Answer all questions. If you do not believe that a question is applicable, you should select a response of "No" or type "Not Applicable". For any "Yes" response, please provide an explanation in the text box provided for each question. For disclosures that require further information that cannot be submitted using this function, please contact Provider Enrollment at (401) 784-8100 for local and long distance calls or (800) 964-6211 for in-state toll calls for further instructions.

* Indicates a required field.

Disclosure Questions

Rhode Island Medicaid Program

Individual Providers

1. Are you a Full or Part-time salaried employee of a hospital or institution?
   - Yes
   - No

Out of State Providers Only

2. Reason for Enrollment:
   - Anticipating or Currently providing services
   - Provided services
   - Business expanding
   - Other (please specify)

3. Services Provided:

4. Number of RI Medical Assistance recipients you treat or anticipate treating annually:

5. Is enrollment based on a contact with a specific recipient?
   - Yes
   - No

All Providers

6. Programs - Please check all other programs that you want to participate in, in addition to Medical Assistance:
   - Behavioral Health, Developmental Disabilities, and Hospitals CNOM
   - Community Medication Assistance Program (CMAP)
   - Dept of Corrections
   - Dept of Health Pharmacy Program
   - Office of Rehab Services
   - RI Pharmaceutical Assistance to the Elderly Program (RIPAE)

7. *Are you currently or have you ever been a provider with Medical Assistance?
   - Yes
   - No

8. *Are you currently enrolled with Medicare? (Please be sure you listed your Medicare number on the Provider Identification panel.)
   - Yes
   - No

9. *Identify any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the five-year period.

10. *Is this application due to a merger, buy out or take over?
    - Yes
    - No

11. *List any outstanding balance owed to the Rhode Island Executive Office of Health and Human Services by a previous provider.
12. * Is there an Owner/Administrator, Agent of the Provider, Managing Employee or Officer for the Corporation?
   ○ Yes  ○ No

13. * Are there any person(s) and their family relationship(s) with an ownership or control interest in the disclosing entity or in any subcontractor totaling 5% or more?
   ○ Yes  ○ No

14. * Are there any persons listed in response to question 12 or 13, who have an ownership or control interest in another disclosing entity?
   ○ Yes  ○ No

15. * Is there an ownership of any subcontractor, as defined in 42 CFR §§ 455.101, with whom the provider has had business transactions totaling more than $25,000 during the previous 12-month period?
   ○ Yes  ○ No

16. * Is there any documented information on any debarment, suspension, exclusion, or conviction of a criminal offense related to the person(s)' listed in question 12, 13, 14 and/or 15 above, from involvement in any Federal program (Medicaid, Medicare, or the Title XX services program) since the inception of those programs?
   ○ Yes  ○ No

17. * Exclusions under 42 CFR and/or sections 1128B and 1932(d)(1) of the Social Security Act: Prohibits you from 1) knowingly having a director, officer, partner, or person with a beneficial ownership of more than 5 percent of the entity's equity who is debarred, suspended, excluded, or has been convicted of a criminal offense related to that person's involvement in any Federal program, or 2) having an employment, consulting, or other agreement with an individual or entity for the provision of items and services that are significant and material to the entity's obligations under its contract with the State where the individual or entity is debarred, suspended, excluded, or convicted of a criminal offense related to that person's involvement in any Federal program. This applies to myself and/or the entity(s):
   ○ Yes  ○ No