Children's Mercy Affiliated Practices

Practice Disclosure Statement

CMAP 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.

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 kbrown@cmh.edu & mjessick@cmpcn.org.