Colleen Golin

From: Jennifer Uberti
Sent: Friday, June 08, 2018 12:02 PM
To: Colleen Golin
Subject: FW: Voluntary Disclosure Program
Attachments: DisclosureApplication_Fillable.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 13, 2017 10:41 AM
To: Linda Murtagh (Director)
Cc: Jennifer Uberti
Subject: Voluntary Disclosure Program

Linda:

Attached is the application that we spoke about yesterday. Please review with your staff and let me know if you have any comments or concerns. I should have a sample of the settlement agreement for you next week.

Thanks.

Andrew

Andrew Poulos, Jr.
Supervising Investigator
State of New Jersey
Office of the State Comptroller
Medicaid Fraud Division
P.O. Box 025
Trenton, NJ 08625-0025
Phone: (609) 789-5081
Fax: (609) 826-4802
Email: andrew.poulos@osc.nj.gov

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 Information (Indicate which program and time period)

Medicaid (NJ FamilyCare and All Other Programs) Start Date _____ End Date _____

Supplemental Nutrition Assistance Program (SNAP) Start Date _____ End Date _____

PART IV. Detailed Description of Reason for Applying to Program (Use Continuation Page if needed)

PART V. 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. 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 mail it to:

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

Or, you can scan and submit your application by email to: **disclosure@osc.nj.gov**.

If you have retained an attorney to handle your application, 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.

WHERE CAN I GET ADDITIONAL INFORMATION REGARDING THE PROGRAM?

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

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

PART I

Make sure that all information is complete. If you are married, you must include your spouse's information. It is very important that you provide us with an accurate address, telephone number and email address.

PART II

If you have retained an attorney to assist you with the application process, you must complete this section. If you do not designate an attorney on the application form, we will be unable to correspond with an attorney regarding your application. Only attorneys can be designated as a representative.

PART III

You must indicate what program(s) you received benefits from and the estimated dates that you received the benefits. The dates can be estimated since we will be obtaining the actual information from applicable State information system.

PART IV

You must provide a detailed description of the reasons you are applying for the Voluntary Disclosure Program. The explanation must include an explanation of the information that was not disclosed in your applications for Medicaid or SNAP (e.g. income, marital status, residency, etc,). If you failed to disclose income, you must provide a description of the source of the income that was not reported and the total amount not reported broken down by year. Please use the continuation page as needed.

If you do not wish to provide a detailed explanation, your application will still be processed, however, the total amount owed will be based on the total amount of benefits you and your family received for up to 5 years.

PART V

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?

Once we receive a completed application it will be assigned to a member of our staff to review. 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 SNAP benefits improperly received.

CIVIL PENALTY RELATED TO MEDICAID BENEFITS

In addition to repaying the actual amount of Medicaid benefits you received (parents or for entire family) you will be assessed a civil penalty. This civil penalty will only apply to Medicaid benefits, not SNAP. The civil penalty to be assessed 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 SNAP benefits improperly received and the civil penalty (for 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 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 eligibility guidelines.

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

The information you disclose 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 will be contacted by a representative of that agency in order to determine if you owe any overpayments, back taxes and penalties.

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.*

CONTINUATION PAGE