SAN BERNARDINO COUNTY
Behavioral Health

FFS Provider Conflict of Interest/ Disclosures

RESET

In accordance with Department of Behavioral Health (DBH) and Department of Health Care Services (DHCS) requirements, including specified state and federal laws, all Fee For Service (FFS) Providers of the Mental Health Plan/ DBH are required to complete this form upon FFS Provider enrollment and re-enrollment or when there are changes to status or disclosures (within 10 days of change).

Provider Name _____

Address _____

Phone Number _____

☐ I HAVE NO PAID OR CONSULTATIVE RELATIONSHIP WITH A DBH CONTRACT AGENCY OR SAN BERNARDINO COUNTY MANAGED CARE PLAN.

☐ I DO HAVE A PAID, UNPAID OR CONSULTATIVE RELATIONSHIP WITH DBH CONTRACT AGENCY OR SAN BERNARDINO COUNTY MANAGED CARE PLAN.

1. Employer or Entity for which Paid or Consultative Relationship Exists:

_____ Phone _____

Address _____

Type of Service/Organization _____

Position Title and/or Role _____

Work Schedule, Job Duties and/or Activities Performed _____

_____

2. Employer or Entity for which Paid or Consultative Relationship Exists:

_____ Phone _____

Address _____

Type of Service/Organization _____

Position Title and/or Role _____

Work Schedule, Job Duties and/or Activities Performed _____

_____

Attach additional sheet to this form as/if needed.

Disclosure of any financial interest in DHCS SMHS or DMC-ODS state contract made by an official capacity or by any body or board of which FFS provider maintains membership. (Gov. Code §§ 1090, 1091; 42 C.F.R. §438.3(f)(2).)

DBH/FFS Provider Disclosure, if/as applicable:

Disclosure if FFS provider is a State officer or employee in the State civil service or other appointed State official unless employment, activity or enterprise is required as a condition of the officer's or employee's regular State employment. (Pub. Con. Code § 10410; 42 C.F.R. § 438.3(f)(2).)

FFS Provider Disclosure, if/as applicable:

Notice of required disclosure upon DBH or State/DHCS request:

- The identity of any person who is a managing employee of the Contractor/FFS Provider who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1),(2).)
- The identity of any person who is an agent of the Contractor/FFS Provider who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).) For this purpose, the word "agent" has the meaning described in 42 Code of Federal Regulations part

Additional FFS Provider Disclosure, if/as applicable:

I hereby certify that all statements made in this disclosure form are accurate and complete to the best of my knowledge. I understand that any false or relevant omissions may subject me to disqualifications or other action. I agree not to self-refer any client if seen by me at DBH or a DBH contract agency.

_____ _____

Name & Signature Date

Any changes to the above information must be reported to within ten (10) working days to DBH Quality Management – Provider Relations with a copy to Office of Compliance:

- Quality Management - FFS Provider Relations - (909) 383-3949
  dbh-ffsproviderrelations@dbh.sbcounty.gov
- Office of Compliance - (909) 386-8294
  dbh-complianceproviderclearance@dbh.sbcounty.gov