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| --- | --- | --- |
| **LEGAL CONTRACTOR NAME** |  | **DBA, IF APPLICABLE** |
| **LINE OF BUSINESS** |  | **CONTRACT YEAR ENDING** |

The Contractor shall complete all information requested below and, in the attachments incorporated by reference. Do not leave any portion blank. If the Contractor believes that particular information is not applicable, the Contractor shall indicate “Not Applicable” in the inapplicable section and in a footnote include the legal and factual basis for its determination. Failure to provide all complete and accurate disclosures and an attestation signed by an individual with appropriate authority may result in the withholding of payments under the Contract and/or the recovery, recoupment, and/or offset of any monies remitted without limitation.

# CERTIFICATION OF ACCURACY OF INFORMATION PROVIDED, NON- COERCION, AND COMPLIANCE - ANTI-KICKBACK / LABORATORY TESTING

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| --- | --- | --- |
| I, |  | , certify that I have authority as specified in 42 CFR 438.606 to sign this |

Certification on behalf of the Contractor.

By signing this certification, the Contractor certifies, under penalty of law, that the information, documentation, and data provided, and all submissions made pursuant to this Attachment/Certification are true, correct, and complete to the best of Contractor's knowledge, information, and belief. The Contractor also acknowledges that should investigation at any time disclose any misrepresentation, omission, or falsification, any current or subsequent contract may be terminated by AHCCCS without penalty to or further obligation by AHCCCS. By signing this certification, the Contractor certifies, under penalty of law, that it has not made to any Provider any requests or inducements not to contract with another potential Contractor. By signing this certification, the Contractor certifies that it has not engaged and will not engage in any violation of the Medicare Anti-Kickback or the “Stark I” and/or “Stark II” laws governing any related-entity and any compensation therefrom. If the Contractor provides laboratory testing, it certifies that it has complied with and has sent to AHCCCS simultaneously with this certification, copies of the information required to be sent to the Centers for Medicare and Medicaid Services (CMS) [Refer to 42 USC § 1320a-7b, PL 101-239, PL 101-432, and 42 CFR 411.361].

By signing this certification the Contractor certifies that it has consulted with counsel prior to the submission of the disclosures, is fully aware of the contents of these disclosures and of their legal effect and has had the opportunity to consult with counsel of its choosing regarding the disclosure requirements set forth in the Contractor’s contract with AHCCCS, AHCCCS policies, and State and Federal law, rules, regulations, and/or policies.

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| **Signature of Authorized Representative** |  | **Job Title** |
| **Printed Name of Authorized Representative** |  | **Date** |

# CONTRACTOR GENERAL INFORMATION

1. If other than a government agency, when was the Contractor organization formed?
2. **License/Certification**: Attach a list of all licenses and certifications (e.g., Federal HMO status or State certifications) maintained by the Contractor organization over the last 10 years. On a separate sheet of paper list all license requirements and the renewal date(s) for each license and/or certification listed regardless of whether the license or certification is **currently** maintained.).

Has any license or certification been denied, revoked, or suspended within the past 10 years?

# Yes No

If yes, for each denial, revocation, or suspension provide the date of each action and explain the basis for each action:

1. **Accessibility Assurance**: Does the Contractor organization provide assurance that no qualified person with a disability will be denied benefits of or excluded from participation in a program or activity because the Contractor's facilities (including the facilities of the Subcontractors) are inaccessible to or unusable by persons with disabilities? (Check Federal and State law, regulations, rules, and local zoning ordinances for accessibility requirements)

# Yes No

If yes, describe how such assurance is provided or how the Contractor organization is taking affirmative steps to provide assurance.

1. Provide the name(s) and address(s) of any in-house or independent actuary, or actuarial firm, used by the Contractor or any Subcontractors to assist in developing capitation rates and/or reviewing published capitation rate information.
2. Did any other firm or organization provide the Contractor with any assistance in making this certification (includes any firm or organization that provided any assistance with developing capitation rates or providing any other technical assistance and/or reviewing published capitation rates)?

**Yes No**

If yes, list all name(s) and address(es) of all firm(s) or organization(s) that provided the assistance:

1. Has the Contractor contracted or arranged for Health Information Systems as described in 42 CFR 438.242, software, or hardware, for the term of the Contract? **Yes No**

If yes, is the Health Information System being obtained from a vendor? **Yes No**

If yes, please provide the vendor's legal name and any d/b/a under which the vendor has conducted business, the vendor's background with AHCCCS, the vendor's background with other HMOs or managed care entities, and the vendor's background with any other Medicaid programs.

1. Has the Contractor complied with 42 CFR 438.242 and made all collected data available to AHCCCS upon its request? **Yes**
2. Has the Contractor organization ever filed for, or received a discharge through, bankruptcy or bankruptcy related reorganization proceeding? **Yes No**

If yes, for each bankruptcy related proceeding provide the jurisdiction, case name, case caption, year of filing and disposition, if available: