Colleen Golin

From: Jennifer Uberti
Sent: Friday, June 08, 2018 12:00 PM
To: Colleen Golin
Subject: FW: Emailing - DisclosureApplication DRAFT.pdf
Attachments: DisclosureApplication DRAFT.pdf

Thanks,

Jennifer Uberti

Assistant Admin. Supervisor of Social Work
Ocean County Board of Social Services
609-242-6101

From: Poulos, Andrew [Andrew.Poulos@osc.nj.gov]
Sent: Thursday, July 27, 2017 3:01 PM
To: Jennifer Uberti
Subject: Emailing - DisclosureApplication DRAFT.pdf

STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION
P.O. BOX 025
TRENTON, NJ 08625

APPLICATION FOR RECIPIENT VOLUNTARY DISCLOSURE PROGRAM

PART I. Recipient Information

HEAD OF HOUSEHOLD. LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY NUMBER
SPOUSE. LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY NUMBER
HOME ADDRESS (NUMBER, STREET, UNIT, APT)	DAYTIME TELEPHONE NUMBER
CITY, STATE AND ZIP CODE	EMAIL ADDRESS

PART II. Designation of Representative (If you are represented by an attorney)

ATTORNEY NAME	NAME OF FIRM	
TELEPHONE NUMBER	ALTERNATE TELEPHONE NUMBER	FAX NUMBER
BUSINESS ADDRESS	EMAIL ADDRESS	
CITY, STATE AND ZIP CODE	LICENSED TO PRACTICE IN THE STATE OF NJ? ☐ YES ☐ NO	

PART III. Program(s) and Period(s) of Ineligibility Reported

☐ MEDICAID (NJ FamilyCare and related programs)

START DATE OF INELIGIBILITY _____

END DATE OF INELIGIBILITY _____

☐ SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

STATE DATE OF INELIGIBIITY _____

END DATE OF INELIGIBILITY _____

PART IV. Certification

I certify that I/we have read all of the information in the instructions section of this application and I/we are eligible for the Recipient Voluntary Disclosure Program. I/we also certify that all of the statements made on this application are true, complete and correct to the best of my/our knowledge.

_____ _____ _____ _____

Signature of Head of Household | Date | Signature of Spouse | Date

APPLICATION FOR RECIPIENT VOLUNTARY DISCLOSURE PROGRAM
INSTRUCTIONS

GENERAL INFORMATION

WHAT IS THE RECIPIENT VOLUNTARY DISCLOSURE PROGRAM?

The program encourages Medicaid and Supplemental Nutrition Assistance Program (SNAP) recipients who have failed to disclose income, accurate residency, or accurate household composition to repay the State for the Medicaid and SNAP benefits they improperly received without fear of criminal prosecution for benefits fraud. The program is being offered as a "pilot program" in Ocean County.

WHO IS ELIGIBLE?

You are eligible for this program if:

- You are a resident of Ocean County.
- You are not currently under investigation by the Medicaid Fraud Division, the Ocean County Prosecutor's Office, the Ocean County Board of Social Services, or the NJ Department of the Treasury – Office of Criminal Investigation.
- You have not previously entered into a settlement agreement with the Medicaid Fraud Division.

HOW DO I APPLY FOR THE PROGRAM?

To apply for the Voluntary Disclosure Program, you must complete this application and either send it by electronic mail it to:

disclosure@osc.nj.gov

Or, you can send it by mail to:

Office of the State Comptroller
Medicaid Fraud Division
Recipient Voluntary Disclosure Program
P.O. Box 025
Trenton, NJ 08625

If you have retained an attorney to represent you, the attorney can submit the application on your behalf. We cannot communicate with an attorney regarding your application if he or she is not designated on the application form.

HOW CAN I OBTAIN ADDITIONAL INFORMATION?

You can make inquiries regarding the Voluntary Disclosure Program by email to: **disclosure@osc.nj.gov,** or by calling **(609) 789-5110**.

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

PART I

Make sure that all information is complete and accurate. Failure to include complete and accurate information may delay processing or disqualify you from participating in this Voluntary Disclosure Program.

PART II

If you have retained an attorney as your representative, you must complete this section. If you do not designate an attorney on the application form, we will be unable to correspond with anyone other than you regarding your application. Only a New Jersey licensed attorney can be designated as a representative.

PART III

You must indicate what program(s) you believe that you improperly received benefits from and the dates that you belief you were ineligible to receive benefits.

PART IV

The application must be signed by you (and your spouse if you are married). Applications that are received without the appropriate signature(s) will not be processed.

ADDITIONAL INFORMATION

WHAT HAPPENS ONCE I APPLY FOR THE PROGRAM?

After you submit a complete application, it will be processed. You may be contacted for additional information. Once the review is complete, you will be contacted to schedule an appointment for a face-to-face review. During the review you will be advised of the total amount owed to the State for Medicaid and/or SNAP benefits improperly received.

CIVIL PENALTY RELATED TO MEDICAID BENEFITS

In addition to repaying for Medicaid benefits, you will be assessed a civil penalty. This civil penalty will only apply to Medicaid benefits, not SNAP. The civil penalty will be based on the following chart:

Total Benefits Received	Civil Penalty
$0 to $50,000	$1,000
$50,001 to $75,000	$2,000
$75,001 to $125,000	$3,000
$125,001 to $150,000	$4,000
$150,001 to $175,000	$5,000
$175,001 to $200,000	$6,000
$200,001 and up	$7,000 to $10,000

REQUIRED TERMINATION OF BENEFITS

In addition to repaying the amount of Medicaid and/or SNAP benefits improperly received and the appropriate civil penalty (Medicaid only), the head of household, and his or her spouse (if applicable), must agree to the termination of his or her Medicaid and/or SNAP benefits for a period of one year from the date of signing the settlement agreement (for active Medicaid and SNAP recipients), or agree not to apply for benefits for a period of one year (if not an active recipient). This will only apply to the head of household and his or her spouse (if applicable). You are still eligible to continue benefits or apply for benefits for your dependent children providing you meet the applicable eligibility guidelines.

DISCLOSURE TO THE NJ DEPARTMENT OF THE TREASURY AND SOCIAL SECURITY ADMINISTRATION

The information you disclose as part of this Recipient Voluntary Disclosure Program and the terms of your settlement agreement will be provided to the NJ Department of the Treasury and the Social Security Administration (if you or a member of your family is a SSI recipient). You may be contacted by a representative of that agency in order to determine if you owe any back taxes, penalties, or overpayments (SSI only).

NOTICE

ALL OF THE INFORMATION DISCLOSED ON THIS FORM IS PROTECTED FROM PUBLIC DISCLOSURE PURSUANT TO N.J.A.C. §10:49-9.7 *et seq.* AND N.J.A.C. §10:87-1.14 *et seq.*