



Iowa Department of Human Services

## Individual Consumer Directed Attendant Care (CDAC) Disclosure

All Individual CDAC providers please complete.

1.Provider Name	2.Date of Birth
3.Social Security Number (SSN)	
4.List all states in which you lived more than a period of one month	
5.List all names and aliases that you have used in your life	
<p>6. Pursuant to 42 CFR § 455.106 (2011), certain Medicaid providers must make ownership and controlling interest disclosures. Individual providers are not required to make these disclosures. Are you applying to Medicaid to deliver service as an individual CDAC provider?</p> <p><input type="checkbox"/> Yes, I am an individual provider. Continue below.</p> <p><input type="checkbox"/> No, I am not an individual provider. You are required to make the disclosures mentioned above and must complete form 470-0254.</p> <p>Pursuant to 42 CFR § 455.106, you must disclose whether you, an agent, or managing employee has a “final adverse action” related to your or that person’s involvement in any program under Medicare, Medicaid, or Title XX. “Final adverse actions” include convictions, exclusions, revocation or suspensions. See the complete definition on page 3. Check one:</p> <p><input type="checkbox"/> No, I (or any agent or managing employee) have not received final adverse action related to any program under Medicare, Medicaid or the Title XX services program.</p> <p><input type="checkbox"/> Yes, I (or any agent or managing employee) have received final adverse action related to any program under Medicare, Medicaid, or the Title XX services program. Who is the adverse action against?</p> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Agent or managing employee: _____</p> <p>Attach a separate sheet with a detailed explanation of the final adverse action. Include with your explanation, the nature of the adverse action, date(s), name of person charged with the adverse action, names of others involved and final adverse action.</p>	

7.  
Have you ever been charged with any criminal offenses, including traffic offenses?  
 YES  NO

If **YES**, attach a separate sheet with each offense listed. List the original charge, the result of the charge, including but not limited to a formal conviction, deferred judgment, probation, acquittal, or exoneration; all the relevant location and dates.

8.  
Have you ever been named as responsible party in a founded child abuse case?  
 YES  NO

If **YES**, attach a separate sheet with each accusation of abuse listed. List the original charge, the result of the charge, including but not limited to whether the charge was founded or unfounded, resulted in a formal conviction, deferred judgment, probation, acquittal, or exoneration; all the relevant location and dates.

9.  
Have you ever been named as responsible party in a founded dependent adult abuse case?  
 YES  NO

If **YES**, attach a separate sheet with each accusation of abuse listed. List the original charge, the result of the charge, including but not limited to whether the charge was founded or unfounded, resulted in a formal conviction, deferred judgment, probation, acquittal, or exoneration; all the relevant location and dates.

**STATEMENT:**

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION IN, OR RELATED TO, THIS DOCUMENT MAY BE PUNISHABLE BY CRIMINAL, CIVIL (INCLUDING A FALSE CLAIMS LAWSUIT) AND/OR ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

**CERTIFICATION:**

I HEREBY CERTIFY that I have read the above statement, and that I have examined this document and all accompanying documents, and that to the best of my knowledge and belief, each is true, correct, and complete. I further certify that I am familiar with the laws and regulations governing the medical assistance program (Iowa Medicaid) and that I am duly qualified to participate as a provider in that program. I PROMISE to apprise Iowa Medicaid immediately of any material changes to this application and provide true, correct, and complete answers to any subsequent questions of me by Iowa Medicaid related to or arising out of this application.

10.Provider Signature:	Date:
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## **Final Adverse Actions include the following:**

### **Criminal Offenses include:**

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

### **Exclusions, Revocations, or Suspensions include:**

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.