

## Mike Escaname

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**From:** Eddie Olivarez <eddie.olivarez@hchd.org>  
**Sent:** Tuesday, August 28, 2012 8:00 AM  
**To:** Mike Escaname  
**Subject:** FW: DSHS Contract No. 2013-042399-001, Child Health Services  
**Attachments:** Hidalgo County Health and Human Services Dept 2013-042399-001 core contract.pdf;  
Hidalgo County Health and Human Services Dept 2013-042399-001 prog attachment.pdf;  
Hidalgo County Health and Human Services Dept 2013-042399-001 disclosure form.pdf;  
FFATACertification DSHS June 2012.pdf; 2013 GP Core Subrecipient Rev July 2012.pdf

## IMPROTANT

**Eduardo Olivarez**  
**Chief Administrative Officer**  
**Hidalgo County Health and Human Services**  
**956-383-8858 Office**  
[www.twitter.com/hidalgohealth](http://www.twitter.com/hidalgohealth)

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**From:** Walk,Bill (DSHS) [<mailto:Bill.Walk@dshs.state.tx.us>]  
**Sent:** Friday, August 24, 2012 2:06 PM  
**To:** 'ramon.garcia@hidalgo.tx.us'  
**Cc:** [eddie.olivarez@hchd.org](mailto:eddie.olivarez@hchd.org); 'ray.eufracio@auditor.co.hidalgo.tx.us'; Loe,Deana (DSHS)  
**Subject:** DSHS Contract No. 2013-042399-001, Child Health Services

Hello Contractor,

Attached are files that contain your Department of State Health Services (DSHS) contract. Please print two copies of each file, in the order they appear in this email, sign and return two copies to this unit as soon as possible. Also attached is the Fiscal Federal Funding Accountability and Transparency Act (FFATA) Certification form that needs to be completed each fiscal year. Additional information regarding this federal requirement is available on the DSHS website at <http://www.dshs.state.tx.us/grants/>.

To expedite contract execution, ensure that all forms are completed, signed and returned via overnight mail to the physical address below.

Your contract will be signed by DSHS and returned to your agency.

Changes made to any portion of the contract document (s) are considered a counter-offer and are not valid without DSHS written concurrence.

DSHS will not pay for reimbursements submitted/postmarked more than 60 days after the end of the contract term. Additional information regarding this policy is available on the DSHS website at <http://www.dshs.state.tx.us>.

NOTE: Return both copies of the contract in their entirety to one of the two addresses below. Contracts returned to any other address may result in contract delays.

<b>Physical Address for Overnight Mail</b> Client Services Contracting Unit MC 1886	<b>Mailing Address for Regular Mail</b> Client Services Contracting Unit MC 1886
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Department of State Health Services 1100 W.49 <sup>th</sup> Street Austin, TX 78756	Department of State Health Services PO Box 149347 Austin, TX 78714- 9347
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Please reference the DSHS contract number in all future correspondence.

If you have questions, contact Bill Walk at (512) 776-2186 or via email at [bill.walk@dshs.state.tx.us](mailto:bill.walk@dshs.state.tx.us).

Thank you,

Bill Walk, CTPM, CTCM  
DSHS Client Services Contracting Unit  
Room T-502 – Mail Code 1886  
Tel 512-776-2186 Fax 512-776-7351  
Email [Bill.Walk@dshs.state.tx.us](mailto:Bill.Walk@dshs.state.tx.us)

## DEPARTMENT OF STATE HEALTH SERVICES



This contract, number 2013-042399 (Contract), is entered into by and between the Department of State Health Services (DSHS or the Department), an agency of the State of Texas, and HIDALGO COUNTY HEALTH & HUMAN SERVICES (Contractor), a Government Entity, (collectively, the Parties).

