Agency for Health Care Administration

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by title V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the Secretary of the Agency for Health Care Administration ("Agency") under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information timely, fully, and completely may result in a refusal by the Secretary or the Agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

For definitions, procedures, and requirements, refer to the appropriate Regulations at 42 C.F.R. §455.100-106. For any of the following responses, if there is not enough space provided to complete each answer fully, clearly label and attach additional pages as necessary.

Section 1. Identifying Information

Specify in what capacity the disclosing entity is doing business as (DBA). E.g., name of trade or corporation.

Section 2. Criminal Offenses

42 C.F.R. §455.106 requires that before the Agency enters into or renews a provider agreement, or at any time by written request by the Medicaid agency, the provider must disclose the identity of any person who: (1) has ownership or control interest in the provider, or is an agent or managing employee of the provider, and (2) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or title XX services program since the inception of those programs.

Answer the following questions by checking "Yes" or "No." If any of the questions are answered "Yes," list the names and addresses of individuals or corporations under "Notes." Identify each item number to be continued.

Section 3. Former Employees

Answer the following question by checking "Yes" or "No." If the question is answered "Yes," list the names and addresses of individuals or corporations under "Notes." Identify each item number to be continued.

Section 4. Ownership, Financial, or Control Interest

(a) In Table 1 list the names, titles, addresses, date of birth, and Social Security Number (SSN) for all individuals having ownership (including indirect ownership interest) or controlling interest in the disclosing entity, fiscal agent, or managed care entity. For owners, indicate the percentage of ownership if applicable. "Persons with an ownership or control interest" is broadly defined at 42 C.F.R. 455.101.

(b) Answer the following question by checking the appropriate box.

(c) In Table 2 list the name, address, tax identification number (TIN), and percentage of ownership of any corporation with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include all applicable primary business addresses, every business location, and P.O. Box addresses.

(d) In Table 3 list the name, address, TIN, and percentage of ownership of any subcontractor in which the disclosing entity, fiscal agent, or managed care entity has direct or indirect ownership interest totaling 5 percent or more.

(e) Answer the following question by checking the appropriate box. If yes, in Table 4 list their names and the relationships.

(f) In Table 4 list the names and relationships of each related party.

(g) Answer the following question by checking the appropriate box. N/A is only an acceptable response for those providers with no owners. If a provider lists owners on the list of persons with ownership or control interest, then the response should be "Yes" or "No."

(h)If the response is "Yes," in Table 5 list the name of each owner and the name of the other disclosing entity(ies) in which they have an ownership or control interest. "Other disclosing entity" is defined at 42 C.F.R. 455.101.

Section 5. Change in Ownership or Control

Answer the following questions by checking the appropriate box. If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Section 6. Facility Management

a) Answer the question by checking the appropriate box.

b) If yes, list the name of the management firm and TIN, or the name of the leasing organization.

Section 7. Management Employees

(a) Answer the question by checking the appropriate box. If yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include the name of the newly appointed person.

(b) In Table 7 list the name, address, date of birth and SSN of any managing employee of the disclosing entity. "Managing employee" is defined at 42 C.F.R. 455.101

Section 8. Chain Affiliates

Answer the question by checking the appropriate box. If yes, list name, address of Corporation, and TIN.

Section 9. Facility Beds

Answer the question by checking the appropriate box. If yes, list the actual number of beds in the facility now and previous number.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

SECTION 1. Identifying Information

Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code

SECTION 2. Criminal Offenses

Are there any individuals or organizations having an ownership or control interest in the institution, organizations, or agency that have been convicted of a criminal offense subject to civil monetary penalty, or excluded from the programs for any activities related to their involvement in such programs established by titles XVII, XIX, XX, or V?

☐ Yes ☐ No

Are there any directors, officers, agents, or managing employees of the institution, agency, or organization, who have ever been convicted of a criminal offense subject to civil monetary penalty, or excluded from the programs for any activities related to their involvement in such programs established by titles XVII, XIX, XX, or V?

☐ Yes ☐ No

SECTION 3. Former Employees

Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

☐ Yes ☐ No

SECTION 4. Ownership, Financial, or Control Interest

(a) Table 1. Individuals with an Ownership or Control Interest

Name	Title	Address	DOB	SSN	% Ownership

(b) Type of Entity:

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated Associations ☐ Other (Specify)

(c) Table 2. Corporations/Subcontractors with an Ownership or Control Interest

Name	Primary Business Address(es)	Other Business Address(es)	P.O. Box Address(es)	TIN	% Ownership

Agency for Health Care Administration

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

(d) Table 3. Subcontractors with an Ownership or Control Interest

Name	Primary Business Address(es)	Other Business Address(es)	P.O. Box Address(es)	TIN	% Ownership

(e) Are any of the parties named in Section 4 related to each other as a spouse, parent, child, or sibling? This includes any individuals listed in Table 1 who are related to individuals with an ownership or control interest in any of the subcontractors listed in Table 3.

☐ Yes ☐ No

(f) Table 4. Related Parties

Name	Relationship

(g) Do any of the owners listed in Table 1 or Table 2 have an ownership or control interest in another organization(s) that would qualify as a disclosing entity?

☐ Yes ☐ No ☐ N/A

(h) Table 5. Ownership or Control Interest in Other Disclosing Entity(ies)

Name of Owner	Name of Other Disclosing Entity

SECTION 5. Change in Ownership or Control

(a) 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, give date:______________________

(c) Do you anticipate filing for bankruptcy within the year? ☐ Yes ☐ No
If yes, give date:______________________

SECTION 6. Facility Management

(a) Is this facility operated by a management company, or leased in whole or part by another organization? ☐ Yes ☐ No

If yes, give date of change in operations:______________________

(b) Table 6. Facility Operators

Name	TIN

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

SECTION 7. Employees

Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? ☐ Yes ☐ No

Table 7. Managing Employees

Name	Address	DOB	SSN

SECTION 8. Chain Affiliates

(a) Is this facility chain affiliated? ☐ Yes ☐ No

Name:____ TIN #____________________________

Address: ____

(b) If the answer to Question 8(a) is "No," was the facility ever affiliated with a chain?

Name:____ TIN #____________________________ ☐ Yes ☐ No

Address: ____

SECTION 9. Facility Beds

Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years? ☐ Yes ☐ No

If yes, give year of change:____________________ Current beds:__________ Prior beds:__________

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 Authorized Representative (Typed)	Title
Signature	Date

Notes: