DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT Part 2

General Instructions

Federal Medicaid regulations (Title XIX – 42CFR 455.100 – 106) require that all Medicaid providers disclose the name and address of each person with an ownership or control interest in the provider and any subcontractor where the provider has a direct or indirect ownership interest of 5% or more. All applicants, except individual practitioners or group of practitioners as mentioned in 42 CFR 455.101, must complete this form in order to enroll as a provider in the Medicaid program. The provider must also comply with all applicable provisions 2 CFR 376 pertaining to debarment and/or suspension, screening all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program and/or all federal health care programs. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.

Please answer all questions as of the **current date**. If the "**Yes**" block for an item is checked, list the requested additional information in that item; attach additional pages or documentation as needed, referencing the item number to which the information corresponds. Return the original to SCDHHS; retain a copy for your files. Failure to provide this form and/or incomplete information will result in a refusal by the South Carolina Department of Health and Human Services (SCDHHS) to enter into an agreement or contract with any such provider or institution or in termination of existing agreements.

This form is to be completed under any programs established by Title XIX and Title XXI and **must be submitted within 35 days of any changes to provider information.** Completion and submission of this form is also a condition of approval or renewal of a contractor agreement between the disclosing entity and SCDHHS. Any substantial delay in completing the form should be reported to SCDHHS.

Disclosure of Social Security Numbers: Disclosure of Social Security Numbers is used for the purpose of determining whether persons and entities names in an application are federal excluded parties and to verify licensure. **Refusal to provide a Social Security Number will result in rejection of the provider's application to participate in the Medicaid program or termination of an existing provider agreement or contract.**

I. Instructions / Definitions: Provider types that must have a NPI must include the NPI. If currently enrolled in South Carolina Medicaid with multiple NPIs, a separate Disclosure of Ownership and Controlling Interest form must be completed for each NPI.

I. Identifying Information			
[a] Name of Provider (Disclosing Entity): Doing Business As (trade or company name):			
Street Address		City, State, Zip + 4	
County	Provider Number	NPI	Telephone Number
[b] Federal Employer Identification Number (FEIN):			
[c] Type of Entity (Applies to either For Profit or Non-Profit) ☐ Limited Liability Corporation (LLC) ☐ Partnership ☐ Corporation ☐ Governmental Unit ☐ Business Proprietorship or Company ☐ Sole Proprietor ☐ Other (Please specify)______________________________			

II. Instructions / Definitions:

Providers must disclose ownership and control information as required by 42 CFR 455.101 - 104. ***Direct ownership interest*** is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. ***A disclosing entity*** is defined as a Medicaid provider, supplier, or other entity, other than an individual practitioner or group of practitioners, that furnishes services or arranges for furnishing services under Medicaid, Medicare, the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. 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. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the direction or management of a disclosing 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 the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing 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 indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Therefore, ***a person with an ownership interest*** means a ***person*** or ***corporation*** that –

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest totaling 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent 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; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Subcontractor means (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 Medicaid agreement.

II. Individuals and Organizations with Ownership and Controlling Interest

[a] List names, addresses, date of birth and social security numbers for individuals, or list names, addresses and the FEIN for organizations, having direct or indirect ownership or a controlling interest, **as defined on pg. 2,** in the entity listed in Section I. Attach pages for any additional names and addresses. **If Sole or Business Proprietor is checked in Section I, skip this section.**

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] Are any persons / entities with ownership or controlling interest in the provider also owners of other Medicare / Medicaid facilities? If yes, list name of the owner from Section II [a] and the name and NPI and/or FEIN for each facility or SSN if an individual provider.

☐ Yes ☐ No

Name of Owner from Section II[a]	Name of Other Provider or Entity	NPI/ SSN	FEIN

III. Subcontractors

[a] Please list any subcontractors of the disclosing entity (provider), **as defined on pg. 2**, in which the disclosing entity has a direct or indirect ownership of 5% or more.

☐ Not Applicable

Name of Subcontractor	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] List the following information for individuals or organizations having direct or indirect ownership or a controlling interest, **as defined on pg. 2,** in the any subcontractor in which the disclosing entity (provider) has a direct or indirect ownership of 5% or more. Attach pages for additional names.

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

IV. Relationships

Are any of the individuals identified in Sections I, II or III related to each other? ☐ Yes ☐ No
If yes, list the individuals identified and the relationship to each other (spouse, sibling, parent, child).

