

APPENDIX A APPLICANT INFORMATION & ATTESTATION/ACKNOWLEDGEMENT

Instructions:

Applicants must complete the attached form entitled “Applicant Information & Attestation/Acknowledgement” as follows, and attach additional information as instructed:

1. Applicant name and address as it appears on the current Ohio Department of Insurance (ODI) certificate of authority (COA) or the COA application filed with ODI, trade name (if different), and mailing address.
2. **Contact Information:** The name, title, address, telephone number, fax, and email address of a single individual that will receive communications from the Ohio Department of Job and Family Services (ODJFS) regarding the Applicant’s application.
3. **CEO/Executive Director Information:** Applicant CEO or Executive Director name, title, address, telephone number, fax, and e-mail address.
4. **Regions of Interest:** Check the box(es) specifying the region(s) the Applicant is proposing to serve.
5. **Organizational Chart:** Submit a organizational chart that lists all entities within the corporate family as defined in II.A. Definitions/Applicable Regulations and their relationship to one another (i.e. show parent/subsidiary relationship).
6. **Applicant’s Tax Status:** Check the appropriate box indicating Applicant’s taxable status (for profit or not-for-profit).
7. **Attestation/Acknowledgement:** The form must be signed by an individual with the authority to legally bind the Applicant to the terms listed.

ODJFS reserves the right to contact Applicants subsequent to application submission for clarification.

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 check region(s) of interest)

Northeast ABD and/or Northwest ABD

5. Organizational Chart:

Include a copy of the Applicant's Organizational Chart with this form.

6. Applicant Tax Status:

For Profit or Not-for-Profit

7. Attestation/Acknowledgment

By placing a signature below, the Applicant is attesting/agreeing to the following:

- 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;

- 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, sex, sexual orientation, age, disability, national origin, veteran's status, or need for health services;
- Applicant will not use, or propose to use, any offshore programming or call center services in fulfilling ODJFS' program requirements;
- Applicant will accommodate site visits to its administrative offices;
- Applicant agrees that it will not delegate 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 to at least 5,000 enrollees within the first two months after execution of the ODJFS provider agreement;
- If awarded a provider agreement, Applicant will maintain an office within the State of Ohio;
- Applicant acknowledges and agrees that the State of Ohio and ODJFS have no liability or responsibility for any costs incurred by Applicant in the preparation and response to this RFA and in undergoing the readiness review process. All such costs are the responsibility of Applicant;
- 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 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;
- Applicant understands that ODJFS, in accordance with its statutory authority, may at any time take actions that would change Ohio's Medicaid managed care system.

These actions could result in changes to the current structure of the program, the service areas, and the managed care plans with which whom ODJFS enters into provider agreements. Due to these changes, Applicant may be required to participate and be successful under a future, independent procurement process in order to continue providing services to Ohio's Medicaid consumers beyond June 30, 2010; 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.

Signature

Date

Printed Name

Position