaCare Advantage (HMO SNP) members. In order to begin the process of joining AlohaCare's Provider Network, we ask that you complete the attached Provider Credentialing Application.

Please return your completed application with all required documents requested below:

- Copy of current Hawaii State Professional License
- Copy of current Professional Liability Insurance
Note: Minimum requirements for Professional Liability Insurance is \$1 million per claim with \$3 million in the annual aggregate.
- Copy of current Hawaii State Controlled Substance Certificate (if applicable)
- Copy of current Federal DEA Certificate (if applicable)
- Copy of CV or Resume
- Completed W-9 Form
- Completed Disclosure Information Form

Fax or mail the completed application, with the required documents to:

Fax: (808) 973-0203
Address: AlohaCare
Attn: Provider Services
1357 Kapiolani Blvd Ste 1250
Honolulu HI 96814

Once we have received the necessary paperwork, we will initiate the formal credentialing and contracting process.

Providers must be credentialed by AlohaCare prior to rendering care or services to AlohaCare members. Services rendered to AlohaCare members prior to the completion of credentialing and provider notification of acceptance into the AlohaCare provider network will not be honored for payment.

Please contact our Provider Services Department at 973-1650 (Oahu) or 1-800-434-1002 (Neighbor Islands) if you have any questions regarding these forms or instructions.



PROVIDER CREDENTIALING APPLICATION

IDENTIFICATION AND DEMOGRAPHICS (please PRINT in **BLACK** ink)

Provider Classification:	<input type="checkbox"/> Primary Care Physician	<input type="checkbox"/> Specialist Physician	<input type="checkbox"/> Hospitalist						
Specialty:	_____								
Provider Type:	<input type="checkbox"/> MD	<input type="checkbox"/> DO	<input type="checkbox"/> DPM	<input type="checkbox"/> DC	<input type="checkbox"/> OD	<input type="checkbox"/> DDS	<input type="checkbox"/> DMD	<input type="checkbox"/> PHD	<input type="checkbox"/> PSYD
	<input type="checkbox"/> Other: _____								

Legal Name

Title: _____	Last Name: _____
First Name: _____	Middle: _____
Suffix (e.g., Jr): _____	

Other Names (please check one): Previously Known As Also Known As Maiden

Last Name: _____	Suffix (e.g., Jr): _____
First Name: _____	Middle: _____
Title: _____	

Provider Info

Date of Birth: _____	Social Security Number: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Contact Phone No. (Optional): _____	Cell Phone No. (Optional): _____	
Individual NPI: _____		
Email Address: _____		
Website: _____		
Medicaid Number: _____	(Medicaid) State: _____	
Medicare PTAN: OT, PT, SP, MNT – Submit Medicare confirmation letter if you will be participating in AlohaCare’s Medicare plan		
Medicare Status:		
<input type="checkbox"/> Participating	<input type="checkbox"/> Nonparticipating	<input type="checkbox"/> Enrolled <input type="checkbox"/> Not Enrolled <input type="checkbox"/> Opt Out
In Process for:		
<input type="checkbox"/> Participating	<input type="checkbox"/> Nonparticipating	
Please select the ALOHACARE programs you would like to participate in below.		
<input type="checkbox"/> Medicare Advantage (HMO SNP)	<input type="checkbox"/> QUEST Integration	
Max number of members: _____	Max number of members: _____	
Have you completed Cultural Competency Training? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you provide EPSDT Services?		
<small>Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program for children up to age 21 which emphasizes the importance of prevention through early screening for medical, dental and behavioral health conditions and timely treatment of conditions that are detected.</small>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have age restrictions (If yes, please describe)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please Describe: _____		

FOR ALOHCARE USE ONLY Type of application: Initial Credentialing Re-Credentialing Next Review Date: _____

OFFICE INFORMATION/LOCATION OF PRACTICE

Note: If you have additional locations, please make copies of this page as needed

