Agenda Item #: 3E-4

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

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Meeting Date: June 21, 2016 [X] **Consent** [ ] **Regular**
[ ] **Ordinance** [ ] **Public Hearing**

Department
Submitted By: **Community Services**
Submitted For: **Division of Senior Services**

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I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to:

A) approve UnitedHealthcare Community Plan (UnitedHealthcare) Provider Credentialing Application, to verify Division of Senior Services (DOSS) credentials for long-term care managed programs, as required by Florida Agency for Health Care Administration (ACHA); and

B) delegate to the County Administrator, or her designee signatory authority on re-credentialing applications, and any other necessary documents related to ACHA requirements.

Summary: DOSS is a service provider and currently has a Standard Agreement (R2013-0864) with UnitedHealthcare, a Florida Statewide Medicaid Long Term Care Managed Care Plan (LTCMCP). DOSS provides services such as Case Management and Adult Day Care to their members. LTCMCP credential verification requires ongoing monitoring and maintenance of providers' records to ensure that information is accurate and up to date as required by AHCA and in accordance with applicable state law. DOSS will continue to provide long-term managed care, in-home care, and community based services as a service provider. (DOSS) Countywide (HH)

Background and Justification: As a Service Provider, DOSS affords eligible seniors with help to avoid long term placement in a nursing facility. Long-term Care Managed Care plans are required to have a sufficient network to provide covered services

Attachments: Provider Credentialing Application

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Recommended By: _____ 6/10/16
Department Director **Date**

Approved By: _____ 6/10/16
Assistant County Administrator **Date**

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2016	2017	2018	2019	2020
Capital Expenditures					
Operating Costs					
External Revenue					
Program Income					
In-Kind Match (County)					
NET FISCAL IMPACT	0	0	0	0	0

# ADDITIONAL FTE POSITIONS (Cumulative)					

Is Item Included In Current Budget? Yes _____ No _____
Budget Account No.:
Fund __Dept _ Unit _Object _.Program Code __ Program Period _____

B. Recommended Sources of Funds/Summary of Fiscal Impact: No Impact

C. Departmental Fiscal Review: _____
Taruna Malhotra, Assistant Department Director

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Development and Control Comments:

OFMB ET 6/03 AK 6/3/16

Contract Development and Control 6/15/16 6/15/16 TM

B. Legal Sufficiency:

Assistant County Attorney

C. Other Department Review:

Department Director

This summary is not to be used as a basis for payment.

UnitedHealthcare
Community Plan

PROVIDER CREDENTIALING APPLICATION
LONG TERM CARE - FLORIDA

PROVIDER BUSINESS

Provider Name: Palm Beach County Board of County Commissioners/ Adult Daycare Center

Corporate Name (if different):

Federal Tax ID Number: 59-6000785

Are there multiple locations? ☒ **Yes** ☐ **No**
Is this Tax ID used for all locations? ☒ **Yes** ☐ **No**

Medicaid # 6700732700

NPI # 1184962847

Are you a participating provider in the Florida Medicaid Program? ☐ **Yes** ☒ **No**

If Minority Business, Check which response applies:
- ☐ **African American**
- ☐ **Hispanic American**
- ☐ **Asian American**
- ☐ **Native American**
- ☐ **American Woman**

PROVIDER DEMOGRAPHICS

Address (Physical Location)

5217 Northlake Boulevard

City Palm Beach Gardens **State** FL **Zip Code:** 33418

Phone: (561) 694 - 5435 **Fax:** (561) 694 - 9611

Billing Address (if different from physical location address above):

810 Datura Street, Suite 300

City: West Palm Beach **State:** FL **Zip Code:** 33401

Contact person: Faith Manfra

Contact person's email: fmanfra@pbcgov.org

Phone: (561) 355 - 4750 **Fax:** (561) 355 - 3222

UnitedHealthcare
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PROVIDER CREDENTIALING APPLICATION
LONG TERM CARE - FLORIDA

Additional Locations (if Applicable)

MULTIPLE LOCATION PROVIDER DEMOGRAPHIC

Provider Name: Palm Beach County Board of County Commissioners/ Adult Daycare Center
Address: 3680 Lake Worth Road, Lake Worth, FL 33461
Phone Number: (561) 357-7100
Tax ID Number (if different): 59-6000785
NPI Number (if different): 1184962847
Medicaid ID Number (if different): 6700732700

