



John C. Lincoln

HEALTH NETWORK

Dear Allied Health Professional:

Thank you for your interest in applying to John C. Lincoln Health Network Allied Health Professional Staff. The Medical Staffs bylaws, rules and regulation, as well as department rules and regulations are available online for your review at www.jcl.com/credentialing. Also enclosed are the following for you to complete and return:

- ◆ Application
- ◆ Identity verification
- ◆ Invoice for non-refundable application fee
- ◆ Release and immunity statement
- ◆ Privilege delineation form (**print from website**)
- ◆ Applicable job scope/description
- ◆ Physician sponsor agreement form (**1 for each physician on staff you will be working with**)
- ◆ CME related to your specialty, for past 2 years (**attach copies of supporting documentation**)
- ◆ Photo request form (**required & must meet criteria**)
- ◆ TB Test Written Results or Chest X-ray results (within 24 mo)
- ◆ NPI form
- ◆ Background Check request form and Release

Please attach copies of the following documents

- ◆ Curriculum Vitae
- ◆ AZ license, wallet size (*if applicable*)
- ◆ PA's must provide a copy of the Licensing boards approval of his/her preceptor
- ◆ DEA certificate (*if applicable*)
- ◆ Malpractice Insurance Certificate (\$1million minimum with approved carrier)
- ◆ Board Certification certificate

PLEASE BE ADVISED THAT DATES & SIGNATURES ARE ONLY VALID FOR NINETY (90) DAYS.

If you have any questions, please feel free to contact the Credentialing office at 623-434-6104. Again, thank you for your interest in John C. Lincoln Network hospitals and we look forward to working with you.

Enclosures



**** FIRST NOTICE ****

IDENTITY VERIFICATION/ID BADGE

John C Lincoln Health Network is requiring all new applicants requesting privileges to provide positive identity verification.

Prior to an applicant's first day of practice in the Hospital, each applicant shall present to the Medical Staff Services office (at either campus) to verify his/her identity and present a legible government issued ID card (current driver's license; military card or passport) or a federal/state government ID with a current photo.

In addition, JCL has instituted a policy requiring all practitioners with approved privileges to be issued photo ID badges which are to be worn when on either campus for security and patient safety purposes. You can have your photo taken for your ID badge at the same time you come in to do your identity verification.

****Please be advised that in accordance with Medical Staff Bylaws Article (6) six, failure to verify identity within 90 days of notification or prior to practicing in the Hospital (which ever comes first) will result in the automatic termination of your privileges.**

If you have any questions, please call either Medical Staff Services Department:

John C. Lincoln North Mountain
250 East Dunlap Avenue
Phoenix, AZ 85020
(602) 870-6317

John C. Lincoln Deer Valley
19829 North 27th Avenue
Phoenix, AZ 85027
(623) 879-5409

APPLICATION FOR ALLIED HEALTH MEMBERSHIP
 () North Mountain () Deer Valley

Name: _____ Degree: _____ DOB: _____ Place of Birth _____

List other names used: _____ Citizenship _____

Specialty: _____ Social Sec #: _____

Home Address _____

Home Phone: _____ City _____ State _____ Zip _____
 Name of Spouse: _____

I. Current/Pending Practice Information

Name of **current** practice group or professional corporation: _____

Dates of Affiliation (or anticipated start date): From: _____ To: _____

Address: _____ City: _____ State: _____ Zip _____

Phone Number: _____ Fax Number: _____

Cell Phone Number: _____ Pager Number: _____

e-mail address: _____

Name(s) of Sponsoring Physician/Employer: _____

II. Practice History (Please list all positions held for the past 10 years, LEAVE NO TIME GAP UNACCOUNTED FOR. If additional space is needed, attach separate sheet)

1. Name of practice group or professional corporation: _____

Dates of Affiliation: From: _____ To: _____

Address: _____ City: _____ State: _____ Zip _____

Phone Number: _____ Fax Number: _____

2. Name of practice group or professional corporation: _____

Dates of Affiliation: From: _____ To: _____

Address: _____ City: _____ State: _____ Zip _____

Phone Number: _____ Fax Number: _____

(If additional space is needed, attach separate sheet)**

III. Education/Training (applicable to position - attach copies of degrees/certificates. If additional space is needed, attach separate sheet)

