Our History

In 1970, the Austin City Council partnered with the Travis County Commissioner's Court to develop a system of primary care, dental care, and family planning clinics. The goal of this effort was to serve residents of Travis County whose incomes and lack of private health insurance kept them from being able to access healthcare services in the community. In 1992, the clinic system earned "Federally Qualified Health Center Look-Alike" status through the federal government. A 15-member Federally Qualified Health Center (FQHC) Board of Directors was appointed. Their job is to govern the Community Health Center system. It was required that a majority of the board's members be active patients in the system. These board members represent the populations served.

In 2001, the Community Health Center system received a Section 330 federal grant from the Bureau of Primary Health Care/Health Resources and Service Administration. The Community Health Centers were officially designated a "Federally Qualified Health Center" system. Federally Qualified Health Centers (FQHCs) represent a vital safety net in the nation's health delivery system. A growing nationwide network of approximately 1,400 FQHCs serves twenty million people. Congress created the FQHC program to support primary care providers who serve larger numbers of uninsured residents and operate in medically underserved communities. The scope of services offered by FQHCs must meet strict requirements. This includes providing accessible care to patients regardless of ability to pay, and having a board that represents the community.

Central Health (the Travis County Healthcare District) was founded in 2004 as a limited-purpose taxing district. It is responsible for providing healthcare to indigent persons residing in Travis County. At that time, funding and oversight for the Community Health Center system was under the City of Austin before it was transferred to Central Health. In 2009, the Community Health Center system became a private, non-profit corporation named CommUnityCare. It currently operates with an annual budget of approximately $102 million and serves about 90,000 patients. The majority of funding comes from the Community Care Collaborative (CCC) and the Federal Bureau of Primary Health Care. Public and private grants also support the work of CommUnityCare. In 2010, CommUnityCare was accredited by The Joint Commission, which recognizes quality healthcare institutions around the world. All eligible CommUnityCare health center sites have also received Level 3 - Patient Centered Medical Home (PCMH) recognition; which is the highest level of recognition available from the National Committee for Quality Assurance.

Our Vision

Improve the health of the community by increasing access to the best care possible.

Our Mission

We will work with the community as peers with open eyes and a responsive attitude to provide the right care, at the right time, at the right place.

Our Services Today

Today, CommUnityCare provides services at 21 locations in Travis County. Each year, our health centers provide approximately 320,000 medical and dental patient appointments. This number represents more than 90,000 individual patients. CommUnityCare provides outpatient primary healthcare, dental care, limited specialty care, lab, radiology including mammography, a full service pharmacy, and behavioral health services. We also provide HIV/AIDS treatment at our David Powell Clinic, and care for the homeless with a location at the ARCH, along with Street Medicine teams that go out in the community to provide primary care to the homeless. These services are provided to all Travis County residents including those whose incomes and lack of private health insurance qualify them for enrollment. Two of our locations, Hancock and William Cannon, were designed to expand access by providing walk-in services to patients in our system. These clinics offer extended hours and weekend care. Many of our providers speak several languages and we also utilize a telephone medical translation service for less common foreign languages. The services we provide include:

Primary Care

- **Prenatal care and specialty care for high-risk pregnancies**
- **Prenatal, labor and delivery, and newborn care and new parent education**
- **Newborn and infant care**
- **Pediatrics**
- **Immunizations**
- **Gynecology and women's health exams**
- **Treatment of minor injuries**
- **Physicals and annual exams**
- **Laboratory services**
- **Management of chronic diseases**
- **Diagnosis and treatment of chronic or acute illnesses**
- **Nutrition counseling**

- Core specialty care services and referrals
- Clinical pharmacy counseling
- Vision and hearing screenings
- Confidential HIV testing and care

Dental

- Routine and emergency dental exams
- Teeth cleaning and sealants
- Dental fillings
- Dental extractions
- Dentures and partials (limited services)

Behavioral Health

- Mental health counseling services
- Family and marriage counseling
- Substance abuse assessments
- Assessment of behavioral problems

Specialty Services

- Gastroenterology (GI), including Hepatitis C
- Pulmonology
- Cardiology
- Telepsychiatry
- Dermatology
- Internal Medicine

About the Board

CommUnityCare is a Federally Qualified Health Center (FQHC). All Federally Qualified Health Centers (FQHC) must be governed by the community, and 51% of their Board of directors must be patients of the FQHC. The resources listed below are tools to assist you understanding the Governance requirements.