Provider Name: _____
Address: _____
Phone Number: _____
Tax ID Number if different: _____
NPI Number (if different): _____
Medicaid ID Number (if different): _____

Provider Name: _____
Address: _____
Phone Number: _____
Tax ID Number (if different): _____
NPI Number (if different): _____
Medicaid ID Number (if different): _____

Provider Name: _____
Address: _____
Phone Number: _____
Tax ID Number (if different): _____
NPI Number (if different): _____
Medicaid ID Number (if different): _____

UnitedHealthcare Community Plan

PROVIDER CREDENTIALING APPLICATION
LONG TERM CARE - FLORIDA

INDICATE COUNTIES SERVED BY CHECKING THE APPROPRIATE BOXES BELOW

☐ Alachua	☐ Collier	☐ Glades	☐ Jackson	☐ Marion	☐ Pasco	☐ Suwannee
☐ Baker	☐ Columbia	☐ Gulf	☐ Jefferson	☐ Martin	☐ Pinellas	☐ Taylor
☐ Bay	☐ DeSoto	☐ Hamilton	☐ Lafayette	☐ Miami-Dade	☐ Polk	☐ Union
☐ Bradford	☐ Dixie	☐ Hardee	☐ Lake	☐ Monroe	☐ Putnam	☐ Volusia
☐ Brevard	☐ Duval	☐ Hendry	☐ Lee	☐ Nassau	☐ Santa Rosa	☐ Wakulla
☐ Broward	☐ Escambia	☐ Hernando	☐ Leon	☐ Okaloosa	☐ Sarasota	☐ Walton
☐ Calhoun	☐ Flagler	☐ Highlands	☐ Levy	☐ Okeechobee	☐ Seminole	☐ Washington
☐ Charlotte	☐ Franklin	☐ Hillsborough	☐ Liberty	☐ Orange	☐ St Johns	
☐ Citrus	☐ Gadsden	☐ Holmes	☐ Madison	☐ Osceola	☐ St. Lucie	
☐ Clay	☐ Gilchrist	☐ Indian River	☐ Manatee	☒ Palm Beach	☐ Sumter	

INDICATE SERVICES YOU CAN PROVIDE BY CHECKING THE APPROPRIATE BOXES BELOW

☐ Adult Companion Services	☐ Caregiver Training	☐ Homemaker Services (may include Chore and Pest Control)
☐ Attendant Care (RN)	☐ Attendant Care (LPN)	☐ Intermittent and Skilled Nursing (RN)
☐ Intermittent and Skilled Nursing (LPN)	☐ Personal Care	☐ Respite Care Services (Non-Facility)
☐ Occupational Therapy	☐ Physical Therapy	☐ Speech Therapy
☐ Respiratory Therapy	☐ Medication Administration	☐ Comprehensive Medication Services (Medication Management)
☐ Consumable Medical Supplies	☐ Home Delivered Meals	☒ Nutrition/Risk Reduction (Requires Dietician or Nutritionist License)
☐ PERS	☐ Environmental Accessibility Adaptation	☐ Pest Control
☐ Assisted Living Services	☐ Nursing Facility Services	☐ Respite Care Services (Facility Based)
☒ Adult Day Health Services	☐ Assistive Care (AFCH only)	

INDICATE HOURS AND DAYS OF OPERATION

Days of Week Facility / Provider is Operational - Please check all that apply

☒ **Monday** ☒ **Tuesday** ☒ **Wednesday** ☒ **Thursday** ☒ **Friday** ☐ **Saturday** ☐ **Sunday**

Indicate Business Office Hours / Days Available:

8;00am – 5;00pm

Indicate After Hours Contact Information:

UnitedHealthcare
Community Plan

PROVIDER CREDENTIALING APPLICATION
LONG TERM CARE - FLORIDA

REQUIRED QUESTIONS (Please answer all questions and provide explanation for affirmative responses)
Failure to check an answer or provide explanations will result in delay of application processing

1. Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed?
☐ YES ☒ NO

2. Has the business been denied participation, suspended from or denied renewal from Medicare or Medicaid?
☐ YES ☒ NO

3. Has business ever had its professional liability coverage cancelled but not renewed?
☐ YES ☒ NO

4. Has the business been denied accreditation by its selected accrediting body (e.g. JCAHO), or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body?
☐ YES ☒ NO

