

PROVIDER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (“AHCCCS”)
and

Provider Name:	Gila County dba: Gila County Division of Health & Emergency Services, Office of Health, Globe
SSN/Tax ID# :	86-6000444
Business Address:	5515 S. Apache Avenue, Suite 100
City/State/Zip:	Globe, AZ 85501
Email Address:	ldalrymp@co.gila.az.us

(Correspondence)

A. PURPOSE:

This Agreement between AHCCCS and the Provider is made pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 et seq. to govern: (1) the registration and payment for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor under contract with AHCCCS (“Contractor”) or who receive emergency services only, (2) the registration for a Provider to participate and deliver health care services to eligible persons who are enrolled with a Contractor, and (3) the registration of a Provider who wishes to participate and qualify under the one-time only waiver option.

Therefore, in consideration of the covenants contained in this Agreement:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, Provider is prohibited from participation in the AHCCCS system unless a provider agreement with the Administration is in effect. Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person with any Contractor if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time a claim is submitted.
2. When AHCCCS issues an amendment to modify this Agreement or to modify documents incorporated by reference as part of this Agreement, the provisions of such amendment will be deemed to have been accepted thirty (30) days after the date AHCCCS provides notice to the Provider, even if the amendment has not been signed by the Provider. If the Provider gives written notice of refusal of the amendment to AHCCCS prior to the end of the (thirty) 30 days stated above, this Agreement shall terminate.
3. Pursuant to 42 C.F.R. §447.10, payment for any service furnished to an AHCCCS eligible person by Provider will not be made to or through a factor, either directly or by power of attorney.
4. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal governments during normal business hours at the Provider’s place of business. The AHCCCS Office of Inspector General (“AHCCCS-OIG”) reserves the right to request and secure original records from Provider at Provider’s expense. The AHCCCS-OIG shall be responsible for maintaining and safeguarding the integrity of these records, and will provide Provider with sufficient time to copy records for Provider’s use.

5. The Provider shall preserve and make available the records described in Paragraph 4 above for a period of five (5) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of five (5) years from the date of any such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all applicable AHCCCS rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
6. The Provider shall comply with all federal, state and local laws, rules, regulations, standards, and executive orders governing performance of duties under this Agreement, without limitation to those designated within this Agreement.
7. The Provider shall comply with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract provisions found on the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement.
8. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract. The Provider shall obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, where applicable, shall comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify the AHCCCS Administration within twenty-four (24) hours of a termination or suspension of its license.
9. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the State, AHCCCS, its agents, officers, or employees or AHCCCS Contractors, through the intentional conduct, negligence or omission of the Provider and its agents, officers or employees.
10. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation on behalf of the Provider.
11. The Provider shall maintain for the duration of this Agreement all necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of Provider to indemnify, hold harmless and defend the State and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees.
12. Confidential and protected health information shall be safeguarded pursuant to all federal and state laws and regulations.
13. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS rules as published in the Arizona Administrative Code. The Provider agrees to waive attorneys' fees in any dispute concerning this Agreement.

14. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider, consistent with State and Federal Law, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal law, and the following documents, including amendments thereto and hereby incorporated by reference: the AHCCCS Fee-for-Service Manuals, the AHCCCS Medical Policy Manual, AHCCCS Claims Clues and other written directives provided by AHCCCS to the Provider. These documents are made available to the provider via the AHCCCS Internet website (www.azahcccs.gov) or in hard copy form.
15. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of payment shall be as set forth in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14, above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
16. Provider shall conform its billing practices to ICD9 or ICD10, whichever is in effect on date of service, CPT, HCPCS, CDT and HIPAA TCS compliance standards. Upon request, Provider shall disclose to AHCCCS which CPT and/or CDT coding guidelines Provider uses prior to any audit of Provider. Any Provider changes to its methodology shall be documented with the date of change.
17. Provider shall ensure that its Electronic Health Records System (EHR) is programmed to track and capture any changes or modifications to the electronic health record.
18. The Provider agrees to bill AHCCCS only after a potential third party payer has been billed. After payment from any potential third party payer, the Provider agrees to bill AHCCCS the balance due only up to the limit of the member's responsibility.
19. No Provider may bill with another Provider's ID number, except in locum tenens situations.
20. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS.
21. In addition to any other remedies available under this Agreement, AHCCCS shall be entitled to offset against any amounts due the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement. AHCCCS also retains the right to offset for Medicare sanctions. Provider may be held financially liable for acts committed by its independent contractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive.
22. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due the Provider, if Provider fails to comply with the rules and regulations governing the billing of AHCCCS eligible persons.
23. Pursuant to the Federal Fraud Enforcement and Recovery Act of 2009 (FERA), AHCCCS defines a "claim" for purposes of fraud enforcement and recovery to mean "a request or demand for money or property that is presented to the government, state, contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest".
24. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least \$5 million dollars must certify its compliance with Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].

25. If Provider or any employee or contractor of Provider discovers, or is made aware, that an incident of potential fraud or abuse has occurred, the Provider shall report the incident to the AHCCCS Office of Inspector General (AHCCCS OIG) in accordance with state statutes and AHCCCS policy.
26. By signing this Agreement, Provider certifies that it is in compliance with State Medicaid Director Letter (SMDL) 09-001 and has screened all its employees and contractors for persons that have been excluded from participation in Federal health care programs.
27. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States (U.S.).
28. Pursuant to Section 6402 of the Affordable Care Act of 2010, if Provider has received an overpayment, Provider shall report and return the overpayment to AHCCCS or the Contractor within 60 days of the date the overpayment was identified.
29. AHCCCS may require Provider or any employees or contractors of Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal background checks and/or fingerprint checks on Provider or any employees or contractors of Provider.
30. Provider agrees to submit, upon request by AHCCCS or the federal government, full and complete information as to ownership, business transactions, and criminal activity, all in accordance with 42 C.F.R. 455 Subpart B and State law. Provider further agrees to report to AHCCCS immediately any debarment or suspension of any its owners, managers, licensed professionals, or any other employees.
31. Upon thirty (30) days written notice, either Party may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with Federal and State laws and regulations; or there is a cancellation, termination or material modification in the Provider's qualifications to provide. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by Provider or any agent or representative of Provider to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to a contract.
32. Upon any termination of this Agreement, Provider shall assist in providing for the orderly transition of care for members assigned to the Provider.

I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

FOR AND ON BEHALF OF THE PROVIDER

FOR AND ON BEHALF OF AHCCCSA

Signature

Date

Authorization

Micheal A. Pastor

Typed Name

Date

Chairman of the Board

Title

Provider Number Assigned

Request for Taxpayer Identification Number and Certification

**Give Form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return) Gila County	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification (required): <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____	
	<input checked="" type="checkbox"/> Other (see instructions) ▶ _____	
	Address (number, street, and apt. or suite no.) 1400 East Ash Street	Requester's name and address (optional)
City, state, and ZIP code Globe, Az. 85501		
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)																			
Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3.																			
	<table border="1" style="margin: auto;"> <tr><th colspan="9">Social security number</th></tr> <tr><td> </td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>	Social security number												-					
Social security number																			
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Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.	<table border="1" style="margin: auto;"> <tr><th colspan="9">Employer identification number</th></tr> <tr><td>8</td><td>6</td><td>-</td><td>6</td><td>0</td><td>0</td><td>0</td><td>4</td><td>4</td></tr> </table>	Employer identification number									8	6	-	6	0	0	0	4	4
Employer identification number																			
8	6	-	6	0	0	0	4	4											

Part II Certification	
Under penalties of perjury, I certify that:	
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person (defined below).	
Certification Instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.	

