APPENDIX A

APPLICANT INFORMATION & ATTESTATION/ACKNOWLEDGEMENT

Applicant Information & Attestation/Acknowledgement

1. Name of Applicant: _____
Street/P.O. Box: _____
City: _____ State:_____ Zip Code:_____

2. Contact Information:
Name of Contact:_____
Street/P.O. Box: _____
City: _____ State:_____ Zip Code:_____
Phone Number: ( )_____
Fax Number: ( ) _____
E-mail address: _____

3. CEO/Executive Director Information:
Name:_____
Title: _____
Street/P.O. Box: _____
City: _____ State:_____ Zip Code:_____
Phone Number: ( )_____
Fax Number: ( ) _____
E-mail address: _____

4. Regions of Interest: Please mark the individual region(s) for which Applicant is applying. Failure to check regions of interest will result in the Applicant NOT being considered for individual regions.

Central/Southeast □ Northeast □ West □

5. Organizational Chart:
Submit an organizational chart that lists all entities within the corporate family as defined in Section IV.A. Definitions/Applicable Regulations and their relationship to one another (i.e. show parent/subsidiary relationship).

6. Applicant Tax Status:

For Profit □ or Not-for-Profit □

7. Disclosure of Controlling Interest:

MCPs must submit a signed letter on the Applicant's letterhead as part of this appendix that provides an affirmative responsive statement and completely addresses the following:

1. In accordance with 42 CFR 455.104, information on ownership and control including at a minimum:
   a. The name and address of each person with an ownership or control interest in the Applicant or in any subcontractor in which the Applicant has direct or indirect ownership of 5 percent or more;
   b. Whether any of the persons named in (a.) above is related to another as spouse, parent, child, or sibling;
   c. The name of any other Medicaid provider (other than an individual practitioner or group of practitioners) or fiscal agent in which a person with an ownership or control interest in the MCP also has an ownership or control interest.
2. In accordance with 42 CFR 455.106, information on persons convicted of crimes including persons that have:
   a. Ownership or control interest in the Applicant, or is an agent or managing employee of the Applicant; and
   b. Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

8. Attestation/Acknowledgment

Applicant must sign the following attestation/acknowledgment. Failure to sign will result in a rejection of the application. By placing a signature below, the Applicant is attesting and agreeing to the following:

- Applicant certifies that all information and statements made to ODJFS in connection with this application are true, complete, and current to the best of the Applicant's knowledge and are made in good faith. All information submitted as part of this RFA, including but not limited to the information

submitted as required by Appendices A through E is true and accurately reflects the status and history of the Applicant;

- Applicant attests that it either is licensed as a health insuring corporation (HIC) in the state of Ohio or it has a HIC license currently under review by the Ohio Department of Insurance;
- Applicant does not discriminate in employment practices with regard to race, color, religion, gender, sexual orientation, age, disability, national origin, genetic information or ancestry, military status, or health status;
- Applicant will comply with the prohibitions for the use of public funds for offshore services as defined in Executive Order 2011-12K, Governing the Expenditure of Public Funds for Offshore Service;
- Applicant agrees to maintain all supporting data and documentation used in completing the application until December 31, 2012. If an Applicant is successful enters into a provider agreement with ODJFS to provide services, it agrees to maintain all books, documents, papers and records that are directly pertinent to this contract for a period of three years after final payments are made by ODJFS and all other pending matters are closed.
- Applicant will accommodate site visits to its administrative office(s) if requested;
- Applicant agrees that it will not delegate or subcontract member grievance and appeal functions, as specified in Ohio Administrative Code (OAC) rule 5101:3-26-08.4(A)(9);
- If awarded a provider agreement, Applicant agrees that marketing representatives utilized for marketing presentations must be employees of the Applicant, in accordance with OAC rule 5101:3-26-08(F)(1);
- If awarded a provider agreement, Applicant agrees to have the capacity to provide covered health services in accordance with the Ohio's Medicaid managed care provider agreement to at least 50,000 enrollees by January 1, 2013;

- If awarded a provider agreement, Applicant will maintain an administrative office within the State of Ohio which serves as the primary offices for the in-state staff identified in the main body of this RFA under “Staffing Requirements”;
- Applicant acknowledges and agrees that the State of Ohio has no liability or responsibility for any costs incurred by Applicant in the preparation and response to this RFA, in undergoing the readiness review process, and any other costs incurred by Applicant before the first day of enrollment. All such costs and expense are the responsibility of Applicant. The only payment that ODJFS agrees to make is the actuarially certified capitation rates as set forth in the Medicaid Provider Agreement beginning the first day of member enrollment;
- Applicant certifies that it is in good standing with Medicare and all state Medicaid programs and is not sanctioned or excluded from providing Medicaid and/or Medicare services;
- Applicant understands that ODJFS, for a period of three (3) years from the implementation date of January 1, 2013, reserves the right, in its sole discretion, to place additional Medicaid population(s) with the successful Applicants of this RFA. If additional populations are added to the managed care program, the successful Applicant may be required to provide additional services that are not medical in nature, such as those services that are currently available to Medicaid waiver consumers. ODJFS may issue future RFAs, or take other actions, to implement alternative care programs with any Medicaid population or to allow the entry of additional care management options, including, but not limited to health homes, accountable care organizations and patient centered medical homes; and
- Applicant acknowledges and agrees that information not submitted with its response to the RFA or in excess of what is required will not be considered by ODJFS.
- Applicant attests that it:

1. Currently and successfully submits the following HIPAA EDI transaction types listed below on at least a monthly-basis:
    - 837 I
    - 837 P
    - 837 D
    - NCPDP file(s)
2. Has the ability to accept and utilize the following files:
    - U277 response transactions
    - 824 response transactions
    - NCPDP response file
3. Has received and process the following 4010A1 ASC X12 EDI transactions:
    - HIPAA 820, Premium Payment Order/Remittance Advice
    - HIPAA 834 C and HIPAA 834 F, Benefit Enrollment and Maintenance
4. Will accept and process updated versions (i.e. 5010) of the transactions listed above in accordance with federal guidelines and Ohio implementation requirements.

_____ _____

Signature Date

_____

Printed Name

_____

Position