Disclosure of Ownership and Control Interest Statement

Purpose of the Form: Completion and submission of this form is a condition of participation in Medicare, Medicaid, Social Security Block Grant or State Children's Health Insurance Program (CHIP). This form must be completed every three years and within 35 days of information changes, to be in compliance with 42 CFR §457.935, 42 CFR §§455.104, 105 and 106. A form is required for each Tax ID associated with a Disclosing Entity or Provider/ Provider Group.

Please answer all question as of the current date. Do not leave any questions or sections blank. If the requested information does not apply, please answer with a NA. There are questions that, when answered 'yes', require additional information be provided. If a correction is made to the document, the error needs to be lined out, dated, and initialed.

Important Note: The entity name in Section 1 of the Disclosure of Ownership and Conflict of Interest Form must match the information on the Contract and W9 that we and the IRS currently have on file for you or your organization.

Anyone fitting the following definitions of Managing Employee, Direct Ownership, Indirect Ownership, or Controlling Interest must be listed in 3a and potentially 3d. Social Security Numbers and Date of Birth must be provided for all persons with ownership, controlling interest or are a managing employee to comply with federal regulations (Sect. 4313 of the Balanced Budget Act of 1997, amended Sect. 1124 and Federal Register Vol. 76 No. 22 for further information). This includes Board Members, Administrators, Director, or other individual who has operation or managerial control, or who directly or indirectly conducts day to day operation of the business.

Definitions/ Information
Disclosing Entity: a Medicaid provider (other than an individual practitioner or group of individual practitioners), or fiscal agent. Normally these are corporations or partnerships where there are owners, officers, partners, or managing employees who run the company. Disclosures on these individuals are captured as these parties are considered "behind the scenes" and direct how the organization will operate. They are responsible for decisions made in policies and procedures for how services will be provided and for billing.
Direct Ownership Interest: possession of stock, equity in capital or any interest in the profits of the Business Entity. A Business Entity is defined as a Medicare and/or Medicaid provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid and/or Medicare Program.
Indirect Ownership Interest: an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity with ownership of 5 percent or more. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity.
Managing Employees: people who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations or head up the business functions of a Provider Entity. State and federal requirements prohibit a Medicaid MCO from contracting with a Provider Entity whose Managing Employees are excluded from federal healthcare programs.
Ownership Interest: possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest: a person or corporation that has (a) an ownership interest totaling 5% or more in a disclosing entity; (b) an indirect ownership interest equal to 5% or more in a disclosing entity; (c) a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity; (d) an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity; or (e) is an officer or director of a Disclosing Entity that is organized as a corporation or a partner in a disclosing entity that is organized as a partnership.

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This document MUST be completed and signed by an Owner of the Business Entity.

The Disclosure of Ownership is a Center for Medicare and Medicaid Services (CMS) and Client Required document to obtain during the contracting/credentialing process. If this documentation is not received, the credentialing process will be delayed. *If there are multiple Service Offices associated with this Business Entity, please attach a complete list of ALL Service Offices including their address.*

Section 1

Completion and submission of this form is a condition of participation in any program established by Medicaid or Medicare only. One full and accurate disclosure of ownership is required for each Business Entity. Failure to submit the requested information will result in refusal to participate in the Network or in termination of an existing agreement. If there are any changes in the ownership an updated form must be submitted within 35 days.

Identifying Information

When completing this section please use the Name of the Entity on file with the IRS, not a "DBA", Doing Business As Name.

Field	Value
Name of Entity	
Tax ID	
Telephone Number	
Street Address	
City	
State	
Zip	
County	

Section 2

Answer the following questions by checking "Yes" or "No".

If any of the questions are answered "Yes", list the names and addresses if the individuals or corporations on a separate page.

