LIBERTY DENTAL PLAN

NEW JERSEY CRIMINAL BACKGROUND CHECK ATTESTATION

Practitioner Name: _____

TIN: _____ NPI: _____

Under penalty of perjury, I hereby swear and affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in 42 CFR §438.214 and N.J.S.A. 45:1-30 et seq., which requires a criminal history background check for every person who possesses a license or certificate as a health care professional. Specifically, I attest that I maintain policies and procedures that comply with New Jersey requirements for pre-employment criminal history check and/ or background investigations on all prospective and current prospective employees, healthcare providers, and other staff members, including those who may have direct physical access to Managed Long Term Services and Supports (MLTSS) Members. In addition, I agree to immediately inform LIBERTY Dental Plan if arrested or convicted of any of the disqualifying offenses during the application process and after being accepted to the provider network as a participating provider.

By signing below, I hereby swear and affirm that: (i) my organization is in compliance with the state required criminal history background screening requirements as described above; (ii) effective, accurate, and economical criminal history check and/background investigations have been completed, and will continue to be performed, for prospective employees, providers, and other staff members, including those who may have direct physical access to MLTSS Members; and (iii) any subcontractor, employee or volunteer having direct physical access to members and a disqualifying offense are prohibited from providing services as set forth by N.J.S.A. section 3 of P.L.2002, c.104 (C.45:1-30) or section 7 P.L.1997, c.100 (C.45:11-24.3). Upon request, verification of compliance will be shared with a LIBERTY Dental Plan representative during the monitoring visit.

SIGNATURE IS REQUIRED TO AFFIRM YOU MEET STATE REQUIREMENTS:

_____ _____/_____/_____

Practitioner Signature **Date**

_____ _____

Practitioner Name **Title**

Social Security No: _____-_____-_____ **Date of Birth:** _____/_____/_____