Disclosure of Ownership and Control Interest Statement

Purpose

The federal regulations set forth in 42 CFR §455.104 -106 require providers to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to Managed Care Organizations that contract with a State Medicaid Agency or CHIP managed care network:

1) The identity of all owners with direct or indirect ownership interests and/or control of 5% or greater;
2) Certain business transactions and significant business transactions between the provider and any wholly owned supplier or any subcontractor during the previous 5 years;
3) The identity of any excluded individual with an ownership or control interest in the provider entity or who is an agent or managing employee of the provider entity.

In addition, 42 CFR Part 420 Subpart C implements sections 1124, 1124A, 1126, and 1861(v)(1)(i) of the Social Security Act sets forth requirements for providers, Part B suppliers, intermediaries, and carriers to disclose ownership and control information and the identities of managing employees.

Definitions

Direct Ownership Interest - Possession of equity in the capital, the stock, or the profits of the disclosing entity.
Disclosing Entity - Medicaid and/or a Medicare provider (other than an individual practitioner or group of practitioners), a part B supplier (as defined in § 400.202), or a fiscal agent.
Fiscal Agent - A contractor that processes or pays vendor claims on behalf of the Medicaid agency.
Indirect Ownership Interest – An ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
Managing Employee - A 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 of an institution, organization, or agency.
Other Disclosing Entity - Any other Medicare or Medicaid disclosing entity and any entity that does not participate in Medicare or Medicaid; but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes: a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); b) Any Medicare intermediary or carrier; and c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.
Person with an ownership or control interest - A person or corporation that: a) Has an ownership interest totaling 5% or more in a disclosing entity; b) Has an indirect ownership interest equal to 5% or more in a disclosing entity; c) Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity; d) Owns 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; e) Is an officer or director of a disclosing entity that is organized as a corporation; f) Is a partner in a disclosing entity that is organized as a partnership.
Significant Business Transaction - Any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5% of a provider's total operating expenses.
Subcontractor a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicare and/or Medicaid agreement.

Instructions

1. Respond to all questions. Read the instructions in each shaded box:
   - If standard applies, complete the fields. **If standard does not apply, please check the box next to N/A.**
2. **No questions can be left blank. Please attach a separate sheet if necessary.**
3. Website and email addresses are not acceptable answers to any of the questions. Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).
4. Any authorized/designated representative of the provider/disclosing entity may complete and sign this form on behalf of the provider/disclosing entity.
5. This disclosure will be renewed every three (3) years and/or at any time there is a revision to the information or upon a request for updated information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity

Name of Provider/Disclosing Entity:

DBA Name:

Complete Address:

Tax Identification Number (TIN): NPI Type 1: NPI Type 2:

Section 1 – Managing Employee

Complete the information below for any managing employees of the Disclosing Entity.

☐ **N/A**

First Name: Last Name:

SSN: TIN: DOB:

Complete Address:

First Name: Last Name:

SSN: TIN: DOB:

Complete Address:

Section 2 –Ownership and Control Interests

List any individual or corporation with an ownership or control interest of 5% or more in the Disclosing Entity.

- For Individuals: List the name, title, home address, date of birth (DOB) and Social Security Number (SSN)
- For Entities: List the name, TIN, business address of each organization, corporation, or entity

☐ **N/A**

First Name: Last Name:

SSN: TIN: DOB:

Complete Address:

First Name: Last Name:

SSN: TIN: DOB:

Complete Address:

Section 2A – Relationships

Complete this section if any of the individuals in Section 2 are related (e.g., spouse, sibling, parent, child, etc.) to each other.

☐ **N/A**

Name: Relationship:

Name: Relationship:

Section 3 – Subcontractors

List subcontractors that Disclosing Entity has direct or indirect ownership of 5% or more.

☐ **N/A**

Name of subcontractor: Name of subcontractor:

Section 3A –Subcontractors

Complete for any person with an ownership or control interest in any subcontractor in section 3. Also indicate if related to anyone in section 2 (e.g., spouse, sibling, parent, child, etc.).

☐ **N/A**

First Name: Last Name:

SSN (individual): TIN (entity): DOB: % of ownership:

Complete Address:

Relationship: Name from section 2: Relationship:

First Name: Last Name:

SSN (individual): TIN (entity): DOB: % of ownership:

Complete Address:

Relationship: Name from section 2: Relationship:

Section 4 – Other Disclosing Entity (or Fiscal Agent or Managed Care Entity)

Complete the fields below if the Disclosing Entity has an ownership or control interest for any Other Disclosing Entity.

☐ **N/A**

Other Disclosing Entity First Name:

Other Disclosing Entity Last Name:

SSN (individual) TIN (entity): DOB: % of ownership:

Complete Address:

Name of person with an ownership or control interest:

Other Disclosing Entity Firs Name:

Other Disclosing Entity Last Name:

SSN (individual): TIN (entity): DOB: % of ownership:

Complete Address:

Name of person with an ownership or control interest:

Section 5 – Business Transactions Disclosures

Indicate if the provider/disclosing entity or part B supplier has any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) months period (12-month period ending as of the date on this request).

☐ **N/A**

Subcontractor First Name: Subcontractor Last Name:

SSN (individual): TIN (entity): DOB: Transaction amount:

Complete Address:

Subcontractor First Name: Subcontractor Last Name:

SSN (individual): TIN (entity): DOB: Transaction amount:

Complete Address:

Section 5A – Significant Business Transactions Disclosure

Indicate if the provider/disclosing entity or part B supplier had any significant business transactions with a Wholly Owned Supplier or subcontractor during the previous 5-year period (5-year period ending on the date on this request).

☐ **N/A**

First Name: Last Name: ☐ Wholly Owned Supplier ☐ Subcontractor

SSN (individual): TIN (entity): DOB: Transaction amount:

Complete Address:

First Name: Last Name: ☐ Wholly Owned Supplier ☐ Subcontractor

SSN (individual): TIN (entity): DOB: Transaction amount:

Complete Address:

Section 6 – Criminal Offense Disclosure

Identify any person who has ownership or control interest in the provider; or is an agent or managing employee of the provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare and/or Medicaid, or the title XX services program since the inception of those programs.

☐ **N/A**

First Name: Last Name:

Title: SSN: TIN: DOB:

Complete Address:

Description of offenses:

First Name: Last Name:

Title: SSN: TIN: DOB:

Complete Address:

Description of offenses:

Attestation

Through signature below, I certify that the information provided herein is true, accurate and complete. Additions to or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate or incomplete data may result in denial of participation. Individuals and Sole Proprietors must sign their own form. An authorized representative may sign for Partnership, Corporation, LLC or Other disclosing entities.

Provider name (please print)	Title (or indicate if authorized Agent)
Provider signature	Date