

Practice Disclosure Statement

CMAA Name: Children's Mercy -- _____

Date of Board Meeting _____

Practice provides the following information to Children's Mercy Hospital's Compliance Department pursuant to the compliance requirements outlined in the Affiliation Agreement between CMH and Practice **for the quarter immediately preceding the current quarter and year provided above.**

1. Did Practice purchase services or goods from staff or family members of staff? Yes No
If yes, complete the following:

Services / Goods	Staff / Family Member	Date	Amount Paid
Accounting			
Billing			
Legal			
Other:			
Other:			

2. Did Practice or any Practice Physician receive gifts from vendors or sales representatives? Yes No If yes, complete the following:

Vendor Name	Date	Gift	Gift Value (Approx.)

3. Do any Practice Physicians perform clinical research? Yes No If yes, please specify what type of research is conducted and a brief description of the relationship with the research entity.

4. Have all Practice compliance educational and training requirements been met? Yes No
If not, what requirements still need to be completed?
5. Are all Business Associate Agreements (BAAs) up to date? Yes No If not, please specify which ones need to be updated.
6. Has the Employee Manual for the Practice changed? Yes No If yes, what changes have been made?
7. How many Hotline calls were received regarding potential Practice compliance issues? _____
Please explain the reason for each call.
8. Are you aware of any privacy breaches or other compliance issues? Yes No
If yes, please explain what they were and how they were resolved.
9. Were any external audits performed on the Practice or its Physicians? Yes No
If yes, please provide auditing entity, date, scope and findings.
10. Have any high risk areas been identified since the last quarterly compliance report?
 Yes No If yes, please specify.

11. Is the Practice in compliance with the Payment Card Industry Data Security Standard (PCI DSS)?
 Yes No If not, please explain.
12. Has the Practice replaced or terminated any of its service vendors? Yes No If yes, please list.
13. Did the Practice, or does the Practice intend to, accept patients covered by Medicaid, Medicare, CHAMPUS, TRICARE, or any other federal or state program? Yes No If yes, please list.
14. Do any Practice Physicians perform professional services outside of the Practice?
 Yes No If yes, please provide Practice Physician's name(s) and describe such services.
15. Please list any additional information Practice identifies as necessary to provide to the Children's Mercy Hospital's Compliance Department below.

CERTIFICATION

I certify that the information set forth on this Practice Disclosure Statement is complete and accurate to the best of my knowledge.

Please provide a contact email or phone number in the event that the Children's Mercy Hospital Corporate Compliance Office requires clarification regarding the above disclosures.

Practice Administrator Signature

Date

Practice Administrator Printed Name

Practice Administrator Email

Practice Administrator Phone

Once completed, please email to mjessick@cmpcn.org.