Board Authority

Health center governing Board maintains appropriate authority to oversee the operations of the center, including:

- Holding monthly meetings;
- Approval of the health center grant application and budget;
- Selection/dismissal and performance evaluation of the health center CEO;
- Selection of services to be provided and the health center hours of operations;
- Measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance; and
- Establishment of general policies for the health center.
  (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304)

Board Composition

The health center governing Board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:

- Governing Board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.
- The remaining non-consumer members of the Board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.
- No more than one half (50%) of the non-consumer Board members may derive more than 10% of their annual income from the health care industry.

Conflict of Interest Policy

Health center bylaws or written corporate Board approved policy include provisions that prohibit conflict of interest by Board members, employees, consultants and those who furnish goods or services to the health center.

- No Board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the Board. (45 CFR 75.327 and 42 CFR 51c.304(b))

New Board Members

Any vacancy on the Board and any Director position to be filled due to an increase in the number of Directors shall be filled in the same manner as the selection process provided herein (including, without limitation, the right of Central Health to fill a vacancy of a Director position selected by Central Health). A vacancy is filled by the affirmative vote of a majority of the remaining Directors, even if it is less than a quorum of the FQHC Board, or if it is a sole remaining Director.

FQHC Board Composition and Qualification

The FQHC Board shall consist of no less than nine (9) and no more than twenty-five (25) voting Directors. The authorized number of Board Directors shall be adopted by the affirmative vote of a majority of the Board Directors. At least a majority of the Directors shall be active and not intermittent primary care users (hereinafter "Consumers") being served by the Health Centers and who, as a group, generally represent the individuals being served by the Health Centers in terms of demographic factors such as race, ethnicity, age, economic status, and gender. The term "non-consumers" will be defined as those who are not active primary care users of the Health Centers. In the event the FQHC receives federal funding to support the delivery of services for a special population, such as the homeless, migratory or seasonal farm-workers, residents of public housing or at-risk school children, there shall be at least one representative from each special population elected to serve on the FQHC Board.

FQHC Board Composition and Qualification:

- All Directors shall live within the Service Area of the FQHC.
- FQHC Board membership should also include, but is not limited to, individuals with skills and expertise in finance, legal affairs, business, health, managed care, social services, and government.
- No more than half of the non-consumer Directors may derive more than ten percent (10%) of their income from the health care industry.
- No Director may be an employee of the FQHC or Central Health, or an immediate family member, by blood or marriage, of an employee of the FQHC or Central Health.

CommUnityCare™ HEALTH CENTERS

PERSONAL INFORMATION		
First Name	Middle Name	Last Name
Ethnicity ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other		
Gender ☐ Male ☐ Female	Date of Birth (Month/Day/Year) ____/_____/_____	Social Security Number - -
Driver's License Number	Driver's License Issuing State	Driver's License Expiration Date
Preferred Mailing Street Address		
City	State	Zip Code
Are You a Resident of Travis County? ☐ Yes ☐ No	Zip Code of Permanent Residence	
Mobile Phone	Home Phone	Work Phone
Employer	Occupation	Email Address
Do you or your employer have any business dealing with the Travis County Health Care District, CommUnityCare or other entity that might present a conflict of interest? ☐ Yes ☐ No	Are you or any of your immediate family members employed by the Travis County Health Care District, CommUnityCare or any other entity that might present a conflict of interest? ☐ Yes ☐ No	
Do you receive more than ten (10%) of your annual income from the health care industry? ☐ Yes ☐ No	Do you agree to complete all financial statements required by law if appointed to the Board of Directors? ☐ Yes ☐ No	
Recognizing that serving on a Board is often time consuming, are you committed to attending all regularly scheduled meetings? ☐ Yes ☐ No	Do you get your regular medical care (i.e., within the last two years) from one of our health center locations? ☐ Yes ☐ No If yes, which health center? _____ How long have you been going to the health center? _____	
Do you have any Special Needs? ☐ Yes ☐ No If yes, what type? ☐ Visual ☐ Hearing ☐ Mobility ☐ Cognitive ☐ Other _____		

DESCRIBE ANY QUALIFICATIONS, EXPERTISE, OR SPECIAL INTERESTS THAT RELATE TO YOUR POSSIBLE APPOINTMENT (HEALTH, FINANCE, LAW, GOVERNMENT, ETC.). PLEASE ATTACH A RESUME IF YOU HAVE ONE AVAILABLE.

EMERGENCY CONTACT INFORMATION		
First Name	Middle Name	Last Name
Street Address		
City	State	Zip Code
Daytime Phone	Alternative Phone	

CRIMINAL HISTORY AUTHORIZATION

In connection with my application to be considered for appointment to the Central Texas Community Health Centers Board, I understand and agree that criminal history inquires may be requested by CommUnityCare or on CommUnityCare's behalf that will seek information as to my character and background.

I understand and agree that CommUnityCare may request information from various federal, state, and other agencies, including public and private sources which maintain records concerning my past activities relating to any criminal record. I acknowledge that a telephonic facsimile or copy of this release shall be as valid as the original. This release is valid for all federal, state, county, and local agencies and authorities.

The following is my complete and legal name, and all information is true and correct to the best of my knowledge.

First Name	Middle Name	Last Name

Driver's License Number	Driver's License Issuing State

Social Security Number
___ - __ - ____

Response to the following two questions are optional and voluntary, for ID only.

Gender	Date of Birth (Month/Day/Year)
☐ Male ☐ Female	____/_____/_____

Former Name and Time Frames (If Applicable)

Current Address

Street	City	State	Zip Code	County	Dates (Month and Year)

Previous Addresses

Street	City	State	Zip Code	County	Dates (Month and Year)

Candidate Name (Printed)	Candidate Signature	Date

CRIMINAL BACKGROUND CHECK FQHC MEMBERS

1. Criminal homicide
2. Kidnaping and false imprisonment
3. Indecency with a child
4. Sexual Assault
5. Aggravated assault
6. Industry to a child, elderly individual, or disabled individual
7. Abandoning or endangering a child
8. Aiding suicide
9. Agreement to abduct from custody
10. Sale or purchase of a child
11. Arson
12. Robbery
13. Aggravated robbery
14. Theft
15. Money laundering
16. Insurance fraud
17. Bribery and corrupt influence
18. Perjury and other falsifications
19. Engaging in organized criminal activity
20. Crime under the Racketeer Influenced and Corrupt Organization Act
21. Mail fraud
22. Wire fraud
23. Insurance fraud
24. Medicare fraud
25. Medicaid fraud
26. Tampering with a government document, and/or violation of Federal False Claims Act
27. An equivalent crime to any of the above
28. Aiding and abetting any of the above listed offense
29. Conspiracies to commit any of the above offense

Travis County Healthcare District (Central Health) # 11726
APPLICANT INFORMATION

APPLICANT'S FULL NAME _____
Any Other Names Used _____
Social Security No. _____ /_____ / _____ Date of Birth[1]_____
Email address: _____ (Provide if you prefer to receive information via email)
Current Address _____
City _____ State _____ Zip _____
Driver's License State _____ D.L. Number _____
Address on D.L.: _____

Name of High School, College, University or Institution of Professional Training where you completed the highest level
(¢ GED – provide state)_____
Campus Name _____Campus City _____Campus State _____
Name on GED or under which you graduated _____
Year(s) Attended _____Year Graduated/GED Completed_____

Please provide any current professional licenses, certifications, or registries you may hold:
Name as it appears on license/Certification/Registry_____
Type _____State/Region or Issuing Organization _____ Country _____ Number_____
Type _____State/Region or Issuing Organization _____ Country _____ Number_____

