Disclosure of Ownership and Conflict of Interest Form

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 (SCHIP). 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 question 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 your Contract and W9 that we currently have on file and must match the information the IRS has on file.

Anyone fitting the following definitions of Managing Employee, Direct Ownership, Indirect Ownership or Controlling Interest must be listed in 3a and potentially 3d. This includes all Board Members.

Definitions / Information
Managing Employees: Managing employees are defined as 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.
Disclosing Entity: This is 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: Is defined as the 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: Is defined as ownership interest in a Business Entity that has direct or indirect ownership interest in the disclosing entity with ownership of 5 percent or more.
Controlling interest: Is defined as the operational direction or management of this Business Entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of this Business Entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of this Business Entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of this Business Entity; the right to control any or all of the assets or other property of this Business Entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of this Business Entity to new ownership or control.
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.

This document MUST be completed and signed by an Owner of the Business Entity. If there are multiple Service Offices associated with this Business Entity, please attach a complete list of ALL Service Offices including their address.

The Disclosure of Ownership is a CMS (Center for Medicare/Medicaid Services) and Client Required document to obtain during the contracting/credentialing process. If this documentation is not received, the credentialing process will be delayed.

Disclosure of Ownership and Control Interest Statement

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.

1. 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.***

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

2. Answer the following questions by checking "Yes" or "No". **If any of the questions are answered "Yes", list names and addresses of individuals or corporations in the Remarks section.**

a. 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?

Checking "Yes" requires additional Information

☐ Yes ☐ No

b. 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

c. 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

Disclosure of Ownership and Control Interest Statement

3a. List names, addresses, and SSN for individuals or organizations having direct or indirect ownership or a controlling interest in this Business Entity of 5% or greater. List each member of the Board of Directors or Governing Board and Managing Employees also including General Manager, Business Manager, Administrator, Director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation. List any additional names and addresses under "Remarks" on page 5. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name of Individual	This is required DOB	If you have additional Owners, Board Members, Managing Employees or management staff with day to day operational responsibilities, please list them in the remarks section. Address		This is required SSN
		Address	Zip	
		City	State	
		Address	Zip	
		City	State	
		Address	Zip	
		City	State	

b. Type of Entity **NOTE: Your selection here must match the W9 we have on file**

☐ Individual/sole Proprietor or single-member LLC

☐ S -Corporation ☐ Partnership ☐ Trust / estate

☐ Other ______________________________

☐ C -Corporation ☐ LLC

The Tax ID, Contract, W9 and IRS check have to match or the document will be returned for correction

c. 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.

Disclosure of Ownership and Control Interest Statement

Check appropriate box for each of the following questions:

d. Are any owners of the Business 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.) If yes, please complete the section below.

This would be yes only if the owners are also owners of another business with a different Tax ID

☐ Yes ☐ No

Name	Address		SSN (if listing an individual) TIN (if listing an entity)
	Address	Zip	
	City	State	
	Address	Zip	
	City	State	
	Address	Zip	
	City	State	

4a. Has there been a change in ownership or control within the last year? ☐ Yes ☐ No

If yes, give date _____________

b. Do you anticipate any change of ownership or control within the year? ☐ Yes ☐ No

If yes, when? _______________

c. Do you anticipate filing for bankruptcy within the year? ☐ Yes ☐ No

If yes, when? _______________

5. Is this entity operated by a management company, or leased in whole or part by another organization? ☐ Yes ☐ No

If yes, give date of change in operations ____________

6. Has there been a change in management (such as: change in Director, a new Administrator, contracting operations of facility to a management corporation, hiring or dismissing employees with 5% or more interest, or similar change) within the last year? ☐ Yes ☐ No

Disclosure of Ownership and Control Interest Statement

7a. Is this entity chain affiliated? (If yes, list name, address of Corporation, and EIN)	☐ Yes	☐ No

Name	EIN
Address	

City	State	Zip

7b. If the answer to Question **7a. is No,** was the entity **ever** affiliated with a chain? (If yes, list Name, Address of Corporation, and EIN) Note: If 7a is NO, 7b is required	☐ Yes	☐ No

Name of Corporation	EIN
Address	

City	State	Zip

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.

Name of Owner (Typed)	Title
Owner Signature (this may be an electronic signature provided there is an electronic date and time stamp)	Date

Remarks - if applicable