School: _____

Degree: _____ Dates attended from: _____ to: _____

Address: _____

City: _____ State: _____ Zip: _____

School: _____

Degree: _____ Dates attended from: _____ to: _____

Address: _____

City: _____ State: _____ Zip: _____

School: _____

Degree: _____ Dates attended from: _____ to: _____

Address: _____

City: _____ State: _____ Zip: _____

IV. Hospital Affiliations

1. Primary Hospital/Surgicenters utilized in the past 2 yrs: _____

2. Please list all hospitals and surgicenters at which you are or were a member of the allied health staff during the previous 10 years, or to which you are in the process of applying for allied health staff membership. Attach an additional sheet if necessary. (C)

Current

Hospital Name/City	Staff Category	Inclusive Dates	(A) Applying (P) Past
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3. Have you ever voluntarily/involuntarily withdrawn/terminated your allied health staff application/ membership or voluntarily/involuntarily experienced a limitation, reduction, or loss/denial of clinical privileges at another hospital/healthcare facility? No___ Yes___*
IF YES, PLEASE EXPLAIN: _____

4. Are you currently, or have you ever been subject to disciplinary or corrective action, such as admonition, censure, reprimand, probation, nonprovisional supervision, suspension, termination, revocation, or reduction of privileges by any allied health staff and/or healthcare organization? No___ Yes___*
IF YES, PLEASE EXPLAIN: _____

(** If additional space is needed, attach separate sheet)

V. Licensure (attach copies of current licenses)

1. List all state licenses applied for or issued (if license not issued, please state reason):

State	License #	Date Issued	Expiration Date

2. Has any license entitling you to practice your profession in any jurisdiction ever been investigated, denied, suspended, placed under stipulation, limited, revoked or been voluntarily/involuntarily relinquished or has a letter of censure or concern been issued to you? No___ Yes___*
 IF YES, PLEASE EXPLAIN:_____

3. Has your narcotics license ever been refused, suspended, limited, revoked, or voluntarily/involuntarily relinquished, or is it currently being challenged or investigated? No___ Yes___*
 IF YES, PLEASE EXPLAIN:_____

4. Are you presently being investigated by any licensing agency? No___ Yes___*
 IF YES, PLEASE EXPLAIN:_____

VI. Board Certification Status

Please provide information regarding your Board Certification status. "Qualified" means that you are considered by the applicable Board to be eligible to sit for its examinations.

Board Name	(Year Certified)	(Year Recertified)	(Expiration)	(Qualified Until)

Board Name	(Year Certified)	(Year Recertified)	(Expiration)	(Qualified Until)

VII. Health Status

1. Have you ever been hospitalized for any medical, surgical and/or psychological reasons? No___ Yes___*
 IF YES, PLEASE EXPLAIN:_____

2. Are you presently, or have you ever been dependent on or treated for alcohol or drugs? No___ Yes___*
 IF YES, PLEASE EXPLAIN:_____

3. Are you able to perform all the services and essential functions of a practitioner with the privileges you are requesting, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? Yes___ No___*
 IF NO, PLEASE EXPLAIN:_____

4. Are you currently taking medication or under any other therapy that is reasonably likely to affect your ability to perform professional or medical staff duties? No___ Yes___*
 IF YES, PLEASE EXPLAIN:_____

(** If additional space is needed, attach separate sheet)

VIII. Other Pertinent Information

1. Have you ever been charged with a crime involving alcohol or controlled substances? No___ Yes___*
IF YES, PLEASE EXPLAIN:_____
2. Have any felony and/or misdemeanor criminal charges ever been brought against you? No___ Yes___*
IF YES, PLEASE EXPLAIN:_____
3. Have you ever been suspended, sanctioned, investigated or otherwise restricted from participating in any private, federal, or state health insurance program (e.g., Medicare, Blue Cross)? No___ Yes___*
IF YES, PLEASE EXPLAIN:_____

IX. Professional Liability Insurance (attach copy of current certificate)

Please list current professional liability insurance information and list ALL policies under which you've been covered for the previous 10 years.

Name of Policyholder:_____ Policy #:_____

Name of Insurance Carrier:_____

Mailing Address:_____

Phone Number:_____ Fax Number:_____ City State Zip

Dates of coverage: From:_____ To:_____ Retro Date: _____

PRIOR CARRIER: (for additional carriers, please copy this section for each carrier)

Name of Policyholder:_____ Policy #:_____

Name of Insurance Carrier:_____

Mailing Address:_____

Phone Number:_____ Fax Number:_____ City State Zip

Dates of coverage: From:_____ To:_____

1. Have there ever been, or are there currently pending, any malpractice claims, suits, settlements, judgements, arbitration proceedings or complaints involving your professional practice? No___ Yes___*

* If **YES**, you must complete the attached "Confidential Information Report" below for **EACH** claim, suit, settlement, or judgement. (If more than one, please copy the Information Report for each.)

2. Does your malpractice coverage exclude you from providing any specific procedures or practicing any portions of your specialty? No___ Yes___*
IF YES, PLEASE EXPLAIN:_____

2. Has your malpractice insurance been canceled or denied by any carrier? No___ Yes___*
IF YES, PLEASE EXPLAIN:_____

(** If additional space is needed, attach separate sheet)

X. Peer Review & Competency References)

In support of my application for clinical activities at John C. Lincoln North Mountain Hospital and/or John C. Lincoln Deer Valley Hospital, I submit the following names of four peer references (no relatives, or current/pending employers or associates) who can attest to my current competency.

A peer is considered someone in the same specialty, example: a Physician Assistant would provide names of other Physician Assistants, Nurse Practitioners would provide names of other Nurse Practitioners, etc. The peer reference must address your training or experience, clinical competence, and ability to perform the privileges requested.

PLEASE INCLUDE FAX NUMBERS TO EXPEDITE THE PROCESS

Name: _____ **Specialty:** _____

Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

***Phone:** _____ ***Fax:** _____

Name: _____ **Specialty:** _____

Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

***Phone:** _____ ***Fax:** _____

Name: _____ **Specialty:** _____

Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

***Phone:** _____ ***Fax:** _____

Name: _____ **Specialty:** _____

Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

***Phone:** _____ ***Fax:** _____

***Indicates required information**



CONFIDENTIAL INFORMATION REPORT
 (Pursuant to A.R.S. 36-445.01)

If you answered "yes" to question 1 under Section IX, you must furnish the following information regarding each lawsuit or complaint. Attach copies of all documentation relating to each case. You may choose to have your attorney complete this form, but it is your responsibility to provide additional documentation.

 Mo/Yr of Incident Where Incident Occurred Name of Plaintiff(s)

Nature of Incident: _____

Outcome of Incident:

Dropped _____ Dismissed _____ Pending _____ Settled _____ Amount \$ _____

Verdict: for You _____ For Plaintiff _____ Amount \$ _____

Recommendation by Legal Panel:

For You _____ For Plaintiff _____ Not Presented to Panel _____

Represented by legal counsel for this claim/malpractice lawsuit? Yes _____ No _____

Name of Insurance Company that provided coverage for this claim:

Insurance Company: _____

Address & Telephone Number _____

 Signature

 Date

 Name (please print)

Additional information may be provided on a separate sheet.

JOHN C. LINCOLN HEALTH NETWORK

**INVOICE APPLICATION FEE
FOR ALLIED HEALTH**

Please make check payable to:

John C. Lincoln Hospital

BOTH NORTH MOUNTAIN & DEER VALLEY HOSPITALS ALLIED HEALTH PROFESSIONAL
\$435.00

NORTH MOUNTAIN ONLY ALLIED HEALTH PROFESSIONAL	DEER VALLEY ONLY ALLIED HEALTH PROFESSIONAL
\$335.00	\$300.00

NETWORK PEDIATRIC ALLIED HEALTH PROFESSIONAL
\$300.00

NOTE: The application fee must accompany the pre-application questionnaire. If payment is not received, your questionnaire will not be processed. This application fee is non-refundable unless qualifications for membership are not met. If you are applying for both North Mountain and Deer Valley both fees apply. One check can be submitted. If you have any questions, please call (623) 434-6104.