Please select all that apply for the following location:

- Primary
 Additional
 Billing
 Home
 Mailing
 Credentialing
 Provider Directory

Office Practice Name: _____

Date Joined: _____

Address

Street: _____

City: _____

State: _____

Zip Code: _____

Office Information

Accepting New Patients: Yes No

Phone/Appointment Phone: _____ E-mail: _____

Contact Name: _____

Contact Phone: _____ Office Fax: _____ Referral Fax: _____

Acceptable to send confidential information? Yes No Credentialing Contact: _____

Clinical Lab Inspection Approval (CLIA) Number (if applicable): _____

Physician Assistants, please provide the name of your supervising physician:

Entity Name: _____

Clinic or Group Name: _____

Group NPI Number: _____ Federal Tax ID Number: _____

Is this practice compliant with the Americans with Disabilities Act (ADA) standards? Yes No

Does this practice provide TeleHealth Services? Yes No

If yes, does your practice have a secure and HIPAA compliant platform to perform these services? Yes No

Languages Spoken (Please check all that apply):

- | | | |
|------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Marshallese | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Mandarin | <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Thai |
| <input type="checkbox"/> Ilocano | <input type="checkbox"/> Japanese | <input type="checkbox"/> Tongan |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Chuukese | <input type="checkbox"/> Samoan | <input type="checkbox"/> Sign Language |

Office Hours

Mon Open	Tue Open	Wed Open	Thu Open	Fri Open	Sat Open	Sun Open
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mon Close	Tue Close	Wed Close	Thu Close	Fri Close	Sat Close	Sun Close
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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Additional Payment

Payment Checks Should be Made Out to:

Provider Provider's Office Practice Name Clinic or Group Other (Specify): _____

Mail Payment Check to: Payment Address Office

Is the mailing address for all locations the same? Yes No

State Licensure

Include all licenses current or held in last five years

Name of State Board Issued by: _____ State: _____

License Number: _____ License Type: _____

Exp. Date: _____ First Issued: _____ Active License Inactive License

Name of State Board Issued by: _____ State: _____

License Number: _____ License Type: _____

Exp. Date: _____ First Issued: _____ Active License Inactive License

Name of State Board Issued by: _____ State: _____

License Number: _____ License Type: _____

Exp. Date: _____ First Issued: _____ Active License Inactive License

Specialty/Board Certification

List any certification received from any nationally recognized specialty certification boards.

Primary Specialty: _____

Outpatient Inpatient

Board Certified? Yes No If no, Eligible to take Exam? Yes No If yes, planning to take exam? Yes No

(If applicable) Name of certifying board: _____

Certificate #: _____ Expiration Date: _____ Original Effective Date: _____ Re-certification Date: _____

Other Specialty: _____

Outpatient Inpatient

Board Certified? Yes No If no, Eligible to take Exam? Yes No If yes, planning to take exam? Yes No

(If applicable) Name of certifying board: _____

Certificate #: _____ Expiration Date: _____ Original Effective Date: _____ Re-certification Date: _____

Other Specialty: _____

Outpatient Inpatient

Board Certified? Yes No If no, Eligible to take Exam? Yes No If yes, planning to take exam? Yes No

(If applicable) Name of certifying board: _____

Certificate #: _____ Expiration Date: _____ Original Effective Date: _____ Re-certification Date: _____

Please check if there are additional Board Certifications and include a copy in attachments

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Professional Education and Training

