Aetna Better Health® of New Jersey
Disclosure Statement of Ownership

Disclosure statement of ownership and control interest, related business transactions and persons convicted of a crime.

This form shall be submitted to the HMO annually and upon request. For definitions, procedures and requirements refer to 42 CFR 455.100-106 (copy attached). ATTACH SEPARATE SHEETS

I. Identifying Information of Disclosing Entity

Name of disclosing entity and D/B/A		
Street address		
City		County
State	ZIP Code	Telephone number

II. Ownership and Control Interest

A. Please complete the information:

1.	Name		
	Address		
	Relationship	% Ownership	IRS ID/Other Tax ID (for corporations)
	Date of birth (for individuals)	Social Security Number (for individuals)	

2.	Name		
	Address		
	Relationship	% Ownership	IRS ID/Other Tax ID (for corporations)
	Date of birth (for individuals)	Social Security Number (for individuals)	

3.	Name		
	Address		
	Relationship	% Ownership	IRS ID/Other Tax ID (for corporations)
	Date of birth (for individuals)	Social Security Number (for individuals)	

B. Please complete the information below: (The name of any other disclosing entity (or fiscal agent or) in which a person with an ownership or control interest in the business (disclosing entity) also has an ownership or control interest.)

Name
Address
Name
Address

C. Please list the name, address, date of birth, and Social Security Number of any managing employee.

1.	Name	
	Address	
	Date of birth	Social Security Number

2.	Name	
	Address	
	Date of birth	Social Security Number

3.	Name	
	Address	
	Date of birth	Social Security Number

III. Information related to business transactions.

Provide ownership information of

(1) Any subcontractor with whom the contractor has had business transactions totaling more than $ 25,000 during the12-month period ending on the date of the request; and

(2) Any significant business transactions between the contractor and any wholly owned supplier, or between theContractor and any subcontractor, during the 5-year period ending on the date of the request.

Name	Address	Ownership

Disclose information on types of transactions with a "party in interest" as defined in Section 1318(b) of the Public Health Service Act (Section 1903(m)(4)(A) of the Social Security Act).

IV. Disclosure of Information on persons convicted of crimes.

Identity of any person who has ownership or control interest in the provider organization, or is an agent or managing employee of the provider organization; and has been convicted of a criminal offense related to that person's involvement inany program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

Are there any directors, officers, agents, or managing employees of the provider 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

If yes list names and addresses of individuals or corporations.

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 the state agency or the secretary, as appropriate.

Name of Authorized Representative (Typed)	Title
Signature	Date

Remarks