John C. Lincoln Health Network Hospitals

ALLIED HEALTH PROFESSIONAL

RELEASE AND IMMUNITY STATEMENT

In making application to the Allied Health Professional Staff of one or more of the John C. Lincoln Health Network Hospitals, I state that the foregoing information is complete and accurate to the best of my knowledge and belief. I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or reappointment and/or cause for summary dismissal from the Allied Health Professional Staff.

In making this application for Appointment or Reappointment to the Allied Health Professional Staff of these Hospitals, I acknowledge that I have received the respective Bylaws and Departmental Rules and Regulations; and that I shall abide by and agree to be bound by the terms thereof if I am appointed.

By applying for Appointment or Reappointment to the Allied Health Professional Staff, I hereby authorize the John C. Lincoln Health Network Hospitals and their Allied Health Professional Staff and representatives to consult with representatives and members of the Medical Staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, health status and ethical qualifications. I hereby further authorize and consent to the inspection or duplication by - and - in the release to the Hospitals, their Medical Staffs and their representatives of all records and documents including medical records at other hospitals that may be material to an evaluation of my professional qualifications and competence to carry out the clinical activities requested, as well as my moral and ethical qualifications for staff membership.

I hereby release from liability all representatives of the John C. Lincoln Health Network Hospitals and their Medical Staffs for their acts performed in connection with evaluating my application and my credentials and qualifications. I hereby release from any liability any and all individuals and organizations who provide information to the John C. Lincoln Health Network Hospitals or their Medical Staffs concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical activities, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by the John C. Lincoln Health Network Hospitals, or their Medical Staffs to other hospitals, medical associations or third party payors with established credentialing mechanisms upon request regarding any information the Hospitals or their Medical Staffs may have concerning me. I hereby release from liability and hereby grant and extend absolute immunity to the John C. Lincoln Health Network Hospitals and their Medical Staffs and all of their representatives for so doing.

I understand and agree that information involving my membership, clinical activities, competence, character, health status and ethical qualifications, including privileged and confidential peer review information, will be shared by and between the John C. Lincoln Health Network Hospitals during the appointment and reappointment process and at any time thereafter including immediately upon the imposition of a summary suspension of my Allied Health clinical activities at one or both Hospitals.

I understand and agree that I, as an applicant for Appointment or Reappointment to the Allied Health Professional Staff, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications for continued Allied Health Professional staff membership and clinical activities and for resolving any doubts about such qualifications.

In addition, I agree to notify the Chief Executive Officer, in writing, within sixty (60) days of my receipt of notice of any lawsuit or claim concerning my professional care or treatment of a patient, or of any circumstances arising subsequent to the date of this application which would change any of the responses I have provided herein.

The authorizations, comments and releases granted herein shall continue in full force and effect and shall survive not only the application process for appointment and reappointment to the Allied Health Professional Staff of the Hospitals, but also the denial, duration and termination of my appointment to such Allied Health Professional Staff

Dated this _____ day of _____, 20_____.

Printed Name

Signature

JOHN C. LINCOLN HEALTH NETWORK
JOHN C. LINCOLN HOSPITAL – NORTH MOUNTAIN
JOHN C. LINCOLN HOSPITAL – DEER VALLEY

**STATEMENT OF THE PHYSICIAN WHO EMPLOYS, SUPERVISES,
COLLABORATES, OR SPONSORS THE ALLIED HEALTH PROFESSIONAL**

(I hereby) request that _____ (“AHP”) be granted permission to perform clinical activities and assist with procedures (“services”) in accordance with the accepted scope of practice for AHP’s category of practice.

I am familiar with AHP’s qualifications, character, competence, and health status and believe that he/she is qualified to provide the Services requested. I further agree to supervise, to the extent the law requires AHP to be supervised, and to assume responsibility for supervising AHP, as set forth in the attached scope of practice.

