PRIMARY HEALTH CARE PROGRAM CERTIFICATION

This certification pertains to the following Primary Health Care Program (PHC) provider:

Provider Name _____

Federal Tax ID Number _____

NPI Number _____

Provider's primary billing address:

Street Address _____

Street Address City/State/Zip Code _____

Telephone Number _____

Provider's primary physical address:

Street Address _____

Street Address City/State/Zip Code _____

Telephone Number _____

DEFINITIONS

For the purposes of this certification the following terms are defined as follows:

The term *"affiliate"* means:
An individual or entity that has a legal relationship with another entity, which relationship is created or governed by at least one written instrument that demonstrates:

1. **common ownership, management, or control;**
2. **a franchise; or**
3. **the granting or extension of a license or other agreement that authorizes the affiliate to use the other entity's brand name, trademark, service mark, or other registered identification mark.**

The "written instruments" referenced above may include a certificate of formation, a franchise agreement, standards of affiliation, bylaws, or a license, but do not include agreements related to a physician's participation in a physician group practice, such as a hospital group agreement, staffing agreement, management agreement, or collaborative practice agreement.

The term *"promote"* means advancing, furthering, advocating, or popularizing elective abortion by, for example:

1. **taking affirmative action to secure elective abortion services for a PHC client (such as making an appointment, obtaining consent for the elective abortion, arranging for transportation, negotiating a reduction in an elective abortion provider fee, or arranging or scheduling an elective abortion procedure); however, the term does not include providing upon the patient's request neutral, factual information and nondirective counseling, including the name, address, telephone number, and other relevant information about a provider;**
2. **furnishing or displaying to a PHC client information that publicizes or advertises an elective abortion service or provider; or**
3. **using, displaying, or operating under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.**

My name is _____. I am the provider or, if the provider is an organization, I am the provider's (title or position)_____. I am of sound mind, capable of making this certification, and I am personally acquainted with the facts stated here. If I am representing an organizational provider, I am authorized to make this certification on the provider's behalf. Throughout the remainder of this document, the word "I" will represent the individual provider that is completing this form or the organizational provider on whose behalf the form is being completed. If this form is being completed on behalf of an organizational provider, the word "I" is inclusive of the organization, owners, officers, employees, and volunteers, or any combination of these.

The Department of State Health Services Primary Health Care Program shall not contract with providers that would be ineligible to participate in the Texas Women's Health Program at the Health and Human Services Commission. I understand that the Texas Legislature has specified that Primary Health Care Program funds may be used to compensate only providers that satisfy the eligibility requirements for the Texas Women's Health Program (TWHP). Accordingly, consistent with the legislative requirement found under Article II, Rider 63 (relating to the Primary Health Care Program) of the General Appropriations Act for State Fiscal Years 2016 and 2017 (H.B. 1, 84th Legislature, Regular Session, 2015, art. II, at II-63), and with the relevant TWHP statute and rules (Texas Human Resources Code, Section 32.024(c-1) and Title 25 of the Texas Administrative Code, Sections 39.33 and 39.38), I understand that I am not qualified to participate in the PHC program or to bill the program for services if I, or any of my organization's subcontractors, perform or promote elective abortions or if I, or any of my organization's subcontractors, are an affiliate of an entity that performs or promotes elective abortions.

By checking the boxes under each statement below, I affirm that each of the following statements is true. I understand that my failure to mark each of the statements will be regarded as my representation that the statement is false:

1. I do not, nor do any of my organization's subcontractors, perform or promote elective abortions outside the scope of the PHC.

   ❒ I affirm that this statement is true and correct.

2. I am not, nor are any of my organization's subcontractors, an affiliate of an entity that performs or promotes elective abortions.

   ❒ I affirm that this statement is true and correct.

3. In offering or performing a PHC service, I do not, nor do any of my organization's subcontractors, promote elective abortions within the scope of the PHC.

   ❒ I affirm that this statement is true and correct.

4. In offering or performing a PHC service, I, as well as my organization's subcontractors, maintain physical and financial separation between any PHC activities and any elective abortion-performing or abortion-promoting activity, In particular:

   a. All PHC services are physically separated from any elective abortion activities, no matter what entity is responsible for the activities;
   b. The governing board or other body that controls me, or any of my organization's subcontractors, does not have any board members who are also members of the governing board of an entity that performs or promotes elective abortions;
   c. None of the funds that I, or any my organization's subcontractors, receive for performing PHC services are used to directly or indirectly support the performance or promotion of elective abortions by an affiliate, and my, and any of my organization's subcontractors', accounting records confirm this;
   d. I do not, nor do any of my organization's subcontractors, display any signs or materials that promote elective abortion at any locations or in any public electronic communications.

   ❒ I affirm that this statement is true and correct.

5. I do not, nor do any of my organization's subcontractors, use, display, or operate under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.

   ❒ I affirm that this statement is true and correct.

In addition, I understand and acknowledge that:

- If I fail to complete and submit this certification, I will be disqualified from the PHC program and the Texas Department of State Health Services (DSHS) or its designee (henceforth, "DSHS") will deny any claims I submit for PHC services.
- If, after I submit this signed certification, I, or any my organization's subcontractors, perform, agree to perform, or promote elective abortions, or I, or any my organization's subcontractors, affiliate or agree to affiliate with an entity that performs or promotes elective abortions, I will notify DSHS at least 30 calendar days before I, or any of my organization's subcontractors, perform or promote an elective abortion or affiliate with an entity that does so. If I fail to notify DSHS as required, I will be disqualified from the PHC program and DSHS will deny any claims I submit for PHC services.

- If, while participating in the PHC program, I, or any of my organization's subcontractors, perform or promote an elective abortion, I will be disqualified from the PHC program, and DSHS will deny any claims I submit for PHC services.
- If I submit this certification and agree to its terms, but DSHS determines that I am in fact ineligible to participate in the PHC program, DSHS may place a payment hold on claims submitted by me or my organization for PHC services until DSHS can make a final determination regarding my eligibility.
- If DSHS determines that I am ineligible to receive funds under the PHC program:

  a) DSHS may recoup PHC funds paid on claims that I have incurred since the date the provider became ineligible;

  b) DSHS will deny all PHC claims that I have submitted since the date of ineligibility; and

  c) I will remain ineligible to participate in the PHC program until I comply with Texas Human Resources Code Section 32.024(c-1) and Title 25 of the Texas Administrative Code, Sections 39.33 and 39.38.
- If I knowingly make a false statement or misrepresentation on this certification, DSHS may consider me to have committed fraud or tampered with a government record under the laws of Texas, and I may be excluded from participation in the PHC program.

I also understand that, to enable DSHS to verify my or my organization's eligibility to participate in the PHC program, I must complete and return this certification form to DSHS at the following addresses:

Texas Department of State Health Services
Division of Family and Community Health Services
ATTN: Contract Development & Support Branch
P.O. Box 149347
Mail Code 1914
Austin, TX 78720-0795

Or, by E-mail to:
CDSB@dshs.state.tx.us

If statements 1 – 5 are all marked "true," indicate the effective dates of your certification as follows: (The effective date of the Certification spans from the date of form completion through the end of the Certification year.)

Effective Date of Certification_____through 8/31/2017.

Note: *Each provider must complete a new certification annually and provide it to DSHS prior to execution of a contract for PHC services. The certification form will be provided to contractors as a part of the annual contracting packet.*

If any of statements 1 – 5 are not true, you must request an immediate termination of your PHC certification:

❒ Terminate PHC certification

Signature: _____

Printed Name: _____

Title: _____

Date: _____