1. **Purpose of the Contract.** DSHS agrees to purchase, and Contractor agrees to provide, services or goods to the eligible populations as described in the Program Attachments.
2. **Total Amount of the Contract and Payment Method(s).** The total amount of this Contract is \$34,833.00, and the payment method(s) shall be as specified in the Program Attachments.
3. **Funding Obligation.** This Contract is contingent upon the continued availability of funding. If funds become unavailable through lack of appropriations, budget cuts, transfer of funds between programs or health and human services agencies, amendment to the Appropriations Act, health and human services agency consolidation, or any other disruptions of current appropriated funding for this Contract, DSHS may restrict, reduce, or terminate funding under this Contract.
4. **Term of the Contract.** This Contract begins on 09/01/2012 and ends on 08/31/2013. DSHS has the option, in its sole discretion, to renew the Contract as provided in each Program Attachment. DSHS is not responsible for payment under this Contract before both parties have signed the Contract or before the start date of the Contract, whichever is later.
5. **Authority.** DSHS enters into this Contract under the authority of Health and Safety Code, Chapter 1001.
6. **Documents Forming Contract.** The Contract consists of the following:
  - a. Core Contract (this document)
  - b. Program Attachments:  
  
2013-042399-001 CHS - TITLE V - CHILD HEALTH SERVICES
  - c. General Provisions (Sub-recipient)
  - d. Solicitation Document(s), and
  - e. Contractor's response(s) to the Solicitation Document(s).
  - f. Exhibits

Any changes made to the Contract, whether by edit or attachment, do not form part of the Contract unless expressly agreed to in writing by DSHS and Contractor and incorporated herein.

7. **Conflicting Terms.** In the event of conflicting terms among the documents forming this Contract, the order of control is first the Core Contract, then the Program Attachment(s), then the General Provisions, then the Solicitation Document, if any, and then Contractor's response to the Solicitation Document, if any.

8. **Payee.** The Parties agree that the following payee is entitled to receive payment for services rendered by Contractor or goods received under this Contract:

Name: HIDALGO COUNTY

Address: HIDALGO COUNTY TREASURER 2810 S BUSINESS 281

EDINBURG, TX 78539-6243

Vendor Identification Number: 17460007176060

9. **Entire Agreement.** The Parties acknowledge that this Contract is the entire agreement of the Parties and that there are no agreements or understandings, written or oral, between them with respect to the subject matter of this Contract, other than as set forth in this Contract.

By signing below, the Parties acknowledge that they have read the Contract and agree to its terms, and that the persons whose signatures appear below have the requisite authority to execute this Contract on behalf of the named party.

DEPARTMENT OF STATE HEALTH SERVICES

HIDALGO COUNTY HEALTH & HUMAN SERVICES

By: \_\_\_\_\_  
Signature of Authorized Official

By: \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Bob Burnette, C.P.M., CTPM

\_\_\_\_\_  
Printed Name and Title

Director, Client Services Contracting Unit

\_\_\_\_\_  
Address

1100 WEST 49TH STREET  
AUSTIN, TEXAS 78756

\_\_\_\_\_  
City, State, Zip

(512) 458-7470

\_\_\_\_\_  
Telephone Number

Bob.Burnette@dshs.state.tx.us

\_\_\_\_\_  
E-mail Address for Official Correspondence

CONTRACT NO. 2013-042399  
PROGRAM ATTACHMENT NO. 001  
PURCHASE ORDER NO. 0000387952

CONTRACTOR: HIDALGO COUNTY HEALTH & HUMAN SERVICES

DSHS PROGRAM: CHS - TITLE V - CHILD HEALTH SERVICES

TERM: 09/01/2012 THRU: 08/31/2013

SECTION I. STATEMENT OF WORK:

Contractor shall provide or assure the provision of child health and/or dental services that include screening and eligibility determination, direct clinical and/or dental services, laboratory services and appropriate referrals as necessary. Contractor shall provide services approved in the Contractor's application or shall have an established referral relationship with a qualified provider of each approved service, which it does not provide.

Contractor shall comply with all applicable federal and state laws, rules, regulations, standards and guidelines in effect on the beginning date of this Program Attachment unless amended, including but not limited to:

- Title V of the Social Security Act, 42 USC § 701, *et seq.*

The following documents are incorporated by reference and made a part of this Program Attachment. These include:

- DSHS FY13 Title V Fee-for-Service Child Health and Dental Renewal Contract Application;
- Contractor's Response to DSHS FY13 Title V Fee-for-Service Child Health and Dental Renewal Contract Application and any revisions;
- DSHS FY11 Competitive Request for Proposal (RFP) for Title V Fee for Services Contracts Child Health and Dental Services, Prenatal Services, Genetic Services;
- Contractor's Response to FY11 Competitive RFP for Title V Fee for Services Contracts Child Health and Dental Services, Prenatal Services, Genetic Services and any revisions;
- Current Policies and Procedures Manual for Title V Maternal and Child Health Fee for Services for Child Health, Dental, and Prenatal;
- DSHS *Department of State Health Services Standards for Public Health Clinic Services*, revised August 2004, or latest revision;
- DSHS Core Tool On-Site Evaluation Report, revised for 2012, and Core Tool Monitoring Instructions, FY2011; or latest revision; and
- DSHS Title V Maternal, Child Health, Dysplasia, Family Planning On-site Evaluation Report, revised for 2012, and Title V Tool Monitoring Instructions, FY2012; or latest revision.

Within thirty (30) days of receipt of an amended standard(s) or guideline(s), Contractor shall inform DSHS Program, in writing, if it shall not continue performance under this Program Attachment in compliance with the amended standard(s) or guideline(s). DSHS may terminate the Program Attachment immediately or within a reasonable period of time as determined by DSHS.

All activities must be performed in accordance with Contractor's final approved work plan.

DSHS Health Service Regional Director or designee, as coordinator of regional services, will assist DSHS staff in providing direction to Contractor. DSHS personnel may, from time to time, provide technical assistance and training to Contractor. Contractor shall cooperate with DSHS staff to attain the goals of policy application, coordinated services, and quality assurance.

Eligible Population:

To be eligible for Title V Child Health and Dental Services, an individual must be:

- An infant not more than eleven (11) months of age,
- A child or adolescent one (1) through twenty-one (21) years of age,
- A Texas resident,
- In financial need based on a gross family income at or below 185% of the most recent Federal Poverty Level, and
- Ineligible for other programs/benefits providing the same services.

Children and adolescents, who would otherwise meet Title V eligibility requirements, shall also be regarded as potentially Title V eligible. Individual client eligibility will be determined on an annual basis, and at other times as necessary, based upon change in pregnancy status or income.

Service Area: Hidalgo

Location: Multiple clinic locations identified through the DSHS website at: [http://www.dshs.state.tx.us/mch/fee/locate\\_services.shtm](http://www.dshs.state.tx.us/mch/fee/locate_services.shtm).

DSHS reserves the right, where allowed by legal authority, to redirect funds in the event of financial shortfalls. DSHS Program will monitor Contractor's expenditures on a quarterly basis. If projected expenditures are below the total contract amount, Contractor's budget may be subject to a decrease for the remainder of the Program Attachment term. Vacant positions existing after ninety (90) days may result in a decrease in funds.

## SECTION II. PERFORMANCE MEASURES:

The following performance measure(s) will be used to assess, in part, the Contractor's effectiveness

in providing the services described in this Program Attachment, without waiving the enforceability of any of the other terms of the contract.

Performance of Contractor, including compliance with DSHS Program procedures, policies and guidance, contractual conditions, attainment of performance measures, maintenance of adequate staff, and submission of required data and narrative reports, if applicable, will be regularly assessed. Failure to comply with stated requirements and contractual conditions may result in the immediate loss of contract funds at the discretion of DSHS.

- Contractor shall provide child health and/or dental services to at least 410 unduplicated clients.
- At least 80% of the total amount of this Program Attachment shall be for services provided to Title V eligible individuals ages one (1) through twenty-one (21) by Contractor.
- Not more than 20% of the total amount of this Program Attachment shall be for services provided to Title V eligible individuals who are not more than eleven (11) months of age.
- Contractor shall screen 100% of individuals considered for Title V eligibility with a DSHS-approved screening process, and refer to other programs and funding sources as appropriate.

### SECTION III. SOLICITATION DOCUMENT: RFP #DFCHS-0388.1

### SECTION IV. RENEWALS:

Contract renewals are contingent upon satisfactory performance and continued availability of funding. The contract may be renewed for up to two (2) additional twelve- (12) month periods.

### SECTION V. PAYMENT METHOD: Fee-for-Service

### SECTION VI. BILLING INSTRUCTIONS:

Within 30 days following the end of the month, Contractor shall request payment using the Monthly Reimbursement Request (MRR), for Title V Fee for Service Program (Form #EF21-12005). With each MRR, contractor shall submit the following acceptable supporting documentation for reimbursement of the required services/deliverables:

- Title V Maternal-Child Services Report (Child Health & Dental) – 185 (Form EF21-12005);
- Title V Maternal-Child Services Report – 186 (Child Health & Dental) (Form EF21-12005); and
- Monthly Aggregate Activity Report (Form EF21-12005). Each report shall detail the total unduplicated number of clients seen for the first time within a service category type during the contract period by age, and race/ethnicity. Billing requests will not be processed for

payment by DSHS unless accompanied by a complete corresponding aggregate report.

MRRs and supporting documentation shall either be emailed to the Family and Community Health Services Division, Performance Management Unit, Contract Development & Support Branch (CDSB) at [cdsb@dshs.state.tx.us](mailto:cdsb@dshs.state.tx.us), or faxed to CDSB at: (512) 776-7521.

MRRs shall be emailed also to the DSHS Claims Processing Unit (CPU) at [invoices@dshs.state.tx.us](mailto:invoices@dshs.state.tx.us), or faxed to CPU at (512) 776-7442.

MRRs shall be submitted each month even if there are zero expenditures. MRRs are submitted each month for actual expenditures of the program even if the contract limit has been reached.

Contractor shall request payment from DSHS as directed by the Policies and Procedures Manual for Title V Maternal and Child Health Fee for Service for Child Health, Dental and Prenatal whether via voucher or a web-based system.

Contractor shall submit a "Financial Reconciliation Report" (Form GC-10) no later than sixty (60) days after the end of the attachment term. This report must be signed and marked "Final" and shall be scanned and emailed to CDSB at the email address listed above. The GC-10 may also be faxed to CDSB at (512) 776-7521. The original, signed version shall also be mailed to the DSHS CPU at:

Department of State Health Services  
Claims Processing Unit, Mail Code 1940  
P.O. Box 149347  
Austin, TX 78714-9347

SECTION VII. BUDGET: Fee for Service

SOURCE OF FUNDS: CFDA # 93.994; 93.994.000

DUNS NUMBER: 103110834

Contractor shall adhere to the current schedule of allowable services and rates as referenced in the Policies and Procedures Manual for Title V Maternal and Child Health Fee for Service for Child Health, Dental and Prenatal.

Total payments will not exceed \$34,833.00.

SECTION VIII. SPECIAL PROVISIONS:

For purposes of this Program Attachment only, the following provisions shall apply:

General Provisions, **Compliance and Reporting** Article I, is revised to include:

Contractor shall report to DSHS using established reports as directed by the Policies and

Procedures Manual for Title V Maternal and Child Health Fee for Service for Child Health, Dental and Prenatal, and other data and/or reports deemed necessary by DSHS, upon reasonable notice to Contractor.

**Eligibility:** All individuals considered for Title V eligibility must be screened and determined eligible using a DSHS or Title V program-approved screening process as updated in the spring of each year when federal poverty levels and eligibility determination forms are revised.

General Provisions, **Services** Article II, is revised to include:

**Co-pay:** Contractor may assess a co-pay from clients who receive services under this Program Attachment. A co-pay shall not be assessed from such clients if their family income is at or below 100% of the most recently defined federal poverty level. A co-pay assessment shall not exceed 25% of the authorized and approved reimbursement amount for allowed services. A client shall not be denied services due to inability to pay.

Contractor shall make reasonable efforts to investigate and apply for all other sources of third party funding available to, or identified by, the client before submitting claims for allowable costs.

General Provisions, **Funding** Article III, is revised to include:

Program Income may be collected and retained by Contractor so long as it is used to provide services specified in the scope of work detailed in this Program Attachment. The use of Program Income shall be reported on the monthly billing vouchers for services provided to Title V eligible clients.