5. If you are an Assisted Living Facility, has your Florida licensing agent approved you to provide Adult Day Care Services? If yes, please include a copy of the letter provided showing that you are approved. Without the letter, we will not be able to include this service in your contract.
☐ YES ☐ NO

UnitedHealthcare Community Plan

PROVIDER CREDENTIALING APPLICATION
LONG TERM CARE - FLORIDA

PROVIDER ATTESTATION OF CREDENTIALING DOCUMENTATION / APPLICATION

Component Attestation/Consent & Release Form

ANY ALTERATION OR FAILURE TO SIGN AND DATE THIS FORM WILL RESULT IN THE DELAY OF PROCESSING THIS APPLICATION

By signing below, I attest that I am the duly authorized representative of the Component, that all information on the Application pertains to the above-named Component, and that such information is current, complete and correct.

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

I, Mary Lou Berger **(name of person completing this form) attest that all credentialing requirements have been met.**

Signature _____

Title Mayor

Date: _____

UNITEDHEALTHCARE LTC MEDICAID CONTRACT/SPECIALIST CONTACT INFORMATION

Community Plan Network Operations
Email Address fl_ltc_network@uhc.com
Address: 495 N. Keller Rd. #200, Maitland, Fl, 32751
Phone: 407-659-7241

Attest:
Sharon R. Bock
Clerk and Comptroller

By:_____
Deputy Clerk

Approved As To Form
And Legal Sufficiency

By:_____
Assistant County Attorney

APPROVED AS TO TERMS AND CONDITIONS

BY:_____
DEPARTMENT HEAD

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
Board of County Commissioners Palm Beach County

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☑ Other (see instructions) ▶ **Government/Political Subdivision**

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)
PO Box 4036

Requester's name and address (optional)

6 City, state, and ZIP code
West Palm Beach, Fl 33402

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
___ - ___ - ____

or

Employer identification number
5 9 - 6 0 0 0 7 8 5

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | Signature of U.S. person ▶ Shawn Rawson - Chairman | Date ▶ 4/14/15

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

UnitedHealthcare®
Community Plan

Provider Entity Disclosure of Ownership, Controlling Interest and Management Statement

UnitedHealthcare Community Plan ("UnitedHealthcare") is required to collect disclosure of ownership, controlling interest and management information from providers that participate in the Medicaid and/or the Children's Health Insurance Program (CHIP) managed care network pursuant to a Medicaid and/or CHIP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455. Required information includes: 1) the identity of all owners and others with a controlling interest of 5% or greater; 2) certain business transactions as described in 42 CFR §455.105; 3) the identity of managing employees, agents and others in a position of influence or authority; and 4) criminal conviction information for the provider, owners, agents and managing employees. The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Completion and submission of this Statement is a condition of participation in the Medicaid and/or CHIP managed care network and is a contractual obligation with UnitedHealthcare for services to members under Medicaid and CHIP benefit plans. Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider contract, or termination of existing provider contracts.

This Statement should be submitted with the initial contract and updated every three (3) years or at the renewal of the contract and at any time there is a revision to the information or upon a request for updated information. A Statement must be provided within 35 days of a request for this information. Physician and health care professional members of a group practice that are credentialed or enrolled into the Medicaid or CHIP managed care program by UnitedHealthcare or by a delegate of UnitedHealthcare must submit a signed Individual Provider Statement attesting to the requirements under these regulations at the time of credentialing, enrollment, or contracting, if requested by UnitedHealthcare or by a delegate of UnitedHealthcare. ***Any members of a group practice that have an ownership or controlling interest in the Provider Entity identified below, or is related to another owner of the Provider Entity, must submit a signed Individual Provider Statement.***

Detailed instructions and a glossary for capitalized terms can be found at the end of this form. If attachments are included, please indicate to which section those attachments refer.

Contracted Provider Entity Information

Please fill out the entire section. Every field must be complete. If fields are left blank, the form will not be processed and will be returned for corrections/completeness. If the form is unreadable due to illegible handwriting, the form will not be processed.