As a responsible physician, I will provide Medical Liability Insurance: Yes_____ No _____

If yes, medical malpractice insurance coverage is provided by: _____ (“Carrier”).

I agree to notify John C. Lincoln North Mountain or Deer Valley Hospital immediately upon notification from carrier of any change that may affect the coverage provided to AHP or me, or if any change occurs that would affect the Carrier.

I further agree to notify John C. Lincoln North Mountain or Deer Valley Hospital immediately, in writing, if my professional relationship with AHP is terminated or otherwise restricted in any way, and the reasons for such.

I am currently a member in good standing of the Medical Staff of John C. Lincoln North Mountain and/or Deer Valley Hospital. Any suspension or termination, temporary or permanent, of my membership or privileges at John C. Lincoln North Mountain or Deer Valley Hospital shall result in the suspension or termination of AHP’s clinical activities at John C. Lincoln North Mountain or Deer Valley Hospital.

Physician (Please Print)

Physician Signature

Date

JOHN C. LINCOLN HEALTH NETWORK
JOHN C. LINCOLN HOSPITAL – NORTH MOUNTAIN
JOHN C. LINCOLN HOSPITAL – DEER VALLEY

STATEMENT OF ALLIED HEALTH PROFESSIONAL

In consideration for my being granted permission to perform certain clinical activities and to assist with certain procedures in John C. Lincoln – North Mountain or Deer Valley (the “Hospital”), I hereby agree that I will not perform any clinical activities or assist with any procedures in the Hospital without proper medical supervision or direction by a physician on the Hospital’s Medical Staff with appropriate privileges. I further agree not to perform any clinical activities or assist with any procedures which are beyond the scope of my training, experience, licensure/certification or the activities or procedures which I have been given permission to perform in the Hospital.

I further agree to maintain medical malpractice insurance coverage covering all of my activities in the Hospital. If such coverage is provided under a policy issued in my name, rather than the name of my supervising physician, I agree to notify the Hospital immediately upon notification from my medical malpractice insurance carrier of any change that may affect the coverage provided to me, or if any change occurs that would affect the carrier.

I further agree to notify the Hospital immediately, in writing, if my professional relationship with my supervising physician is terminated or otherwise restricted in any way, and the reasons for such.

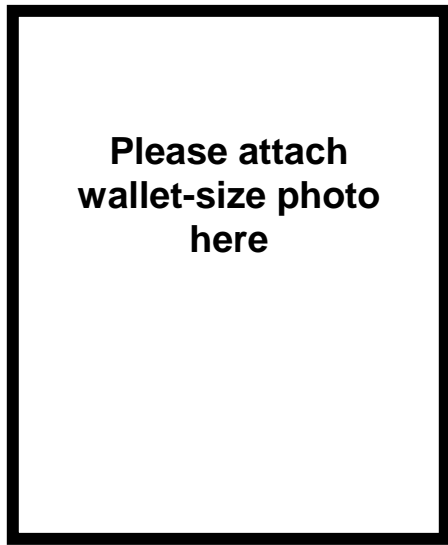
Date: _____

Allied Health Professional (Please Print)

Allied Health Professional Signature



The John C. Lincoln Health Network is requiring all applicants to provide a current wallet-size photograph for our Medical Staff data base. **This photograph MUST be black & white or colored but needs to be a GLOSSY finish.** Please do not send copies of photos, as we cannot scan these into our data base. Please feel free to call either Medical Staff Services Office if you have any questions. Deer Valley 623-879-5409/ North Mountain 602-331-5712.



NAME: _____



TO: Applicant

FROM: Timothy Kuberski, MD
Chairman, Infection Control Committee

SUBJECT: **TB SKIN TEST**

The Arizona Department of Health Services (DHS) requires each medical staff and allied health member to provide evidence of freedom from infectious pulmonary tuberculosis at least once every 24 months or more often as required by the hospital's infection control committee. This evidence of freedom from infectious pulmonary tuberculosis can be established by a current report of a TB skin test.

