**APPENDIX A**

**APPLICANT INFORMATION & ATTESTATION/ACKNOWLEGEMENT**

**NOTE: Any documentation that must be submitted to support information required for Appendix A must be included in the application immediately following the completed and signed Appendix A.**

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. Applicants must indicate for which regions they are applying to participate in the ICDS program under this RFA by checking those regions below. Failure to check regions for which Applicant wishes to apply may result in the Applicant NOT being considered.

Central □ East Central □ Northeast □

Northeast Central □ Northwest □ Southwest □

West Central □

**Applicants shall mark only those regions for which they are willing to enter into a 3-way Agreement with ODJFS and CMS, and/or ODJFS Provider Agreement. If an Applicant is**

**awarded one or more regions based on their selection above, and the Applicant declines one or more of those regions awarded, the Applicant shall be disqualified.**

**5. Organizational Chart:**

Submit an organizational chart that lists all entities within the corporate family as defined in Section III.A. Definitions and their relationship to one another (i.e. show parent/subsidiary relationships).

**6. Applicant Tax Status:**

For Profit □ or Not-for-Profit □

**7. Status of Health Insuring Corporation (HIC) Licensure:**

Submission is limited to a single health insuring corporation (HIC) that currently has an appropriate Ohio Certificate of Authority or an entity that has applied to ODI for it prior to submission of this application. All Applicants must submit a copy of its current Certificate of Authority from ODI or a copy of the ODI application signature page as a part this application.

**8. Disclosure of Controlling Interest**:

Applicant 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:

A. In accordance with 42 CFR 455.104, information on ownership and control including at a minimum:
    1. 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;
    2. Whether any of the persons named in response to the foregoing paragraph above is related to another as spouse, parent, child, or sibling;
    3. 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 Applicant also has an ownership or control interest.
B. In accordance with 42 CFR 455.106, information on persons convicted of crimes including persons that have:
    1. Ownership or control interest in the Applicant, or is an agent or managing employee of the Applicant; and
    2. 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.

**9. Attestation/Acknowledgment**

Applicant must sign the following attestation/acknowledgment. Failure to sign, or making a false statement, will result in a rejection of the application. By placing a signature below, the Applicant attests and agrees to the following:

A. 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 F is true and accurately reflects the status and history of the Applicant;

B. Applicant attests that it maintains a currently approved Medicare Advantage (MA) Plan contract(s) with CMS in at least one state;
C. Applicant attests that it has submitted a Notice of Intent to Apply (NOIA) for the CMS 2013 Capitated Financial Alignment Demonstration Plan according to the specifications in the January 25, 2012 memo, "Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans" and intends to pursue approval as a qualified plan through the joint selection process specified in that memo;
D. Applicant attests that it has submitted and will complete the Capitated Financial Alignment Demonstration Application according to the specifications set forth in the March 29, 2012 CMS memo, "Additional Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans";
E. Applicant attests that it is the single entity applying for this RFA and 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;
F. Applicant attests that it is willing and able to implement the strategies described in response to this RFA if the Applicant is selected to enter into a 3-way agreement (with CMS and ODJFS) and/or ODFJS Provider Agreement under this RFA;
G. Applicant attests that if it does not currently provide Ohio Medicaid managed health care services then the Applicant or its corporate family currently serves at least 100,000 lives across all lines of business (LOB) and all states;
H. 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;
I. 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;
J. Applicant agrees to maintain all supporting data and documentation used in completing the application until December 31, 2012. If an Applicant is successful and contracts 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;
K. Applicant will accommodate site visits to its administrative office(s) if requested;
L. 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);
M. If awarded a 3-way agreement and/or ODJFS 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);
N. If awarded 3-way agreement and/or ODJFS Provider Agreement, Applicant will maintain an administrative office within the State of Ohio which serves as the primary office for the in-state staff identified in the main body of this RFA under Section I.E. "Staffing Requirements-In State Positions";

O. 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;
P. 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; and
Q. 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.
R. Applicant attests that it:
    1. Has the ability to submit the following 5010 HIPAA EDI transaction types listed below on at least a monthly-basis:
        a. 837 I
        b. 837 P
        c. 837 D
        d. NCPDP file(s)
    2. Has the ability to accept and utilize the following files:
        a. U277 response transactions
        b. 824 response transactions
        c. NCPDP response file
    3. Has the ability to process the following 5010A1 ASC X12 EDI transactions:
        a. HIPAA 820, Premium Payment Order/Remittance Advice
        b. HIPAA 834 C and HIPAA 834 F, Benefit Enrollment and Maintenance
    4. Will accept and process updated versions of the transactions listed above in accordance with federal guidelines and Ohio implementation requirements.

**10.** For each corporate family or partnership, only one Application shall be submitted. In the case where more than one Application is submitted from a corporate family (for example from more than one subsidiary of a parent company), or from more than one entity in a partnership, ODJFS shall have the sole discretion to decide which application will be scored. As part of the application, the Applicant may provide information related to other members of its corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in this RFA.

Applicant must submit a signed letter on the Applicant's letterhead as part of this Appendix that specifies any information included as part of this Application that documents experience or information from other entities with which the Applicant is or was in a partnership. The letter shall identify those partners and which parts of the application represent that partnership experience.

**11.** Applicant must provide the name, company, address, phone number, fax number and email address for the individual signing this attestation/acknowledgment:

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

**By signing below, the individual confirms that he or she is authorized to execute and bind the Applicant to the terms of this attestation/acknowledgment.**

_____ _____
Signature Date

_____
Printed Name

_____
Position