|  |  |
| --- | --- |
| **FACILITY NAME:** |  |

1. **Identify the persons and entities with 5% or greater direct or indirect ownership or controlling interest in the Applicant (*If additional space is needed, continue on a separate sheet of paper and clearly label*)*.***

|  |  |
| --- | --- |
| **NAME:** |  |
| **ADDRESS:** |  |
| **TELEPHONE:** |  |
|  | |
|  | |
| **NAME:** |  |
| **ADDRESS:** |  |
| **TELEPHONE:** |  |
|  |  |

|  |  |
| --- | --- |
| **NAME:** |  |
| **ADDRESS:** |  |
| **TELEPHONE:** |  |
|  | |
|  | |
| **NAME:** |  |
| **ADDRESS:** |  |
| **TELEPHONE:** |  |

|  |  |
| --- | --- |
| **NAME:** |  |
| **ADDRESS:** |  |
| **TELEPHONE:** |  |
|  | |
|  | |
| **NAME:** |  |
| **ADDRESS:** |  |
| **TELEPHONE:** |  |
|  |  |

|  |  |
| --- | --- |
| **NAME:** |  |
| **ADDRESS:** |  |
| **TELEPHONE:** |  |
|  | |
|  | |
| **NAME:** |  |
| **ADDRESS:** |  |
| **TELEPHONE:** |  |

1. **List of the names, addresses and health care experience of the individual[s] who are responsible for the overall business direction of the Applicant.** ***If additional space is needed, continue on a separate sheet of paper and clearly label.***

|  |  |
| --- | --- |
| **NAME:** |  |
| **ADDRESS:** |  |
| **EXPERIENCE:** |  |
|  | |
|  | |
| **NAME:** |  |
| **ADDRESS:** |  |
| **EXPERIENCE:** |  |

|  |  |
| --- | --- |
|  | |
| **NAME:** |  |
| **ADDRESS:** |  |
| **EXPERIENCE:** |  |

1. **List of the names, addresses and health care experience of the individual[s] to be appointed by the Applicant to act on its behalf in the overall management and operation of the facility/NTP regardless of form of ownership.** ***If additional space is needed, continue on a separate sheet of paper and clearly label.***

|  |  |
| --- | --- |
| **NAME:** |  |
| **ADDRESS:** |  |
| **EXPERIENCE:** |  |
|  | |
|  | |
| **NAME:** |  |
| **ADDRESS:** |  |
| **EXPERIENCE:** |  |

|  |  |
| --- | --- |
|  | |
| **NAME:** |  |
| **ADDRESS:** |  |
| **EXPERIENCE:** |  |

1. **If you are also applying for a certificate of approval as a NTP, provide the name, address and health care experience of the individual who will serve as the Medical Director. If additional space is needed, continue on a separate sheet of paper and clearly label.**

|  |  |
| --- | --- |
| **NAME:** |  |
| **ADDRESS:** |  |
| **EXPERIENCE:** |  |

|  |  |
| --- | --- |
| **NAME:** |  |
| **ADDRESS:** |  |
| **EXPERIENCE:** |  |

1. **Names, addresses, and type(s) of facilities/NTPs currently or previously owned, managed or operated by Applicant(s): *(attach additional pages “clearly labeled” if needed)***

|  |  |  |  |
| --- | --- | --- | --- |
| **APPLICANT NAME (if more than one applicant):** | | |  |
| **FACILITY NAME:** | |  | |
| **ADDRESS:** |  | | |
| **FACILITY TYPE:** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **APPLICANT NAME:** | | |  |
| **FACILITY NAME:** | |  | |
| **ADDRESS:** |  | | |
| **FACILITY TYPE:** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **APPLICANT NAME:** | | |  |
| **FACILITY NAME:** | |  | |
| **ADDRESS:** |  | | |
| **FACILITY TYPE:** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **APPLICANT NAME:** | | |  |
| **FACILITY NAME:** | |  | |
| **ADDRESS:** |  | | |
| **FACILITY TYPE:** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **APPLICANT NAME:** | | |  |
| **FACILITY NAME:** | |  | |
| **ADDRESS:** |  | | |
| **FACILITY TYPE:** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **APPLICANT NAME:** | | |  |
| **FACILITY NAME:** | |  | |
| **ADDRESS:** |  | | |
| **FACILITY TYPE:** |  | | |