As applicable, if Provider Entity is a medical group or facility, attach a roster of individual providers covered under this Statement. Please include provider name, address, date of birth, and social security number.
Do you have a roster to attach? ____Yes ____No

Type of disclosing entity. Please choose appropriate category:	**Name of Person Completing the Form**
___**Partnership** ___**Non-Profit** ___**Corporation** ___**Limited Liability Corporation (LLC)** _X_**Government/Public Entity** ___**HCBS Provider** ___**Other:**_____	Faith Manfra Title Director Phone Number (561) 355-4750 Fax (561) 355-3222 Email fmanfra@pbcgov.org
In which state do you participate in Medicaid? FL	

Legal Name ("**Provider Entity**"): Palm Beach County Board of County Commissioners
DBA Name (if different from Provider Entity Legal Name):

Complete Address (must include at least one street address; corporations must include the primary business address *and* every business location and P.O. Box address):
STREET 810 Datura Street, Ste 300 CITY West Palm Beach STATE FL ZIP 33407

Additional Addresses (list **all** Practice locations – attach a separate sheet if necessary): Do you have a list to attach? ___Yes _X_No
North County ADC 5217 Northlake Blvd, PBG, FL 33418 and MCADC 3680 Lake Worth Rd, LW, FL 33461

**Federal Tax ID/SSN #:	*Medicaid ID #:	*National Provider ID (NPI) #:	*CAQH #:
59-6000785	6700732700 ___Applied for Medicaid ID ___Not Applicable	1184962847 ___Applied for NPI ___Not Applicable	___Applied for CAQH ___Not Applicable

These fields cannot be left blank; "N/A" non-applicable and "applied for" are acceptable responses.
****Individual providers please use social security number; field cannot be left blank: "N/A" non-applicable and "applied for" are acceptable responses***

Section I: Provider Entity Ownership Information

Are there any individuals or organizations with a Direct or Indirect Ownership or Controlling Interest of 5% or more in the Provider Entity? ___**Yes**__X__**No** **Do you have a list to attach?** ___**Yes**____**No**

If 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) ***Attach additional sheet as necessary***

Name of Owner	**DOB (mm/dd/yyyy)**	**Complete Address (Street/City/State/Zip)**	** **SSN (individual) and/or TIN (entity)** *List both as applicable*	**% Interest**
Palm Beach County Board of County Commissioners		810 Datura Street, Ste 300, WPB, FL 33401		
		Street **City** **State** **Zip**		
		Street **City** **State** **Zip**		
		Street **City** **State** **Zip**		

*** SSN and TIN required under §455.104; see Sect 4313 of Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No. 22*

Section II: Ownership in Other Providers & Entities

Does the Provider Entity's Owner *identified in **Section I*** have an Ownership or Controlling Interest in *any other provider or entity*?
___**Yes** _X_**No**

Do you have a list to attach? ___**Yes**_X__**No**

If yes, list the name and the SSN or TIN of **the other provider or entity** in which the Owner identified in **Section I** also has an

Name of Owner from Section I	**Name of *Other Provider or Entity***	**Other Provider or Entity's SSN (individual) or TIN (entity)**

Section III: Subcontractor Ownership

Does the Provider Entity have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor? ___**Yes** ___**No**

If yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor? ___**Yes** ___**No**

If yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which the Provider Entity *also has* Direct or Indirect Ownership Interest of 5% or more. (42 CFR §455.104) ***Attach additional sheets as necessary***

Do you have a list to attach? ___**Yes**____**No**

Legal Name of Subcontractor	NOT APPLICABLE		
Name of Subcontractor's *Other Owner*			
***Other Owner's* Complete Address Street/City/State/Zip)**	**Street** **City** **State** **Zip**		
***Other Owner* TIN**	***Other Owner* SSN**	***Other Owner* DOB (mm/dd/yyyy)**	**% Interest in Subcontractor**
Legal Name of Subcontractor			
Name of Subcontractor's *Other Owner*			
***Other Owner's* Complete Address**	**Street** **City** **State** **Zip**		
***Other Owner* TIN**	***Other Owner* SSN**	***Other Owner* DOB (mm/dd/yyyy)**	**% Interest in Subcontractor**

Section IV: Familial Relationships of All Owners

Are any of the individuals identified in Sections I, II or III related to each other? ____**Yes** __X__**No**

