

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

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 must complete this form in order to enroll as a provider in the Medicaid program.

Failure to provide this form may 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.

Please answer all questions as of **the current date**. If the “**Yes**” block for **an** item is checked, list the requested additional information under the “**Remarks**” section on page 4, referencing the item number to which the information corresponds. If additional space is needed, use another sheet. Return the original to SCDHHS; retain a copy for your files.

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

I. Instructions / Definitions: Specify in what capacity you do business as (D/B/A); for example, trade name or corporation. Provider types that must have a NPI must include this information. If a valid telephone number is not included, this form will be returned and enrollment into the Medicaid program will not proceed.

I. Identifying Information			
[a] Name of Provider		(D/B/A)	
Street Address		City, State, Zip + 4	
County	Provider Number	NPI Number	Telephone Number
[b] Employer Identification Number (EIN), if applicable:			
[c] Type of Entity			
<input type="checkbox"/> Sole Proprietorship (includes individual practitioner or group of practitioners) <input type="checkbox"/> Limited Liability Corporation (LLC) <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation (Either For Profit or Non-Profit) <input type="checkbox"/> Other (Specify)			
[d] If “Sole Proprietorship” is checked, please go next to Section II and check “Not Applicable” . [e] If “Corporation,” “LLC,” “Partnership,” or “Other” is checked, list the names, addresses, and Social Security Numbers of the Directors/Partners below. (Continue in “Remarks” section if more room is needed.)			
Director/Partner Names	Director/Partner Addresses	Social Security Number (SSN)	

II. Instructions / Definitions:

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.

II. If no organization has a direct or indirect ownership or controlling interest in the provider, check Not Applicable and proceed to Section III[b]. <input type="checkbox"/> Not Applicable			
[a] List names, addresses, and social security numbers for individuals, or list names, addresses and the EIN for organizations, having direct or indirect ownership or a controlling interest of 5% or more in the entity listed in Section I. List any additional names and addresses under "Remarks" on page 4. If more than one individual is reported and if any of these persons are related to each other , this must be reported under "Remarks".			
Name	Address	SSN	EIN
[b] Are any owners of the provider also owners of other Medicare / Medicaid facilities? If yes, list name, address and NPI and/or EIN for each facility. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Facility	Address	NPI	EIN

III. 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.

III. If any of the questions are answered "Yes", list names, addresses, and SSNs for individuals and names, addresses, and EINs for organizations under "Remarks" on page 4.			
[a] Are there any individuals or organizations having a direct or indirect ownership or control interest of five (5) percent or more in the institution, agency, or organization (provider) that have 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])? <input type="checkbox"/> Yes <input type="checkbox"/> No			
[b] Are there any directors, officers, agents, or managing employees of the institution, agency, or organization (provider) who have 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Items IV-VII. Instructions/Changes in Provider Status:

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.

IV. 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

[b] Do you anticipate any change or ownership or controlling interest within the year?
 Yes - Date: / / No Not Applicable

V. 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 or the name of the leasing organization and the EIN.

Is the facility operated by a management company or leased in whole or part by another organization?
 Yes No Not Applicable

If Yes, what are the dates of operation? Beginning Date / / to Ending Date / / .

Name	EIN

VI. List current managing employees by name, work telephone number, and Social Security number. "Managing employee" means a general manager, 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.
 Not Applicable

Name/ Title	Work Telephone	Social Security Number

VII. 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

Item VIII. Instructions/ Definitions: A chain affiliate is any free-standing health care facility that is either 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.

VIII. Chain Affiliation		
[a]. Is this facility chain-affiliated? If Yes, list name, address and EIN of parent Corporation below. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable		
Name	Address	EIN
[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 EIN of parent Corporation. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name	Address	EIN

IX. (For facilities) Have you increased your bed capacity by ten (10) percent or more, or 10 beds, whichever is greater, within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give year of change: _____ Current number of beds: _____ Prior number of beds: _____
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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	SSN
Signature	Date	
Remarks (Please attached additional sheet or other documentation if needed)		