Name of Person 1	Name of Person 2	Relationship

V. Managing Employees

[a] List current managing employees by name, work telephone number, and Social Security number. "Managing employee" means general manager, office or business manager, administrator, director, or other individual who exercises operational or managerial control over the institution, agency, or organization, or who directly or indirectly conducts the day-to-day operations. Attach pages for additional names.
☐ Not Applicable

Name/ Title	Address	Social Security Number	Date of Birth

[b] Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
☐ Yes ☐ No ☐ Not Applicable
If Yes, give date for change: Date / / . List names, titles, and Social Security Number of the prior Administrator, Director of Nursing, or Medical Director.

Name	Title	Social Security Number

VI. Management Company

A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility. If the answer is yes, list the name of the management firm as well as the managing employees of the firm (i.e., CEO, CFO, etc.) Attach additional pages if needed.

Is the provider/entity/facility operated by a management company?
☐ Yes ☐ No
If Yes, what is the term of the agreement?
Beginning Date / / to Ending Date / / .

Name of Management Co.	Address	FEIN

Name(s) of Managing Employee(s)	Social Security Number	Date of Birth

VII. Instructions/ Definitions: Criminal Offenses related to the delivery of services or items under Medicare or Medicaid programs include convictions relating to patient neglect or abuse in connection with the delivery of a health care item or service; felony and/or misdemeanor convictions related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; felony and/or misdemeanor convictions related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

VII. Criminal Offenses

If any of the questions are answered "Yes", list names, addresses, and SSNs for individuals and names, addresses, and FEINs for organizations, or attach documentation or additional pages if needed.

[a] As listed in **Sections II or III**, have any individuals and organizations with a direct or indirect ownership of 5% or more in the disclosing entity (provider), or any subcontractor(s) in which the provider has a direct or indirect ownership of 5% or more, been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, XX or XXI (Medicare, Medicaid, the Social Services Block Grant program or the State Children's Health Insurance Program [SCHIP])?

☐ Yes ☐ No

[b] As listed in **Sections V or VI**, have any directors, officers, agents, or managing employees of the disclosing entity (provider) ever been convicted of a criminal offense related to their involvement in such program established by Titles XVIII, XIX, XX or XXI (Medicare, Medicaid, the Social Services Block Grant program or SCHIP)?

☐ Yes ☐ No

Name	Address	SSN/FEIN

VIII. Instructions/ Definitions: Sanctions and other adverse actions include any revocation or suspension of a license to provide health care by any State licensing authority; any revocation or suspension of accreditation; and/or any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

VIII. Sanctions and Other Adverse Actions

Has your organization, under any current or former name or business identity, or any individuals and organizations listed in **Sections II, III, V, or VI,** ever had a final adverse action imposed against it? If yes, report the individual(s) or organization(s) involved, each final adverse action, when it occurred, and the Federal or State agency or the court/administrative body that imposed the action.

☐ Yes ☐ No

Individual/Organization	Adverse Action	Date	Taken by

IX. Instructions/ Definitions:

Changes in provider status are defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership, the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any changes of ownership.

IX. Changes in Provider Status
If there has been a change in ownership /partnership within the last year or if you anticipate a change, indicate the date in the appropriate space. If there are no owners (i.e., the provider is a sole proprietorship), check Not Applicable.
[a] Has there been a change in ownership or controlling interest within the last year? If Yes, give date. ☐ Yes - Date: / / ☐ No ☐ Not Applicable

X. Instructions/ Definitions: A chain affiliate is any free-standing health care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other devices, control and direction of a private, charitable or propriety. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

<table>
<tr><th colspan="3">X. Chain Affiliation</th></tr>
<tr><td colspan="3">[a]. Is this facility chain-affiliated? If Yes, list name, address and FEIN of parent Corporation below.
☐ Yes ☐ No</td></tr>
<tr><th>Name</th><th>Address</th><th>FEIN</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">[b]. If the answer to part [a] of this item was “No”, was the facility ever affiliated with a chain? If Yes, list name, address and FEIN of parent Corporation.
☐ Yes ☐ No</td></tr>
<tr><th>Name</th><th>Address</th><th>FEIN</th></tr>
<tr><td></td><td></td><td></td></tr>
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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 IN MEDICAID, OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF THE AGREEMENT OR CONTRACT WITH SCDHHS.

Name of Authorized Representative (Printed or Typed)	Title
Signature	Date