If yes, list the individuals identified and the relationship to each other (e.g., spouse, sibling, parent, child) (42 CFR §455.104(b)(2)) ***Attach additional sheets as necessary*** **Do you have a list to attach?** ___**Yes**__X__**No**

Name of Owner 1:	Name of Owner 2:	Relationship
NOT APPLICABLE		

Medical Groups Only: Are any provider members of the group related to the listed owners or those with a controlling interest?
___**Yes** __X__**No**

Do you have a list to attach? ___**Yes**__X__**No**

If yes, list the following information for each group provider member related to the listed owners and those with a controlling interest. *Attach additional sheets as necessary.* **Note: each provider member listed must submit a signed Individual Provider Statement.**

Name of group provider	Relationship	DOB (mm/dd/yyyy)	SSN
NOT APPLICABLE			

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations*

1. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **convicted of a crime** related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title XX program since the inception of those programs? ___Yes ___No

If yes, list those persons and the required information below. (42 CFR §455.106)

Attach documentation and additional sheets as necessary **Do you have documents to attach? ___Yes____No**

Name NOT APPLICABLE		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	**State of Conviction**
Complete Address (Street/City/State/Zip) **Street** **City** **State** **Zip**		
Matter of the Offense		
Date of Conviction(mm/dd/yyyy)	**Date of Reinstatement(mm/dd/yyyy)**	

2. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **sanctioned, excluded or debarred** from Medicaid, Medicare, CHIP or a Title XX program?___Yes ___No

If yes, list those persons and the required information below. (42 CFR §455.436)

Attach documentation and additional sheets as necessary **Do you have documents to attach? ___Yes____No**

Name		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	
Complete Address (Street/City/State/Zip) **Street** **City** **State** **Zip**		
Reason for Sanction, Exclusion or Debarment		
Date(s) of Sanctions, Exclusions or Debarments (mm/dd/yyyy)	**Date of Reinstatement (mm/dd/yyyy)**	**List all States where currently excluded:**

3. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? ___Yes ___No

If yes, list those persons and the required information below.

Attach documentation and additional sheets as necessary **Do you have documents to attach? ___Yes____No**

Name			
DOB (mm/dd/yyyy)	**SSN(individual) or TIN (entity)**		
Complete Address (Street/City/State/Zip) **Street** **City** **State** **Zip**			
Reason for Termination			
Date of Termination (mm/dd/yyyy)	**State that originated Termination**	**Date of Reinstatement (mm/dd/yyyy)**	**Terminated from Medicare?** **Yes_____ No_____**

At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (See Fed. Register, Vol. 44, No. 138)

Section VI: Business Transaction Information

Business Transactions - Subcontractors: Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? ____**Yes** ____**No** **Do you have a list to attach?** ___**Yes**____**No**

If yes, list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) *Attach additional sheets as necessary*

Name of **Subcontractor**: NOT APPLICABLE		Subcontractor's SSN (individual) or TIN (entity):	
Subcontractor's Street Address	City:	State:	ZIP
Name of Subcontractor's Owner:	Subcontractor's Owner's SSN/TIN:		
Subcontractor's Owner's Street Address	City:	State:	ZIP

Significant Business Transactions – Wholly Owned Suppliers: Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses during any one fiscal year in the past five (5) year period? ____**Yes** ____**No** **Do you have a list to attach?** ___**Yes**____**No**

If yes, list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period
(42 CFR §455.105(b)(2))
Attach additional sheets as necessary. See Glossary for definition.

Name of **Supplier**:		Supplier's SSN (individual) or TIN (entity):	
Supplier's Street Address	City:	State:	ZIP

Significant Business Transactions – Subcontractors: Has the Provider Entity had any Significant Business Transactions with a Subcontractor exceeding the lesser of $25,000 or 5% of operating expenses during any one fiscal year in the past five (5) year period? ____**Yes** ____**No**

Do you have a list to attach? ___**Yes**____**No**

If yes, list the information for Subcontractor with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period (42 CFR §455.105(b)(2))
Attach additional sheets as necessary. See Glossary for definition.