General Provisions, **Payment Methods and Restrictions** Article IV, Section 4.02 is revised to include:

Contractor's contract amount under this Program Attachment is a ceiling against which it may bill, on a fee-for-service basis, for the provision of allowable services to Title V eligible clients. Only allowable services provided to Title V eligible clients may be billed against this ceiling. The current schedule of allowable services and rates, as well as Title V eligibility requirements, may be modified at the sole discretion of DSHS with thirty (30) days written notice to Contractor. The notice will provide Contractor with an opportunity to terminate this Program Attachment should the modification include a reduction in rates. Contractor shall have thirty (30) days from receipt of this notice to exercise the option for termination. If the Contractor does not exercise the option during the thirty (30) day time period, Contractor shall be deemed to have waived the option.

A Request for "Financial Reconciliation Report", Form GC-10, or the form specified in the Contractor's Financial Procedures Manual, is due no later than sixty (60) days after the end of the Program Attachment term. This report shall be marked "Final".

**Billing Requirements:** Contractor shall bill DSHS on a monthly basis for allowable services provided to Title V eligible clients. Bills for all allowable services shall be submitted as aggregate activity reports with a DSHS Monthly Reimbursement Request and shall not refer to or identify individual clients. Contractor shall bill within thirty (30) days after the end of the month in which services were provided or within sixty (60) days in cases of potentially Medicaid eligible individuals who are denied eligibility by the Health and Human Services Commission. All bills shall be submitted within sixty (60) days of the end of the Program Attachment term.

In billing DSHS, Contractor shall certify that all billed services have been provided only to individuals who have been determined to be eligible for Title V services. DSHS will pay Contractor for all acceptable vouchers submitted up to Contractor's contract ceiling amount. Billing vouchers submitted outside of the timeframes indicated above shall be subject to disallowance.

**Billing Activity:** DSHS shall distribute funds in a way that will maximize the delivery of authorized services to eligible clients. DSHS will monitor Contractor's billing activity. If utilization is below that projected in Contractor's contract ceiling amount, shown in SECTION VII. BUDGET, Contractor's ceiling may be subject to a decrease for the remainder of the Program Attachment period. Contractor may be subject to contract ceiling amount decreases if Contractor's billing activity is less than projected.

DSHS may pay for additional services as specified in this Program Attachment if provided by Contractor during the term of this Program Attachment (but not otherwise paid during the term of this Program Attachment) if it is in the best interest of the State and the DSHS Program to do so, and if funds are available. If Contractor exceeds the ceiling amount of the Program Attachment, Contractor shall continue to bill DSHS for the services provided. DSHS may pay for these additional services if funds become available at a later date.

General Provisions, **Terms and Conditions of Payment** Article V, is replaced with the following:

Contractor shall accept reimbursement or payment from DSHS and any applicable fees from clients for clinical health services as payment in full for services or goods provided to clients. Contractor shall not seek additional reimbursement or payment for services or goods from clients other than applicable fees for clinical health services.

General Provisions, **Access and Inspection** Article IX, is revised to include:

Contractor shall allow DSHS to conduct on-site quality assurance reviews as deemed necessary by DSHS. Unsatisfactory review findings may result in implementation of General Provisions, **Breach of Contract and Remedies for Non-Compliance** Article XIV.

General Provisions, **Assurances and Certifications** Article XI, is revised to include:

If appropriate, Contractor certifies that neither the Contractor, nor any individual who has a direct or indirect ownership or controlling interest of 5% or more of the Contracting Agency, nor any officer, director, agent or managing employee (e.g. general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over the Contractor or who directly or indirectly conducts the day-to-day business of the Contractor is an entity or individual who:

- Has been convicted of any offense under 42 U.S.C. § 1320a-7(b)(1)-(3);
- Has had a civil monetary penalty assessed under 42 U.S.C. § 1320a and/or 42 U.S.C. § 1320a-8; or,
- Has been excluded from participation in a program under 42 U.S.C. § 1395 *et seq.*; or under a State health care program.