ECFMG Number (<input type="checkbox"/> if applicable): _____			
Name of Medical/Professional School: _____			
Address of Medical/Professional School: _____			
Degrees Earned: _____	From(mm/yy): _____	Through(mm/yy): _____	Date of Completion: _____
Specialty: _____ Name of Medical/Professional School: _____			
Address of Medical/Professional School: _____			
<input type="checkbox"/> Internship	<input type="checkbox"/> Residency	<input type="checkbox"/> Fellowship	Date of Completion: _____
From(mm/yy): _____	Through(mm/yy): _____		
Specialty: _____ Name of Medical/Professional School: _____			
Address of Medical/Professional School: _____			
<input type="checkbox"/> Internship	<input type="checkbox"/> Residency	<input type="checkbox"/> Fellowship	Date of Completion: _____
From(mm/yy): _____	Through(mm/yy): _____		
Specialty: _____ Name of Medical/Professional School: _____			
Address of Medical/Professional School: _____			
<input type="checkbox"/> Internship	<input type="checkbox"/> Residency	<input type="checkbox"/> Fellowship	Date of Completion: _____
From(mm/yy): _____	Through(mm/yy): _____		

Hospital Affiliations and Privileges

Primary Hospital Affiliation Name: _____			
Address / City / State / Zip: _____			
Initial Appointment Date: _____		Next Re-Appointment Date: _____	
Staff Category: _____		Admitting Privileges?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Hospital Affiliation Name: _____			
Address / City / State / Zip: _____			
Initial Appointment Date: _____		Next Re-Appointment Date: _____	
Staff Category: _____		Admitting Privileges?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Hospital Affiliation Name: _____			
Address / City / State / Zip: _____			
Initial Appointment Date: _____		Next Re-Appointment Date: _____	
Staff Category: _____		Admitting Privileges?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>*If no admitting privileges, you are required to have a written arrangement with another healthcare practitioner that has admitting privileges with an acute care hospital that is within the AlohaCare Network and on the island of service.</i>			
Please list the physician's information below AND provide a copy of the written agreement.			
Admitting Physician Name: _____		Name of Hospital: _____	
Address / City / State / Zip: _____			
Phone: _____		Fax: _____	Email: _____

Please check if there are additional Hospital Affiliations and include a copy of attachments

FOR ALOHCARE USE ONLY Type of application: Initial Credentialing Re-Credentialing Next Review Date: _____

Work History

For Initial Credentialing, five (5) years of work history is required in MM/YYYY format. For re-credentialing the requirement is three (3) years. If attaching a CV in lieu of completing below, please include Month and Year of start and end date.

Office Practice Name: _____	From: _____	To: _____
Have you had a break in service for more than six months? If yes, please explain:		
Office Practice Name: _____	From: _____	To: _____
Have you had a break in service for more than six months? If yes, please explain:		
Office Practice Name: _____	From: _____	To: _____
Have you had a break in service for more than six months? If yes, please explain:		

Controlled Substances Registration (if not applicable, leave this section blank.)

Hawaii Controlled Substance Certification (CSC)		
CSC No: _____	Effective Date: _____	Expiration: _____
Restrictions: _____		
Federal Drug Enforcement Association (DEA) Certificate – Must Have a Hawaii Certificate		
DEA No: _____	Effective Date: _____	Expiration: _____
Restrictions: _____		

Professional Liability Coverage Information

(Please list the names and complete addresses of each professional malpractice insurer, attach additional sheets if necessary)

Current Carrier Name: _____			Policy Number: _____		
Address / City / State / Zip: _____					
Effective Date: _____		Expiration Date: _____		Retroactive Date: _____	
Amount Per Incident: _____		Aggregate Amount: _____		Umbrella Amount: _____	
Exclusions or Limitations: _____					
Current Carrier Name: _____			Policy Number: _____		
Address / City / State / Zip: _____					
Effective Date: _____		Expiration Date: _____		Retroactive Date: _____	
Amount Per Incident: _____		Aggregate Amount: _____		Umbrella Amount: _____	
Exclusions or Limitations: _____					
Current Carrier Name: _____			Policy Number: _____		
Address / City / State / Zip: _____					
Effective Date: _____		Expiration Date: _____		Retroactive Date: _____	
Amount Per Incident: _____		Aggregate Amount: _____		Umbrella Amount: _____	
Exclusions or Limitations: _____					