*Have you ever been convicted of a crime? Yes ¢ No ¢ (Please attach a separate sheet of paper to provide additional entries)
Offense _____ County _____ State _____ When_____
Offense _____ County _____ State _____ When_____

Please provide all locations where you have resided for the past seven (7) years, starting with your current residency.
(Please attach a separate sheet of paper to provide additional entries)
1. **City:**_____**State:**_____**Date From:**_____**Date To:**_____
2. **City:**_____**State:**_____**Date From:**_____**Date To:**_____
3. **City:**_____**State:**_____**Date From:**_____**Date To:**_____
4. **City:**_____**State:**_____**Date From:**_____**Date To:**_____

STATE LAW NOTICES

Minnesota or **Oklahoma** applicants or employees only: Please mark an X in the designated field if you would like to receive a free copy of a consumer report if one is obtained by the Company. The report will be mailed to the current address you indicated on this form. _____
California applicants or employees only: Please mark the following field if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. The report will be mailed to the current address indicated above. _____
California applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. _____
New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Client by directly contacting PreCheck Inc. Additionally, please mark this field to receive and acknowledge receipt of a copy of Article 23-A of New York Correction Law. _____
Maine applicants or employees only: Under Chapter 210 Section 1314 of Maine Revised Statutes, you have the right, upon request, to be informed within 5 business days of such request of whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.
Massachusetts applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.
Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

I have read and understand the above information and assert that all information provided by me is true and accurate.

Signature: _____ **Date** _____

[1] The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

Nevada Private Investigator License # 1618

Travis County Healthcare District (Central Health) # 11726
DISCLOSURE & AUTHORIZATION

APPLICANT'S FULL NAME _____

Any Other Names Used _____

Social Security No. _____ /_____ / _____ Date of Birth[1]_____

Current Address _____

City _____ State _____ Zip _____

Driver's License State _____ D.L. Number _____

Address on D.L.: _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Travis County Healthcare District (Central Health) ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application for employment, contract for services, appointment, volunteering or clinical rotation. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment, contract, volunteering, privileges or appointment to the extent permitted by law.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout the term of my employment, contract or privileges, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

My present employer may be contacted for a job reference. Yes ☐ No ☐

By signing below, I confirm that I have read and understand the above information and that I provide my consent.

Signature: _____ **Date** _____

www.PreCheck.com info@precheck.com
ph: 800-999-9861 fax: (800) 207-2778

Nevada Private Investigator License # 1618

Board Member and Officer Questionnaire

CommUnityCare participates in the Medicare Program through CMS (the Centers for Medicare and Medicaid Services) and in the Texas Medicaid Program through TMHP (Texas Medicaid & Healthcare Partnership).

CMS and TMHP each have their own application that must be completed, submitted and approved in order to be issued a Medicare and Medicaid billing number for each of our healthcare centers.

As a part of the application process, we are required to list all our Board Members and Officers and to disclose information they each require by answering a series of questions. Medicare and Medicaid then each run their own background checks to make sure the information we supplied matches theirs.

CommUnityCare must supply this information each time we open a new healthcare center, revalidate our Medicare and Medicaid billing numbers, and/or to report any changes as they occur.

CommUnityCare

Centers for Medicare & Medicare Services (CMS) and Texas Medicaid & Healthcare Partnership (TMHP) Information Disclosure Form

As a participation requirement in the Texas Medicaid and Medicare Programs, information regarding an organization's Officers, Directors and managing employees must be disclosed at time of application or revalidation. Please read and complete the form below.

This form is broken into 2 sections, Section I is a Texas Medicaid & Healthcare Partnership (TMHP) requirement and Section II is a Centers for Medicare & Medicaid Services (CMS) requirement.