**5a. Description of any adverse action taken by any state or federal agency against any of the facilities/NTPs identified in #5 and any documentation regarding the action taken and its resolution. *(attach additional pages “clearly labeled” if needed)***

**NO**  **YES (explanation below)**

1. **Have any of the facilities/NTPs identified and/or individual(s) identified in this document been subject of CRIMINAL CHARGES?** *(attach additional pages “clearly labeled” if needed)*

**NO (if no, skip to # 7)  YES ( if yes, provide information below)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility *or* individual name:** | |  | | | |
| **Nature of Crime:** |  | |  | **Date(s):** |  |

**Provide documentation regarding the action taken and its resolution in space provided below:**

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility *or* individual name:** | |  | | | |
| **Nature of Crime:** |  | |  | **Date(s):** |  |

**Provide documentation regarding the action taken and its resolution in space provided below:**

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility *or* individual name:** | |  | | | |
| **Nature of Crime:** |  | |  | **Date(s):** |  |

**Provide documentation regarding the action taken and its resolution in space provided below:**

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility *or* individual name:** | |  | | | |
| **Nature of Crime:** |  | |  | **Date(s):** |  |

**Provide documentation regarding the action taken and its resolution in space provided below:**

|  |
| --- |
|  |

1. **Have any of the facilities/NTPs identified and/or individual(s) identified in this document been subject of CIVIL FRAUD CHARGES?** *(attach additional pages “clearly labeled” if needed)*

**NO (if no, skip to # 8)  YES ( if yes, provide information below)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility *or* individual name:** | |  | | | |
| **Nature of charges:** |  | |  | **Date(s):** |  |

**Provide documentation regarding the action taken and its resolution in space provided below:**

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility *or* individual name:** | |  | | | |
| **Nature of charges:** |  | |  | **Date(s):** |  |

**Provide documentation regarding the action taken and its resolution in space provided below:**

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility *or* individual name:** | |  | | | |
| **Nature of charges:** |  | |  | **Date(s):** |  |

**Provide documentation regarding the action taken and its resolution in space provided below:**

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility *or* individual name:** | |  | | | |
| **Nature of charges:** |  | |  | **Date(s):** |  |

**Provide documentation regarding the action taken and its resolution in space provided below:**

|  |
| --- |
|  |

1. **Have any of the facilities/NTPs identified and/or individual(s) identified in this document been subject of MEDICARE AND/OR MEDICAID FRAUD AND/OR ABUSE?** *(attach additional pages “clearly labeled” if needed)*

**NO  YES ( if yes, provide information below)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility *or* individual name:** | |  | | | |
| **Nature of crime:** |  | |  | **Date(s):** |  |

**Provide documentation regarding the action taken and its resolution in space provided below:**

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility *or* individual name:** | |  | | | |
| **Nature of charges:** |  | |  | **Date(s):** |  |

**Provide documentation regarding the action taken and its resolution in space provided below:**

|  |
| --- |
|  |

1. **Been ordered to pay a civil monetary penalty (other than previously listed)?**

**NO**  **YES** (If yes, provide information below)

|  |
| --- |
|  |

1. **Is there any ongoing fraud and abuse investigations involving any facility or individual(s) previously identified in this document?**

**NO  YES** (If yes, provide information below)

|  |
| --- |
|  |

1. **A description of the Applicant’s intentions with respect to the level of charity and uncompensated care to be provided.**

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| **Applicant Signature** |  | **Date** |