Thurston-Mason Behavioral Health Administrative Service Organization, LLC

EXCLUSION ATTESTATION FORM

Completion and submission of this form is a condition of participation in the TM BH-ASO Provider Network and is required. A failure to submit the form monthly may result in termination of any existing contracts.

Pursuant to 42 CFR 455, the TM BH-ASO Provider Guide and Policy CO201 Program Integrity, TM BH-ASO requires network providers to implement procedures to screen its employees, contractors and subcontractors prior to hiring or contracting, monthly and as directed by contract, including members of Governing Boards/Committees, and members of other Boards in a position to influence funds.

Network Providers are responsible for completing and submitting this form in its entirety no later than the **10th of each month for the previous month** (see below for example). Completed forms may be submitted via email to: program.integrity@tmbho.org.

DATE FORM IS BEING COMPLETED:			
NAME OF AGENCY:			
INDIVIDUAL COMPLETING FORM:			
TITLE:			
PHONE:		EMAIL:	
EXCLUSIONARY CHECK Period:	Month:		Year:

Example: Exclusionary checks for January would be performed after January 15th and submitted no later than February 10th. Using this example, the “month” identified in table above would be January.

I hereby attest on behalf of the above-referenced Agency, that such Agency has completed exclusionary checks for the following individuals (check all that apply):

☐ New Hires ☐ Current Employees ☐ New Contracts ☐ Current Contracts ☐ All Subcontracts

☐ Governing Board Members and any Board Members who are in a position to influence funds

☐ Any individual or entity with direct or indirect ownership of 5% or more of the Agency

I hereby attest on behalf of the above-referenced Agency, that such Agency has completed exclusionary checks against the following exclusionary databases:

☐ Office of Inspector General, List of Excluded Individuals and Entities website database (HHS OIG LEIE) http://oig.hhs.gov/exclusions/index.asp

☐ System for Awards Management Excluded Parties Listing System (SAM EPLS) website search https://www.sam.gov/index.html/#1

☐ Verification of HCA Medicaid Exclusions. (https://www.hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/provider-termination-and-exclusion-list)

By signing below, I attest the information in this document is true and accurate.

____________________________ ____________________
Signature Date

Electronic Signature is considered valid only when document is submitted by e-mail from the signer’s designated e-mail address. If faxing application, signature must be handwritten.