WORKERS' COMPENSATION PPO CHARACTER AND COMPETENCE REVIEW INFORMATION

INSTRUCTIONS: Section I-III should be duplicated and forwarded to each of the following individuals for completion:

- All owners of record or beneficial owners;
- All members of the governing body, officers, directors and controlling persons. Controlling person for the purpose of this section means any person who has the ability directly or indirectly, to direct or cause the direction of the management or policies of a corporation partnership or other entity. Control shall be presumed to exist if any person directly owns, controls or holds the power to vote ten (10) percent or more of the voting securities or voting rights of any other person or is a corporate member of a not-for-profit corporation;
- All partners of a partnership; and
- The administrator and the medical director.

At the end of Section III is an affidavit that must be completed by each individual listed above. Without all signed and notarized affidavits this application will be considered incomplete.
Omission of any information requested may lead to exclusion of the applicant from consideration for a Certificate of Authority or revocation of the certificate if such certificate is already awarded.

I) PERSONAL QUALIFYING INFORMATION

A. PERSONAL IDENTIFYING

NAME (Last) **(First)** **(Middle Initial)**

STREET ADDRESS

CITY **STATE** **ZIP CODE**

TELEPHONE NUMBER (Area Code)

BUSINESS NAME AND ADDRESS

CITY **STATE** **ZIP CODE**

TELEPHONE NUMBER (Area Code)

DATE OF BIRTH MONTH / DAY / YEAR **PLACE OF BIRTH** **SOCIAL SECURITY #**

CURRENT OR PROPOSED POSITION WITH PROPOSED PPO

B. INDIVIDUAL EMPLOYMENT HISTORY

Start with MOST RECENT employment and include employment for the last ten (10) years. A resume may be included but any additional information requested below and not contained in such resume should be added. Photocopy and attach additional sheets if necessary.

NAME OF EMPLOYER

STREET ADDRESS OF EMPLOYER

CITY **STATE** **ZIP CODE**

DATES OF EMPLOYMENT **TYPE OF BUSINESS**
FROM: **TO:**

NAME OF SUPERVISOR/REFERENCE **TELEPHONE NUMBER**

POSITION/RESPONSIBILITIES

REASON FOR DEPARTURE

C LICENSES

Type of License (including specialty)	Institution Granting License and Address	Date Received	Date of Expiration

D EDUCATIONAL HISTORY (High School and Subsequent Education)

Institution	Address	Attended From/to	Degree	Date Received

E HISTORY OF ANY LEGAL ACTIONS

1. Have you ever changed your name or used an alias?

☐ YES ☐ NO

NOTE: If "YES" attach an explanation including other name(s) date(s) and the reason(s) for each change.

2. Except for minor traffic violations, have you ever been indicted or been convicted or had a sentence imposed or suspended, or been pardoned of a conviction for any crime?

☐ YES ☐ NO

3. Are there any criminal actions pending against you?

☐ YES ☐ NO

4. Have you ever been named as a defendant in any civil action or proceeding in which there was an issue of morale turpitude, including but not limited to fraud or breach of fiduciary responsibility?

☐ YES ☐ NO

NOTE: If "YES," to 2, 3, or 4 attach explanation(s) including the date of the action or proceeding, place (county of the filing), the civil docket number, if available, and the disposition of the case, if any.

5. Have you ever been an officer, trustee, management employee or controlling stockholder of a company which, while you occupied any such position or served in any such capacity with respect to it:

a. became insolvent, declared or was forced to declare bankruptcy or was placed in receivership or conservatorship?

☐ YES ☐ NO

b. was enjoined from or ordered to cease and desist from violating any securities, insurance or health law or regulation?

☐ YES ☐ NO

c. suffered the suspension or revocation of its certificate of authority or license to do business in any state?

☐ YES ☐ NO

d. was denied a certificate of authority or licensed to do business in any state?

☐ YES ☐ NO

NOTE: if "YES", to any of the above, attach an explanation.

6. During the last 10 years have you been refused a professional occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has such a license held by you during such period ever been suspended or revoked?

☐ YES ☐ NO

7. Have you ever been named as a defendant in an action or proceeding brought by any public or governmental licensing agency or regulatory authority for violation of or to prevent the violation of any securities, insurance or health law or regulation?

☐ YES ☐ NO

NOTE: If "YES", to number 6-7 above, attach an explanation.

8. Have you ever been in a position that required a fidelity bond?

☐ YES ☐ NO

a. If "YES", were any claims made against the bond?

☐ YES ☐ NO

b. Have you ever been denied a fidelity bond or had such fidelity cancelled or revoked?