Name of **Subcontractor**:		Subcontractor's SSN (individual) or TIN (entity):	
Subcontractor's Street Address	City:	State:	ZIP
Name of Subcontractor's Owner:	Subcontractor's Owner's SSN/TIN:		
Subcontractor's Owner's Street Address	City:	State:	ZIP

This information must be provided and/or updated within 35 days of a request. *Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received.* (42 CFR §455.105)

Instructions for Disclosure of Ownership/Controlling Interest and Management Statement

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. (For example: Section I Ownership Information, continued). Please see Glossary for definitions of capitalized terms.

Section I: Provider Entity Ownership Information:
Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Controlling Interest in your entity. If the Owner is a corporation: the primary business address must be listed and every business location and P.O. Box address. Provider members of a group practice who have ownership or a controlling interest in Provider Entity must submit a separate Statement.

Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104; please see Section 4313 of the Balanced Budget Act of 1997, amended Section 1124, and the Federal Register Vol. 76 No. 22. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.

Section II: Ownership in Other Providers & Entities:
Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section I that has an Ownership or Controlling Interest in your entity. This information is to identify shared and interconnected ownership and controlling interests.

Section III: Subcontractor Ownership:
If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

Section IV: Familial Relationships of All Owners:
Report whether any of the persons listed in Sections I, II, and III are related to each other and identify the parties and their relationship. Provider members of a group practice who are related to the Provider Entity's owners or those with a controlling interest must submit a separate Statement.

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations:
List your own criminal convictions, exclusions, sanctions, debarments and terminations, ***and*** for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information:

1. Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at https://oig.hhs.gov/exclusions/index.asp

2. Sanction information is available in the GSA's SAM (System for Award Management) database

3. State specific exclusion/sanction databases may be accessed through the State Agency's website

Section VI: Business Transaction Information:
1. List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2. List any ***Significant Business Transaction*** between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any ***Significant Business Transaction*** between your entity and any Subcontractor during the past 5 years.

Remember that a ***Significant Business Transaction*** is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year.

This information must be available within 35 days of a request by the U.S. Department of Health and Human Services (HHS), the State Medicaid Agency, and the Medicaid Managed Care Organization responding to an HHS or State request.

Section VII: Management & Control:
1. List the required information for all employees that hold a position of Managing Employee within your entity.
2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.
3. List the required information for all individuals on the governing board or board of directors if your entity is organized as a corporation. CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

GLOSSARY

Provider Entity: an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing entity.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

Ownership or Control Interest: an individual or corporation that—
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Direct Ownership Interest: the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Indirect Ownership Interest: an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Controlling Interest: defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Determination of ownership or control percentages :(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Other Entity: any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XV III, or XX of the Act. This includes:
(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XV III);
(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Significant Business Transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand ($25,000) or five percent (5 %) of a Provider Entity's total operating expenses.

Subcontractor: (a) an individual, agency, or organization to which a Provider Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity.

Agent: any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

Managing Employee: 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.

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

AFFIDAVIT OF COMPLIANCE WITH Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 if the person has not been unemployed for more than 90 days.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name: Teresa Pedicino
Health Care Provider/ Employer Name: Palm Beach County Board of County Commissioners
Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S

a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 782.04, relating to murder.

(e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(f) Section 782.071, relating to vehicular homicide.

(g) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(h) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(i) Section 784.011, relating to assault, if the victim of the offense was a minor.

(j) Section 784.03, relating to battery, if the victim of the offense was a minor.

(k) Section 787.01, relating to kidnapping.

(l) Section 787.02, relating to false imprisonment.

(m) Section 787.025, relating to luring or enticing a child.

(n) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(o) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(p) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(q) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(r) Section 794.011, relating to sexual battery.

(s) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(t) Section 794.05, relating to unlawful sexual activity with certain minors.

(u) Chapter 796, relating to prostitution.

(v) Section 798.02, relating to lewd and lascivious behavior.

(w) Chapter 800, relating to lewdness and indecent exposure.

(x) Section 806.01, relating to arson.

(y) Section 810.02, relating to burglary.

(z) Section 810.14, relating to voyeurism, if the offense is a felony.

(aa) Section 810.145, relating to video voyeurism, if the offense is a felony.

(bb) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(cc) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(dd) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ee) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(ff) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(gg) Section 826.04, relating to incest.

(hh) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

(ii) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(jj) Former s. 827.05, relating to negligent treatment of children.

(kk) Section 827.071, relating to sexual performance by a child.