If the foregoing statement is not true, Contractor shall submit a disclosure/ownership form to DSHS. Contractor shall immediately notify the DSHS in writing, in the event that the foregoing statement changes during the term of this Program Attachment. A false statement regarding Contractor's status will be treated as a material misrepresentation.

General Provisions, **General Business Operations of Contractor** Article XII, is revised to include:

Contractor shall notify the Contract Development and Support Branch in writing of any clinic site information changes, e.g., changes in contact person, hours of operation, address, Texas Provider Identification (TPI) number, National Provider Identification (NPI) number, the closure, relocation, and/or opening of clinic site(s).

General Provisions, **ARTICLE XIII, GENERAL TERMS, Section 13.15, Amendment**, is amended to include the following:

Contractor must submit all amendment and revision requests in writing to the Family and Community Health Services (FCHS) Division Performance Management Unit at least 90 days prior to the end of the term of this Program Attachment.

## INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the Department of State Health Services (DSHS) under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by DSHS to enter into an agreement or contract with any such institution or in termination of existing agreements.

### SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete part II of this form. Only those title XX providers rendering medical, remedial, or health related homemaker services must complete parts II and III. Title V providers must complete parts II and III.

#### General Instructions

For definitions, procedures and requirements, refer to the appropriate Statutes or Regulations:

Title V – 42 USC §1397d

Title XVIII – 42CFR 420.200 – 206

Title XIX – 42CFR 455.100 – 106

Title XX – 42 USC §1397d

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks section on page 2, referencing the item number to be continued. If additional space is needed, use an attached sheet.

Return the original to DSHS and retain a copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

#### DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

**Item I** - Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

**Item II** - Self-explanatory.

**Item III** - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

#### Items IV – VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

**Item IV** - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

**Item V** - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

**Item VI** - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

**Item VII** - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

**Item VIII** - If yes, list the actual number of beds in the facility now and the previous number.

## DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

**I. Identifying Information**

Name of Entity: HIDALGO COUNTY HEALTH & HUMAN SERVICES	D/B/A	Provider No.:	Vendor No.: 17460007176	Telephone No.
Street Address:	City, County, State:			Zip Code:

II. Answer the following questions by checking "Yes" or "No." If any of the questions are answered "Yes," list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

(a) Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by titles XVIII, XIX, or XX?

Yes \_\_\_ No \_\_\_

(b) Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by titles XVIII, XIX, or XX?

Yes \_\_\_ No \_\_\_

(c) Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

Yes \_\_\_ No \_\_\_

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN #
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(b) Type of Entity:      Sole Proprietorship \_\_\_      Partnership \_\_\_      Corporation \_\_\_  
                                     Unincorporated Associations \_\_\_      Other (Specify) \_\_\_\_\_

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions:

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.      Yes \_\_\_ No \_\_\_

Name	Address	Provider Number
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IV. (a) Has there been a change in ownership or control within the last year?

Yes\_\_\_ No\_\_\_

If yes, give date\_\_\_\_\_

(b) Do you anticipate any change of ownership or control within the year?

Yes\_\_\_ No\_\_\_

If yes, when?\_\_\_\_\_

(c) Do you anticipate filing for bankruptcy within the year?

Yes\_\_\_ No\_\_\_

If yes, when?\_\_\_\_\_

V. Is this facility operated by a management company, or leased in whole or part by another organization?

Yes\_\_\_ No\_\_\_

If yes, give date of change in operations\_\_\_\_\_

VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?

Yes\_\_\_ No\_\_\_

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)

Yes\_\_\_ No\_\_\_

Name EIN #

(b) If the answer to Question VII(a) is No, was the facility ever affiliated with a chain?

(If yes, list Name, Address of Corporation, and EIN)

Yes\_\_\_ No\_\_\_

Name EIN # Address

VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?

Yes --- No ----

If yes, give year of change \_\_\_\_\_

Current beds \_\_\_\_\_ Prior beds \_\_\_\_\_

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH DSHS.

Name of Authorized Representative (Typed)

Title

Signature

| Date

Remarks: