



Subject: Disclosure of Ownership and Control Interest Statement

Dear Provider:

By federal law, the U.S. Department of Health and Human Services' Office of Inspector General (HHSOIG) can exclude individuals and entities from participating in federal health care programs – including Medicaid and Medicare. If the HHS-OIG excludes a health care provider under a Medicaid program, the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) policy also prohibits the reimbursement of any items or services furnished, ordered or prescribed by that provider.

The federal regulation set forth in 42 CFR 455.106 requires providers who are entering into or renewing a provider agreement to disclose the identity of any excluded individuals/entities with ownership or control interest in the provider of 5 percent (5%) or greater. This disclosure of information is required to the U.S. Department of Health and Human Services and managed care organizations that contract with DHHS. Please see the definitions for further explanation of an ownership interest, managing employee and direct and indirect ownership.

Federal regulation 42 CFR 455.105 requires contracting providers to disclose information within 35 days of a request by CMS, DHHS or managed care organizations on:

1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
2. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

Instructions

Please follow these instructions to adhere to federal regulations:

1. Review the HHS-OIG list for excluded individuals at <http://www.oig.hhs.gov/fraud/exclusions.asp> and determine if any individuals who meet the criteria for ownership or control interest are on the exclusion list.
2. Please return the completed form with your credentialing application.

Please Email/Fax/Mail Completed form to:

Attention: Credentialing Department • 220 East 42nd Street, 3rd Floor • New York, NY 10017
Email: CHOICEcredentialing@vnsny.org



Definitions

Agent: Any person who has been delegated with the authority to obligate or act on behalf of the provider

Disclosing Entity: A Medicaid provider (other than a practitioner or group of practitioners) or fiscal agent

Other Disclosing Entity: Any other Medicaid disclosing entity and any entity that does not participate in 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 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; OR, any entity (other than a 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.

Group of Practitioners: Two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff or common equipment).

Indirect Ownership: Any ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes 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.

Ownership Interest: The possession of equity in the capital, the stock or the profits of the disclosing entity.

Person with an Ownership or Control Interest: 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 equal to 5 percent or more in a disclosing entity;
- c) Has a combination of direct and indirect interests 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 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.

Significant Business Transaction: Any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of \$25,000 and 5 percent of a provider's total operational expenses.

Subcontractor: An individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of provider medical care to its patients.

Supplier: An individual, agency or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid.

Wholly Owned Supplier: A supplier whose total ownership interest is held by a provider or by a person, persons or other entity with an ownership or control interest in a provider.



Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: 1) the identity of all owners with a control interest of 5% percent or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. Please attach a separate sheet if necessary.

Practice Information

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

Name of Individual, Group Practice or Disclosing Entity:	
DBA Name:	
Address:	
Federal Tax Identification Number:	

Section I

List the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest of **5 percent or greater** in this provider entity. List the name, Tax Identification Number (TIN) and business address of each organization, corporation or entity having an ownership or control interest of **5 percent or greater**. Please attach a separate sheet if necessary. (42 CFR455.104)

Name of Individual or Entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? Yes No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Relationship

Section III

Are there any subcontractors that the **Disclosing Entity** has direct or indirect ownership of 5% percent or more? Yes No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of **5 percent or more**. (42 CFR455.104)

Name of Individual or Entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)



Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare or Title XX program (verify through HHS-OIG Web site)? Yes No
If yes, please list those persons below. (42 CFR 455.106)

Name of Individual or Entity	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than \$25,000 or any significant business transactions with any subcontractors? Yes No
If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than \$25,000 during the previous twelve 12-month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past five-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name/Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information1) as a Disclosing Entity? Yes No
If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN) and percent of interest.

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate or incomplete data may result in a denial of participation.

Signature

Title (or indicate if authorized Agent)

Name (please print)

Date