(ll) Section 843.01, relating to resisting arrest with violence.

(mm) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(nn) Section 843.12, relating to aiding in an escape.

(oo) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(pp) Chapter 847, relating to obscene literature.

(qq) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(rr) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(ss) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(tt) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(uu) Section 944.40, relating to escape.

(vv) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(ww) Section 944.47, relating to introduction of contraband into a correctional facility.

(xx) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(yy) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(g) Section 817.234, relating to false and fraudulent insurance claims.

(h) Section 817.505, relating to patient brokering.

(i) Section 817.568, relating to criminal use of personal identification information.

(j) Section 817.60, relating to obtaining a credit card through fraudulent means.

(k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(l) Section 831.01, relating to forgery.

(m) Section 831.02, relating to uttering forged instruments.

(n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(p) Section 831.30, relating to fraud in obtaining medicinal drugs.

(q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____

Screened conducted by: Date of Prior Screening: _____

- ☐ Agency for Health Care Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities
- ☐ Department of Children and Family Services
- ☐ Department of Financial Services

Affidavit

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature	Title	Date

UnitedHealthcare
Community Plan

495 N. Keller Rd. Suite 200
Maitland, FL 32751

Re: Attestation of training on Abuse, Neglect and Exploitation

The Agency for Health Care Administration (AHCA) requires that each provider who has direct contact with any Medicaid enrollee certify that they, and all their sub-contractors, have received AHCA-approved training on abuse, neglect and exploitation.

Please complete **this attestation within 30 days of receipt of this letter**. A copy of the attestation will be retained in your provider file. This information will also be on file for inspection by AHCA.

To be in compliance with AHCA requirements, please sign this attestation verifying that you, your employees and/or your subcontractors have attended an ACHA-approved training and return with your completed application. If you have not attended a training and need information on accessing the course or if you have questions, please call 407-659-7241 or visit
http://elderaffairs.state.fl.us/doea/docs/APS_Training_for_Professionals_2013.pdf

Thank you for your prompt response to this matter.

Sincerely,

LTC Provider Networks, FL
UnitedHealthcare Community Plan

Provider Name: Palm Beach County Commissioners / Adult Daycare Cntr. Tax ID # 59-6000785

Contact Person: Faith Manfra Phone: (561) 355-4750

I attest that I, each of my employees and/or sub-contracts have attended training on Abuse, Neglect and Exploitation approved by AHCA

Name: Mary Lou Berger, Mayor Date: _____

Signature: _____

Attest:
Sharon R. Bock
Clerk and Comptroller

By: _____
Deputy Clerk

Approved As To Form
And Legal Sufficiency

By: Helene C. Lloyd
Assistant County Attorney

Doc# UHC2297d_20121108

UnitedHealthcare®
Community Plan

495 N. Keller Rd. Suite 200
Maitland, Fl, 32751

Re: Provider Attestation to Compliance with Employment Eligibility Verification Requirements

We require participating providers in our long-term care plans to a one-time attestation to their compliance with the following Agency for Health Care Administration requirements:

- A provider may not contract with any other provider who has a record of illegal conduct; (i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in Florida statute 435.04, F.S.).
- Use of Employment Eligibility Verification System
  - Verification of direct service workers' information (citizenship or legal alien verification documentation), and social security numbers with the Social Security Administration's Verification Service
  - Verification of employment legibility using the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp for all new hires.

Please sign this attestation verifying your compliance with the employment eligibility verification requirements and return with your completed application.

If you have any questions, please contact Fl_ltc_network@uhc.com, or 407-659-7241.

Thank you.
Sincerely,

LTC Provider Networks, FL
UnitedHealthcare Community Plan

Attest:
Sharon R. Bock
Clerk and Comptroller

By:_____
Deputy Clerk

Approved As To Form
And Legal Sufficiency

By: Helene Castriyal
Assistant County Attorney

Provider Name: Palm Beach County Commissioners/ Adult Daycare Cntr. Tax ID #: 59-6000785

Contact Person: Faith Manfra Phone: (561) 355-4750

I attest that my facility meets the state of Florida requirements for Employment Eligibility Verification.

Signature: _____ Date: _____

Print Name: Mary Lou Berger, Mayor

Doc#: UHC2297f_20121213