If a medical staff or allied health member signs this attestation and cannot produce this evidence upon request, DHS has indicated that it will report the practitioner to AMB/OBEX or the appropriate licensing board.

If you need a TB skin test done, we can assist you at JCLNMH through:

Employee Health Services	<u>Direct Dial #</u> 602-870-6332	<u>Hosp. Ext.</u> x1477
Betty Rogers, Infection Control Practitioner	602-870-6060	x1320

The test is available between 7:30 a.m. and 4:00 p.m., Monday through Friday. Please bring this form with you if you plan to receive the TB skin test at JCLNMH.

***IF you have a history of a positive TB skin test, please contact the Medical Staff office and we will provide you with a health questionnaire.**

Person receiving skin test must sign below:

I attest that I was evaluated for infectious pulmonary tuberculosis and am providing a report of a negative TB skin test dated: _____

Signature

Date

Printed Name



M E M O R A N D U M

TO: New Applicants
FROM: Medical Staff Services
RE: **NPI Number**

Effective May 23, 2007, CMS will only accept your National Provider Identifier (**NPI**) number for electronic transactions for healthcare. All practitioners must have an NPI number. All claims submitted by the hospital must have the practitioners NPI number on it.

You can apply for your NPI number beginning May 23, 2005 by submitting an online application.
(<https://nppes.cms.hhs.gov>)

Please provide your NPI number below. **PLEASE NOTE:** this is not your Social Security Number or your Tax ID Number.

NPI Number

PLEASE PRINT NAME

POLICIES AND PROCEDURES

SECTION: COMPLIANCE

Topic: Reporting & Investigating Allegations of Suspected Improper Activities

Reviewed: New (9/06)

Last Revision: _____

Approval: _____ Date: 11/06

1.0 Purpose

1.1 The Network is subject to numerous local, state and federal laws pertaining to all aspects of its operation. All employees are required to understand and abide by those laws which are applicable to them in the performance of their jobs. Additionally, all employees are required to comply with laws which prohibit health care fraud, abuse and waste. Examples of prohibited activities include, but are not limited to:

- 1.1.1 Intentionally or knowingly making false or fraudulent claims for payment or approval.
- 1.1.2 Claiming reimbursement for services that have not been rendered.
- 1.1.3 Filing duplicate claims.
- 1.1.4 "Up-coding" to more complex diagnoses or procedures than were actually performed.
- 1.1.5 Including inappropriate or inaccurate costs on Network cost reports.
- 1.1.6 Falsely indicating that a particular health care professional attended a procedure or that services were otherwise rendered in a manner they were not.
- 1.1.7 Billing for services or items that are not medically necessary.
- 1.1.8 Failing to provide medically necessary services or items.
- 1.1.9 Offering or receiving remuneration (such as a kickback, bribe or rebate) as an inducement to make a referral for the furnishing (or arranging for the furnishing) of any item or services.
- 1.1.10 Submitting false information for the purpose of gaining or retaining the right to participate in a plan or obtain reimbursement for services.
- 1.1.11 Billing excessive charges.

- 1.2 To set forth the Network's policy for detecting and preventing waste, fraud, and abuse.
- 1.3 To provide information regarding the provisions of the federal False Claims Act, the administrative remedies that could be imposed for false claims and statements, the state laws regarding penalties for false claims and statements, and the protection from reprisal, retribution, or retaliation that is available for anyone reporting suspected fraudulent activities in good faith. A description of the federal False Claims Act and its associated administrative remedies is included in the attached Exhibit.
- 1.4 To be in compliance with the provisions of Section 6032 of the Deficit Reduction Act of 2006 regarding the prevention of waste, fraud, and abuse.
- 1.5 To be in compliance with state laws regarding fraudulent activities, including the following:
 - 1.5.1 Criminal Medicaid Fraud Penalties/Felonies 13-2310; 13-2311
 - 1.5.1.1 **13-2310:** Any person who, pursuant to a scheme to defraud, knowingly obtains any benefit by fraudulent purposes is guilty of a class 2 felony.
 - 1.5.1.2 **13-2311:** Any person who, pursuant to a scheme to defraud, falsifies or covers up material fact or uses any false documents are guilty of a class 5 felony.
 - 1.5.2 Reporting Medicaid Fraud (Whistle blower protection) 23-1501; 38-531
 - 1.5.2.1 **23-1501:** The disclosure by an employee that he/she has information that his/her employer or an employee of the employer, has violated, is violating or will violate the law, to his/her supervisor or another management representative of the employer who has the authority to investigate information provided.

Employee protection from retaliatory discharge following disclosure of information regarding a violation or a potential violation of the law.
 - 1.5.2.2 **38-531:** Definition of terms, to include employee, former employee, personnel actions, etc.
 - 1.5.3 Recipient Issues (Fraud) 36-2905.04; 39-161;13-2310
 - 1.5.3.1 **136-2905.04:** A person shall not provide false or fraudulent information to the state.
 - 1.5.3.2 **13-2310:** A person who, pursuant to a scheme to defraud, knowingly obtains any benefit by means of fraudulent promises is guilty of a class 2 felony.

Scheme to defraud serves to deprive a person of intangible right of honest services.

SECTION: COMPLIANCE Policy #: C-304

Topic: Reporting & Investigating Allegations of Suspected Improper Activities Page: 19 of 20

2.0 Policy:

- 2.1 The Network does not tolerate fraud, waste, abuse or unethical behavior in conducting business and delivering services to patients and families.
- 2.2 Network employees, contractors, and agents who prepare or submit claims should be alert so as to prohibit inaccuracies and other errors on claims.
- 2.3 The Network is committed to compliance with all federal and state laws and regulations. We expect that all employees shall act in a manner which upholds the law and are accountable for ethical behavior in their job performance.
- 2.4 Any employee of the Network who has knowledge of facts concerning the organization's activities that he or she believe may violate the law has an obligation, promptly after learning such facts, to report the matter to his or her immediate supervisor; to the Director of Compliance or to the JCL Compliance Hotline at (602) 870-6060, ext 5888.
- 2.5 Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation. Every effort will be made to protect the complainant's identity.
- 2.6 Employees are encouraged to put their names to allegations because appropriate follow-up questions and investigation may not be possible unless the source of information is identified. Concerns expressed anonymously will be investigated, but consideration will be given to: (a) the seriousness of the issue raised; (b) the credibility of the concern; and (c) the likelihood of confirming the allegation from attributable sources.
- 2.7 There will be no retribution or discipline for anyone who reports a violation or suspected violation in good faith.
 - 2.7.1 Anyone filing a complaint must have reasonable grounds for believing the information disclosed indicates misconduct, dishonesty, unethical behavior, fraud or fraudulent behavior. Allegations which prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious offense and worthy of disciplinary action.
- 2.8 An employee who retaliates against someone who has reported a violation or suspected violation in good faith is subject to discipline up to an including termination of employment.
- 2.9 This policy applies to all John C. Lincoln employees, contractors, and agents.

SECTION: COMPLIANCE Policy #: C-304

Topic: Reporting & Investigating Allegations of Suspected Improper
Activities Page: 20 of 20

Exhibit 1

False Claims Act and Associated Provisions Description

The False Claims Act (the FCA) is a provision of federal law dating to the Civil War. The law was designed to prevent the submission of false or fraudulent claims to the US Government. In general, the FCA prevents the following activities:

- Knowingly presenting a false or fraudulent claim for payment by the federal government.
- Knowingly using a false record or statement to get a claim paid by the federal government.
- Conspiring with others to get a false or fraudulent claim paid by the federal government.
- Knowingly using a false record or statement to conceal, avoid, or decrease a payment due to the federal government.

Violation of the FCA can result in penalties of up to three times the amount of the federal government may have been defrauded, including civil penalties of \$5,000 to \$11,000 for each false claim.

The FCA also contains a *qui tam* provision that in some situations permits a private individual to sue those who defrauded the government and receive a percentage of any resulting recovery from the defendant.