Last Name:		First Name/Middle Name:	
Maiden Name:		List any other alias, name, or form of your name ever used:	
Social Security Number:		Date of Birth: MM/DD/YYYY	
Driver's license number:		Driver's license expiration date: MM/DD/YYYY	
Driver's license State:	Country of Birth:	Place of Birth: (State)	Gender:
			☐ Male ☐ Female

Section I: Texas Medicaid & Healthcare Partnership (TMHP)

1.	Do you have one or more professional Licenses, accreditations or certifications?	☐ Yes	☐ No
If **yes**, please provide: (use back of this page if more space is needed) **Issuer:** _____ **Number:** _____ **Issue Date:** _____ **Expiration Date:** _____ **List any additional licenses here:** _____			
2.	**"Sanction"** is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action. Have you ever been sanctioned in any State or Federal program?	☐ Yes	☐ No
If **yes**, please provide: (use back of this page if more space is needed) **Date:** _____ **State Occurred:** _____ **Agency Taking Action:** _____ **Program Affected:** _____ **Details:** _____ _____ _____			

CommUnityCare

Centers for Medicare & Medicare Services (CMS) and Texas Medicaid & Healthcare Partnership (TMHP) Information Disclosure Form

3.	Presently, or have you ever had your professional license, certification or accreditation revoked, suspended or otherwise restricted?	☐ Yes	☐ No
4.	Are you currently, or have you ever been, subject to a licensing, certification or accreditation board order?	☐ Yes	☐ No
5.	Have you voluntarily surrendered your professional license, certification or accreditation in lieu of disciplinary action?	☐ Yes	☐ No

If **yes, to 3, 4 or 5**, please provide: (use back of this page if more space is needed)

Date: _____ **State Occurred:** _____

Name of Board or Agency: _____ **Adverse Action:** _____

Details: _____

_____

_____

6.	Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐ Yes	☐ No
7.	Do you currently have any outstanding debt in relation to any State or Federally funded programs?	☐ Yes	☐ No

If **yes, to 6 or 7**, please provide: (use back of this page if more space is needed)

Date: _____ **State Occurred:** _____

Name of Board or Agency: _____

Details: _____

_____

_____

	"Convicted" means that: (a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether: (1) There is a post-trial motion or an appeal pending, or (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed; (b) A Federal, State or local court has made a finding of guilt against an individual or entity; (c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or (d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.		

CommUnityCare

Centers for Medicare & Medicare Services (CMS) and Texas Medicaid & Healthcare Partnership (TMHP) Information Disclosure Form

8.	Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?	☐ Yes	☐ No
If **yes,** please provide: (use back of this page if more space is needed) **Date:** _____ **State/County Occurred:** _____ **Cause Number:** _____ **Convicted of (specifically):** _____ **Details:** _____ _____ _____ _____ _____			
9.	Have you been arrested for a crime but not yet charged or is there an outstanding warrant for your arrest?	☐ Yes	☐ No
If **yes,** please provide: (use back of this page if more space is needed) **Date:** _____ **State/County Occurred:** _____ **Cause Number:** _____ **Convicted of (specifically):** _____ **Details:** _____ _____ _____ _____ _____			
10.	Are you currently subject to court ordered child support payments?	☐ Yes	☐ No
If **yes**, please provide the details. (use back of this page if more space is needed)			
11.	Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes	☐ No
If **yes**, please provide details of how these past due payment obligations will be met. (use back of this page if more space is needed)			
12.	Are you a citizen of the United States?	☐ Yes	☐ No
If **no**, please provide the country of which you are a citizen.			
13.	If you are not a citizen of the United States, do you have a legal right to work in the United States?	☐ Yes	☐ No
If **yes**, please provide a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.			

CommUnityCare

Centers for Medicare & Medicare Services (CMS) and Texas Medicaid & Healthcare Partnership (TMHP) Information Disclosure Form

Section II Centers for Medicare & Medicaid Services (CMS)

Please read the definition provided below by CMS and answer the following question(s).

Final Adverse Legal Actions/Convictions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, director, officer, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

CommUnityCare

Centers for Medicare & Medicare Services (CMS) and Texas Medicaid & Healthcare Partnership (TMHP) Information Disclosure Form

Questions:

1. Have you, under any current or former name or business identity, ever had a final adverse action listed on page 4?

☐ Yes–Continue below	☐ No- Form Complete, no further action needed

2. If yes, report each final adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse action documentation and resolution.

Final Adverse Legal Action	Date	Taken By	Resolution