Sign Here	Signature of U.S. person ▶ <i>Debra Savage</i>	Date ▶ <i>5-24-11</i>
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.



STATE OF ARIZONA
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROMOTING HONESTY AND INTEGRITY
OFFICE OF INSPECTOR GENERAL

Janice K. Brewer
 Governor,
 Thomas J. Betlach
 Director

Re-Enrollment Address Verification Form

(Completed W-9 Must Be Included, for each unique Tax Identification Number listed)

NAME (Last, First, M.I. or Company Name): Gila County dba: Division of Health & Emergency Services, Office of Health - Globe
 SOCIAL SECURITY NUMBER: _____ GENDER: FEMALE MALE DATE OF BIRTH: _____
 AHCCCS PROVIDER ID#: 479718 NPI # 1700941507

LIST ALL CURRENT ADDRESSES

NOTE: Form will be returned if not completed.

CORRESPONDENCE ADDRESS

STREET LINE #1: 5515 S. Apache Avenue
 STREET LINE #2: Suite 100
 CITY: Globe STATE: Arizona ZIP: 85501
 BUSINESS PHONE: (928) 402 - 8807 EMERGENCY PHONE: () -
 ATTENTION TO: Lorraine Dalrymple, RN

PAY-TO ADDRESS (SITE 01)

STREET LINE #1: 5515 S. Apache Avenue
 STREET LINE #2: Suite 100
 CITY: Globe STATE: Arizona ZIP: 85501
 BUSINESS PHONE: (928) 402 - 8811 EMERGENCY PHONE: () -
 ATTENTION TO: Lorraine Dalrymple, RN
 EMPLOYER TAX ID# 86-6000444 BEGIN DATE: _____ END DATE: _____

SERVICE ADDRESS (SITE 01) *Must be a Street Address*

STREET LINE #1: 5515 S. Apache Avenue
 STREET LINE #2: Suite 100
 CITY: Globe STATE: Arizona ZIP: 85501
 BUSINESS PHONE: (928) 402 - 8811 EMERGENCY PHONE: () -
 FAX PHONE: (928) 425 - 0794 ATTENTION TO: Lorraine Dalrymple, RN
 BEGIN DATE: 11/01/1999 END DATE: _____ PAY-TO LOC. CODE:* 01

(*=Please indicate the locator code for the pay-to address that applies to this service address.)

I affirm under penalty of law that the information on this form is true, accurate, and complete to the best of my knowledge.

SIGNATURE:** _____ TITLE: _____ DATE: _____

**Must be signature of Provider or Authorized Signor on file with AHCCCS

PAY-TO ADDRESS (SITE 02)

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () _____ EMERGENCY PHONE: () _____

ATTENTION TO: _____

EMPLOYER TAX ID# _____ BEGIN DATE: _____ END DATE: _____

SERVICE ADDRESS (SITE 02) *Must be a Street Address*

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () _____ EMERGENCY PHONE: () _____

FAX PHONE: () _____ ATTENTION TO: _____

BEGIN DATE: _____ END DATE: _____ PAY-TO LOC. CODE:* _____

(*Please indicate the locator code for the pay-to address that applies to this service address.)

PAY-TO ADDRESS (SITE 03)

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () _____ EMERGENCY PHONE: () _____

ATTENTION TO: _____

EMPLOYER TAX ID# _____ BEGIN DATE: _____ END DATE: _____

SERVICE ADDRESS (SITE 03) *Must be a Street Address*

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () _____ EMERGENCY PHONE: () _____

FAX PHONE: () _____ ATTENTION TO: _____

BEGIN DATE: _____ END DATE: _____ PAY-TO LOC. CODE:* _____

(*Please indicate the locator code for the pay-to address that applies to this service address.)

I affirm under penalty of law that the information on this form is true, accurate, and complete to the best of my knowledge.

SIGNATURE:** _____ TITLE: _____ DATE: _____

**Must be signature of Provider or Authorized Signor on file with AHCCCS

Michael A. Pastor, Chairman

Copy if additional pages are needed

02/2013





DISCLOSURE OF OWNERSHIP/CONTROL AND CRIMINAL OFFENSES STATEMENTS

Item I. Identifying Information

- (a) Name of Individual, Facility or Organization: Gila County Board of Supervisors
- (b) DBA Name: Gila Co. Division of Health & Emergency Services, Office of Health, Globe
- (c) Federal Tax Identification Number (TIN) or Social Security Number (SSN): 86-6000444
- (d) Check the entity type that best describes the structure of the enrolling provider entity. Check **only one** box.
- For-Profit Corporation
 Non-Profit Corporation
 Partnership
 Government Owned
 Sole Proprietorship
- (e) Is this entity chain affiliated? No Yes

As required by 42 CFR Part 455, Subpart B which implements Section 1124, 1126, 1902(a) (38), 1903(l) (2) and 1903(n) of the Social Security Act and sets forth State Plan requirements regarding Full Disclosure of Ownership and Control and Related Party Transactions, the following information must be submitted to AHCCCS prior to registration and upon each renewal of certification or licensure in order to participate as an AHCCCS provider.

AHCCCS may refuse to enter into or renew an agreement with a provider if the provider fails to disclose ownership and control interest information, information related to business transactions and information on persons convicted of crimes, or if the provider did not fully and accurately make the disclosures as required.

Item II. Ownership and Control Interest Information (Reference-42CFR, Part 455.104 and SSA 1124)

- (a) List the name, title, address, SSN and DOB for each officer and/or individual who has direct or indirect ownership or control interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. List the name, TIN, and address of any organization, corporation, or entity having direct or indirect ownership or control interest, separately or in combination, amounting to an ownership interest of 5% or more in the provider entity. Also, list below all officers, owners, managing employees and ownership entities. Use attachment A if additional space is needed.

Name	Title	Address	SSN/TIN	Date of Birth	Percentage

- (b) For any corporate entity, listed in (a), that has an ownership or control interest of 5% or more, list the following information for that entity: Include all business addresses, both service addresses and P.O. boxes. Use attachment A if additional space is needed.

Name	Address	TIN	Percentage

- (c) List the name, title, address and SSN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more.

Name	Title	Address	SSN	Percentage

- (d). List those persons named in Item II (a),(c) that are related to each other (spouse, parent, child, or sibling).

Name	Relationship	SSN	Date of Birth

- (e) List the name, address and TIN of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has ownership or control interest of at least 5% or more.

Name	Address	TIN	Percentage



DISCLOSURE OF OWNERSHIP/CONTROL AND CRIMINAL OFFENSES STATEMENTS

Item III. Criminal Offenses <i>(Reference-42CFR, Part 455.106 and SSA 1124)</i>			
(a) List the name, title, SSN and address of each officer and/or individual who has ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.			
Name	Title	Address	SSN (or TIN in organization)
(b) List the name, title, SSN and address of any individual who has an ownership or control interest in the disclosing entity and has been suspended or debarred from participation in Medicare, Medicaid or Title XX program at any time since the inception of those programs.			
Name	Title	Address	SSN
Item IV. Board of Directors			
List the name, title and address of each member of the Board of Directors of the disclosing entity.			
Name	Title	Address	
Michael A. Pastor	Chairman	1400 E. Ash Street, Globe, AZ 85501	
Tommie C. Martin	Vice-Chairman	1400 E. Ash Street, Globe, AZ 85501	
John D. Marcanti	Member	1400 E. Ash Street, Globe, AZ 85501	
I affirm under penalty of law that the information I have provided for this form is true, accurate and complete to the best of my knowledge.			
Michael A. Pastor		Chairman	
_____ Print Name of Authorized Representative		_____ Title	
_____ Signature of Authorized Representative		_____ Date	

Revised 06/2012