2a. Are there any individuals or organizations that have a direct or indirect ownership or controlling interest of 5% or more in the Business Entity that have been convicted of a criminal offense related to the involvement of persons in any of the programs under Medicaid and Medicare Programs? ☐ Yes ☐ No

2b. Have any directors, officers, agents, or managing employees of the Business Entity ever been convicted of a criminal offense related to their involvement in such programs established by Medicaid and Medicare? ☐ Yes ☐ No

2c. Are there any individuals currently employed by the Business Entity in a managerial, accounting, auditing, or similar capacity who were employed by the entity's fiscal intermediary or carrier within the previous 12 months? ☐ Yes ☐ No

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Section 3

Owners & Managing Employees

3a. List names, addresses, Dates of Birth and SSN for all Persons with an ownership interest in; or who are Managing Employees of the Disclosing Entity. List any additional names and addresses on a separate page. If more than one individual is reported and any of these persons are related to each other, this must be reported on a separate page. For Persons who are corporations, substitute the corporation's Tax Identification Number (TIN) for the SSN.

Owner/ Managing Employee #1
Name of Person
Date of Birth
SSN
Address
City, State and Zip
Owner/ Managing Employee #2
Name of Person
Date of Birth
SSN
Address
City, State and Zip
Owner/ Managing Employee #3
Name of Person
Date of Birth
SSN
Address
City, State and Zip

3b. Type of Entity – Check one that applies

Please Note: Your selection here MUST match how you are registered with the IRS and the W9 we have on file.

- ☐ Limited Liability Company (LLC)
- ☐ S-Corporation
- ☐ C-Corporation
- ☐ Sole Proprietor/Single Member LLC
- ☐ Partnership
- ☐ Trust/Estate
- ☐ Government Entity
- ☐ Other ____

3c. If this Business Entity is a corporation, list names, addresses of the Directors, and EINs for entities, if different than what is listed in 3a.

3d. Are any owners of the Disclosing Entity also owners of ***other*** Medicare/Medicaid facilities, with ***different*** Tax Id's that are different from that listed in section 1? (Example: sole proprietor, partnership or members of Board of Directors.)

☐ Yes ☐ No

If yes, please complete the section below:

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Owner/ Entity #1		
Name of Individual/ Entity		
SSN/ TIN		
Address		
City, State and Zip		
Owner/ Entity #2		
Name of Individual/ Entity		
SSN/ TIN		
Address		
City, State and Zip		
Owner/ Entity #3		
Name of Individual/ Entity		
SSN/ TIN		
Address		
City, State and Zip		
Section 4		
Answer the following questions by checking “Yes” or “No”. If any of the questions are answered “Yes”, list the date of the change.		
4a. Has there been a change in ownership or control within the last year? If yes, give date: ________	□ Yes	□ No
4b. Do you anticipate any change of ownership or control within the year? If yes, give date: ________	□ Yes	□ No
4c. Do you anticipate filing for bankruptcy within the year? If yes, give date: ________	□ Yes	□ No
Section 5		
5. Is the Disclosing Entity operated by a management company or leased in whole or in part by another organization?	□ Yes	□ No
Section 6		
6. Has there been a change in management within the last year? *(change in Director, a new Administrator, contracting operations of the facility to a management corporation, hiring or dismissing employees with 5% or more interest, or similar change)*	□ Yes	□ No
Section 7		
7a. Is the Disclosing Entity currently chain affiliated? If yes, please complete the section below:	□ Yes	□ No
Name		
EIN		
Address		
City, State and Zip		
7b. If “No”, was the Disclosing Entity <u>ever</u> chain affiliated?	□ Yes	□ No
Name		
EIN		
Address		
City, State and Zip		

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WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE. BY SIGNING BELOW THE NAMED INDIVIDUAL REPRESENTS, WARRANTS AND ACKNOWLEDGES THAT S/HE HAS THE LEGAL AUTHORITY TO BIND THE ABOVE-NAMED ORGANIZATION AND ATTESTS TO THE VALIDITY AND ACCURACY OF THE INFORMATION PRESENTED HEREIN.

Name (Typed)

Title

Signature (this may be an electronic signature provided there is an electronic date and time stamp)

Date