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Health Status		
Health status is defined as the physical and mental conditions of the applicant as they relate to the individual's ability to exercise those clinical privileges requested.		
a. Can you perform the functions of the privileges that you are requesting, and/or the contractual arrangement for which you are applying, with or without accommodations? If no, please explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Are you presently using illegal drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Have you in the past five years used and/or been treated for substance abuse (i.e., drugs, prescription medications or alcohol)? If yes, please explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Restrictive Actions		
* If you answer "Yes" to any of the questions below, please attach an explanation of each occurrence to include the date, parties involved, and circumstances surrounding the situation, outcome, and any copies of court documents.		
a. Are you currently a named defendant to any pending malpractice claim or suit?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
b. Have you ever been a named defendant in any malpractice claim or suit where judgment was made against you or where you settled out of court with plaintiff?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
c. Is there any current or pending due-process action relating to denial, revocation, suspension, or restriction for any of your clinical privileges, appointment, membership, employment, and/or contractual arrangement at any health care organization?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
d. Have any of your applications for clinical privileges, appointment, membership, employment, and/or contractual arrangement at any health care organization ever been denied, revoked, suspended, restricted, limited, reduced, or terminated voluntarily or involuntarily?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
e. Have any of your clinical privileges, appointment, membership, employment, and/or contractual arrangement at any health care organization ever been subject to any type of monitoring that is not routinely applied to other practitioners of your specialty?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
f. Is there any current or pending due-process action relating to denial, revocation, suspension, or restriction for any of your professional licenses or applications for professional license in any jurisdiction?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
g. Have any of your professional licenses or applications for professional licenses ever been challenged, denied, revoked, suspended, restricted, limited, conditioned, or voluntarily or involuntarily relinquished?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
h. Does your current liability malpractice coverage exclude specific procedures?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
i. Have you been without malpractice coverage in the past five consecutive years?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
j. Has your professional liability insurance coverage ever been denied, suspended, restricted, limited, modified, canceled, or not renewed by the action of any insurance company?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
k. Have any of your controlled substance certificates or federal drug enforcement agency certificate ever been challenged, denied, revoked, suspended, restricted, limited, conditioned, or voluntarily or involuntarily relinquished?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
l. Are there any current or pending investigations or actions being taken against you, or have there ever been any restrictive actions taken against you by the Medicare program, Medicaid program, Regulated Industries Complaints Office, Medical Inquiry and Conciliation Panel (MICP), the Hawaii Department of Commerce and Consumer Affairs, and/or the Hawaii Board of Medical Examiners?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
m. Has your membership to local, state, or national medical societies ever been placed on probation, revoked, suspended, or terminated?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
n. Have you ever been convicted of a crime, pled guilty or "no contest" to a crime (other than a traffic offense), or are you currently under indictment for an alleged crime?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
o. Do you currently employ anyone who has been excluded from the Medicare or Medicaid program?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
p. Has there ever been any disciplinary action, suspension, probation, formal reprimand or request to voluntarily or involuntarily resign during your education, internship, residency, fellowship, preceptorship, or additional applicable training?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No

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Accessibility

Physicians, provide what type of arrangements your practice has to ensure continuous 24-hour accessibility to medical services (i.e., emergency and vacation coverage). Please provide the name, address, and telephone number of the physician(s) covering for you.

Attestation

I hereby affirm that the above information is complete, accurate and true, to the best of my information, knowledge, and belief.

Signature _____

Date _____

Printed or Stamped Name _____

Please return application and attachments to:

AlohaCare
Attn: Provider Services
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814
Phone (808) 973-1650 on Oahu
1 (800) 434-1002 toll-free on the Neighbor Islands
Fax: (808) 973-0203 on Oahu



CONSENT & RELEASE FORM

I HEREBY AUTHORIZE representatives and agents of AlohaCare, to request and obtain information regarding my professional credentials and qualifications from all educational facilities, hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing agencies, professional liability insurance carriers, other professional monitoring entities, professional associations, managed health care plans, other physicians, present and past employers and federal and state agencies for criminal background checks (hereafter collectively referred to as “persons or entities”). The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I RELEASE AND AGREE to hold harmless AlohaCare and its respective officers, directors, representatives, employees and agents from any and all liability for any damages, costs and expenses which may result from their acts in obtaining and verifying information during the credentialing process.