☐ YES ☐ NO

NOTE: If "YES" to any question in number 8, complete the following chart:

DATE OF ACTION	LOCATION
TYPE OF ACTION	CASE IDENTIFICATION
PERSONS AND/OR FACILITIES INVOLVED	
FURTHER DETAILS	

II) AFFILIATION WITH OTHER HEALTHCARE OPERATIONS

INSTRUCTIONS: The purpose of this section is to obtain a complete listing of any health care operations with which the owners, officers, directors, governing board members, controlling persons, partners or medical director of the proposed PPO have been affiliated within the past 10 years. Affiliation with health care operations for the purposes of this section includes serving as an officer, director, member of the management staff, stockholder of 10 percent or more of stocks or key advisor for health care operation. Affiliations with New York State health care or health-related operations will be verified through available records in the Department of Health, and the performance of those operations will be reviewed. Affiliations with out-of-state health care or health related operations will be checked for compliance of those operations with the appropriate state regulatory agencies. The applicant is responsible for submitting letters to appropriate state regulatory agencies in order to obtain documentation that those health care operations were in compliance with applicable laws and regulations. Sample Letter A and Form DOH-794 attacked may be used for this purpose and may be sent directly to the appropriate state regulatory agency by the applicant. The completed Form DOH-794 must be returned to the Workers' Compensation Programs in the Department of Health at the address provided in Sample Letter A.

1. For the last 10 years, have you owned or operated any health care or health related operations or held a management position or had any affiliations with health care or health related operations in New York, the United States, or in any other countries?

☐ YES ☐ NO

NOTE: If "YES" complete the following chart:

Name and Address of Health Care Operation	Affiliation Dates From/To	Nature of Affiliation with Facility	Agency Licensing	License Number

2. Are/were these facilities in compliance with applicable laws and regulations during your affiliation?

☐ YES ☐ NO

NOTE: If "NO", complete the following: (attach additional pages if necessary)

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING VIOLATION (name & address)

STEPS TAKEN BY FACILITY TO REMEDY VIOLATION

Has suspension, revocation or accreditation since been restored? ☐ YES ☐ NO **NOTE:** If "NO" give an explanation.

III) PERSONAL FINANCIAL INVOLVEMENT IN PPO

A. Financial Support for the Proposed PPO

As the applicant, owner, all members of a partnership or officers, director and controlling persons of for profit and not-for-profit corporations or other business corporations intending to provide capital for use in owning, organizing or operating proposed PPO? (Controlling person means any person who has the ability, directly or indirectly to direct or cause the direction of the management or policies of a corporation, partnership or other entity.)

☐ YES ☐ NO

NOTE: If "YES", provide the following:

- Attach a personal financial statement for each individual providing support from personal finances for the proposed PPO.
- Make clear the percent of the business which each person controls, and document its value.
- Lessors are to attach documents showing their financial ability to fulfill any construction obligations.
- Any additional information pertinent to determination of either the applicant's financial capabilities or the project's feasibility must also be attached.
- For a change in ownership control, submit affidavits from both the applicant and the party from which the operational interest is being acquired. Interest, for the purpose of this section, means right, title or share in a facility, participation in any advantage, profit and responsibility from or for the facility.

B. Transactions with the Proposed PPO

Have any transactions involving money, extension of credit, leans, notes, bonds, or mortgages occurred or are such transactions anticipated between the proposed PPO and you or any of your relative(s)?

☐ YES ☐ NO

NOTE: If "YES", complete the Disclosure of Transactions Form below identifying such transactions.

DEFINITIONS:

RELATIVE, *for the purpose of this section, includes each parent, child, spouse, brother or sister whether such relationship arises by reason of birth or adoption.*

TRANSACTION, *for the purposes of this section, is any business transaction or series of transactions which during any one fiscal year, represents 5 percent of the total annual operating expenses of any of the parties to the transaction. Transaction includes any sale or leasing of any property. Salaries paid to employees for services provided in the normal course of their employment are not included in this definition. No single transaction of less than $500 need be reported.*

DISCLOSURE OF TRANSACTION FORM

PARTIES INVOLVED IN TRANSACTION

TYPE OF TRANSACTION

VALUE OF TRANSACTION

% OF OPERATING COSTS **DOLLAR AMOUNT: $**

% INTEREST RATE **DOLLAR AMOUNT: $**

REASON FOR TRANSACTION

METHOD OF REPAYMENT

(Attach additional sheets if necessary)

AFFIDAVIT
(to be completed with Sections I, II, and III)

State of _____

County of _____

I, _____ **being duly sworn deposes and says**
NAME (last, first, middle initial)

I am a proposed _____ **of**
POSITION

_____.
ORGANIZATION/CORPORATION

I certify that I have provided all the information requested in Section I, II, and III including a complete list of any and all hospitals, nursing homes, clinics, health maintenance organizations, halfway houses, managed care organizations, preferred provider organizations, other institutions of care, operations involving the care or treatment for the physically or mentally afflicted within the past 10 years as an operator, director, partner, medical director, or stockholder with 10 percent or more total shares.

I certify, under penalty of perjury, that if no names of such health care operations have been provided, I have had no such affiliations in the past 10 years and that the information contained is accurate, true and complete.

Signature_____ **Date**_____

Subscribed and sworn to before me this
_____ **day of** _____, **20**_____

Name of Notary Public_____

Signature of Notary Public_____

AFFILIATIONS WITH A MANAGEMENT CONTRACTOR

INSTRUCTIONS: This section is to be completed by the PPO and the management contractor seeking to provide management services to the proposed PPO.

A. Using the following form, list all health care or health related operations, institutional or noninstitutional, that the management contractor has provided services for during the past 10 years. The applicant is responsible for obtaining documentation that any management contractors were/are in compliance with applicable state laws and regulations. The applicant may use Sample Letter B and Form DOH-794 directly to the appropriate state agency. When Form DOH-794 is completed, it should be returned directly to the Workers' Compensation Programs in the Department of Health at the address provided in Sample Letter B to be added to the application. The applicant is encouraged to initiate this activity as soon as possible.

Name of Operation and Location	Type of Operation	Date Licensed	Name and Address of Contact Person in State Regulatory Agency

(attach additional sheets if necessary)

1. Are all the operations listed above in compliance with applicable state laws and regulations?

☐ YES ☐ NO

NOTE: If "NO", provide or attach an explanation including the date and nature of the violation, the plan of correction or other resolution.

2. Has the management contractor ever been subjected to financial penalties or suspension of revocation of its operating certificate or license because of failure to comply with provisions governing the conduct and operation of the facility(ies)?

☐ YES ☐ NO

NOTE: If "YES", complete for each violation.

NAME AND ADDRESS OF OPERATION INVOLVED

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING IT

STEPS TAKEN TO REMEDY VIOLATION

SAMPLE LETTER A

Dear _____

_____ is applying for a Certificate of Authority to operate a
Name of Proposed PPO
preferred provider organization in New York State. As part of the certification process, a 10 year character and competency review must be conducted for owners, members of the governing board officers, directors, controlling persons, partners and the medical director who have been affiliated with other health care operations during the past 10 years.

According to the disclosure forms submitted, _____ has
Name of Individual
been affiliated with the following health care operation(s) in your state:

NAME OF OPERATION	DATES OF AFFILIATION

Please complete the enclosed Character and Competence Review Form (DOH-794) at your earliest convenience. Without the review, _____
Proposed PPO
Cannot successfully complete the application process. Return the completed Form (DOH-794) to the following address:

Workers' Compensation Programs
New York State Department of Health
Room 2001, Corning Tower
Empire State Plaza
Albany, New York 12237-0094

Sincerely,

Enclosure

SAMPLE LETTER B
For Management Contractors

Dear _____

_____, is applying for a Certificate of Authority to operate a
Proposed PPO

preferred provider organization in New York State.

_____ is seeking to provide management services
Name of Management Contractor
Through a management contract. As part of the certification process, a character and competence review must be conducted to ascertain that other health care operations managed by _____ during the dates provided.
Name of Management Contractor

NAME(S) OF OPERATION	DATES OF OWNERSHIP/OPERATION BY THIS MANAGEMENT CONTRACTOR

Please complete the enclosed Character and Competence Review Form (DOH-794) for the _____ at your earliest convenience. Without this review,
Name of Management Contractor
_____ cannot successfully complete the application process.
Proposed PPO
Return the completed form (DOH-794) to the following address:

Workers' Compensation Programs
New York State Department of Health
Room 2001, Corning Tower
Empire State Plaza
Albany, New York 12237-0094

Sincerely,

Enclosure

New York State Department of Health
Workers' Compensation Programs

CHARACTER AND COMPENTENCE REVIEW FORM

NAME OF PERSON REPLYING (Last, First, Middle Initial)

TITLE

OFFICE NAME

OFFICE STREET ADDRESS

CITY **STATE** **ZIP CODE**

TELEPHONE NUMBER (area code)

HEALTH CARE OPERATION: Name **TYPE**

DATES OF AFFILIATION: From: **To:**

During this period, was/is this health care operation in compliance with appropriate state regulations?

☐ YES ☐ NO If "NO", please explain:

During this period, to your knowledge, did/do regulators in your state have any concerns about the management or performance of this health care operation?

☐ YES ☐ NO If "YES", please explain:

During this period, did/do regulators in your state have any concerns about the quality of health care provided by this health care operation?

☐ YES ☐ NO If "YES", please explain.

Other Comments:

Signature: **Date:**

Sample Letter A and B Enclosure