I HEREBY AUTHORIZE the education facilities, the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing agencies, professional liability insurance carriers, other professional monitoring entities, professional associations, managed health care plans, other physicians, present and past employers and federal and state agencies for criminal background checks, to release information requested by AlohaCare, including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure.

If applicable, I HEREBY AUTHORIZE the Physician Recovery Network or applicable recovery program to release to AlohaCare information regarding my health status and participation status in any treatment program(s).

I HEREBY FURTHER RELEASE AND AGREE to hold harmless all such persons or entities referenced above, their representatives, employees, and agents from any and all liability for any damages which may result from providing this information.

I AGREE that the photocopy, facsimile, and/or electronic image of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original, and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I UNDERSTAND that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is a cause for automatic and immediate rejection of this application by AlohaCare and may result in denial of my application or termination of my participation in the AlohaCare Network. I further understand that any representation, misstatement or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of those privileges.

I UNDERSTAND AND AGREE that I, as an applicant, have the burden of producing adequate information to demonstrate to the satisfaction of AlohaCare my professional qualifications, clinical competence, moral character and ethical qualifications and for resolving doubts thereto.

I AGREE to use my best efforts to inform AlohaCare in writing within 15 calendar days if there is any change in the information provided or the answers to questions on the application as a result of developments subsequent to my signing this application.

I WARRANT that I have the authority to sign this application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity.

I AGREE that submission of the application does not constitute approval or acceptance as a participating provider.

If I am accepted for participation, I CONSENT to the inspection of my patient records for AlohaCare members as necessary for peer review and utilization review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual.

I UNDERSTAND that I have the right to review and correct erroneous information obtained by AlohaCare to evaluate my credentialing application. This includes information obtained from primary source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank). The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require AlohaCare to allow a provider to review references or recommendations or other information that is peer-review protected.

I UNDERSTAND that if my application is rejected for reasons relating to my professional conduct or competence, AlohaCare may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

I REPRESENT that the information provided in or attached to this application is true, accurate and complete to the best of my information, knowledge, and belief.

AlohaCare does not discriminate on the basis of race, color, creed, national origin, ancestry, sex, including gender identity or expression, sexual orientation, religion, age, health status, income status, or physical or mental disability.

Your signature is required to complete this application. Stamped signatures are not acceptable.

Practitioner Name (Print)

Practitioner Signature

Date

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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 AlohaCare 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	<p>Enter current NPI/Medicaid Provider number combination that this DI is in reference to, if applicable.</p> <p>NPI: _____ Provider number: _____</p> <p>Provider number <i>(Enter only if you are not required to have a NPI/Taxonomy Code for billing purposes)</i>: _____</p> <p><input type="checkbox"/> Check here for Not Applicable (N/A)</p>
3	<p>If there has been a change in ownership, change of tax ID number (FEIN), or change in Medicaid Provider Number for previously enrolled Hawaii Medicaid provider, enter the previous provider number(s) and their effective date(s): <input type="checkbox"/> Check here for N/A</p> <p>Previous Medicaid Provider #: _____ Start Date: _____ End Date: _____</p>
4	<p>If you completed item #3, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) coporate 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.)</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p>
5	<p>If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. <input type="checkbox"/> Check here for N/A</p> <p>Date: _____ Change: _____</p>
6	<p>If you anticipate filing for bankruptcy within the year, enter: <input type="checkbox"/> Check here for N/A</p> <p>Anticipated date of filing: _____</p>
7	<p>If this facility is a subsidiary of a parent corporation, complete below.</p> <p>Corporate FEIN#: _____</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>

8	<p>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 application provider. (Attach extra pages if necessary.) Complete item #9 with the officer's and board members' information for the owning entities.</p> <p><input type="checkbox"/> <i>No owner has more than 5% of ownership</i></p> <p>Name/Business Name: _____</p> <p>SSN: _____ FEIN: _____ DOB: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p><i>If a corporate entity is disclosed in items #8 above, all business location (s) of this corporate entity must be disclosed. Please attach a sheet to disclose this information.</i></p>
9	<p>List officer's and board members' information of owning entities. (Attach extra sheet if necessary, listing same details below.) <input type="checkbox"/> <i>Check here for N/A</i></p> <p>Name (a): _____</p> <p>Title: _____ SSN: _____ DOB: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <hr/> <p>Name (b): _____</p> <p>Title: _____ SSN: _____ DOB: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
10	<p>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.) <input type="checkbox"/> <i>Check here for N/A</i></p> <p>Name (a): _____</p> <p>Relationship: _____ SSN: _____ FEIN: _____</p> <hr/> <p>Name (b): _____</p> <p>Relationship: _____ SSN: _____ FEIN: _____</p>
11	<p>If this facility or organization employs a management company, please provide the following information: <input type="checkbox"/> <i>Check here for N/A</i></p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
12	<p>List the names of any other disclosing entity in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities. <input type="checkbox"/> <i>Check here for N/A</i></p> <p>Name: _____ Provider #, if applicable: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>

13	<p>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.)</p> <p><input type="checkbox"/> Check here for N/A</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
14	<p>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.)</p> <p><input type="checkbox"/> Check here for N/A</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
15	<p>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.</p> <p><input type="checkbox"/> Check here for N/A</p> <p>Name (a): _____</p> <p>Title: _____ SSN: _____ DOB: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <hr/> <p>Name (b): _____</p> <p>Title: _____ SSN: _____ DOB: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
16	<p>List the names 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.)</p> <p><input type="checkbox"/> Check here for N/A</p> <p>Name (a): _____</p> <p>Hawaii Medicaid Provider Number(s), if applicable: _____</p> <hr/> <p>Name (b): _____</p> <p>Hawaii Medicaid Provider Number(s), if applicable: _____</p>

17	<p>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 pages if necessary) If individual or organization is associated with a Hawaii Medicaid provider number(s), indicate below. (Attach extra page if necessary.)</p> <p><input type="checkbox"/> Check here for N/A</p> <p>Name (a): _____</p> <p>Hawaii Medicaid Provider Number(s), if applicable: _____</p> <p>Name (b): _____</p> <p>Hawaii Medicaid Provider Number(s), if applicable: _____</p>
18	<p>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.)</p> <p><input type="checkbox"/> Check here for N/A</p> <p>Name (a): _____</p> <p>Title: _____ SSN: _____ DOB: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Name (b): _____</p> <p>Title: _____ SSN: _____ DOB: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
19	<p>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)</p> <p><input type="checkbox"/> Check here for N/A</p> <p>Name (a): _____ SSN: _____ FEIN: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Name (b): _____ SSN: _____ FEIN: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
20	<p>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.</p> <p>Initials _____</p>

21	Contact Information – This information is used only for questions regarding the information on this form. Name: _____ Telephone: _____ E-mail address: _____
22	I certify that all the Information I have provided on this AlohaCare 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: _____
FOR ALOHACARE USE ONLY:	
23	Signature: _____ Date signed: _____ Printed name: _____ Title: _____
_____ <div style="display: flex; justify-content: space-between;"> EPLS/SAM: OIG/HHS: SSA Death Master File: </div>	

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/we 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 AlohaCare in writing of the information required to be provided.

Signature of Provider/Authorized Business Agent	Date signed
Printed Name of Provider/Authorized Business Agent	