



**DEPARTMENT OF HEALTH CARE FINANCE**  
**Provider Instructions and General Information Pertaining to**  
**Disclosure of Ownership and Control Interest Statement and Criminal Information**

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles 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 appropriate state agency under any of the above-title programs. A full and accurate disclosure of ownership and financial interest is required. Direct or indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the Provider. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution or termination of existing agreements. This form must be submitted at the time a Provider is initially enrolling, or revalidating, or reenrolling, or whenever there is a change in ownership of a Provider, or a material change in the information required by this form and/or upon request by the Department of Health Care Finance (DHCF) or federal agencies.

**DIRECTIONS**

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued (For example: Item II. (a) continued.). Return the original to DHCF and please retain a copy for your files. Completely answer the applicable questions. If a question is not applicable to your provider type, please answer not applicable for that question. **NO QUESTIONS SHOULD BE LEFT BLANK.** P.O. Box, website and email addresses are not acceptable answers to any of the questions and should not be referenced in the statement.

This form is submitted to DHCF for either of one (1) or two (2) of the following purposes: (1) to gather information about the provider/entity and (2) to gather personal information about the individual providers.

If you are the only provider furnishing services in this entity you need to fill out only one form. It will contain both the information about the Provider entity (i.e. if you are an LLC you would list the fact that you are a corporation and that you are the 100 percent owner) [Purpose 1] and information about you personally [Purpose 2].

*In all other cases* there must be more than one form. The entity must have an authorized person (i.e. corporate president or a partner in a partnership) fill out the form on behalf of the entity [Purpose 1], while each rendering provider must fill out the form with the personal information applicable to that provider [Purpose 2].

Purpose (1): This form is submitted by all Provider types that are either enrolling or reenrolling as a DC Medicaid program Provider. The form is used for the purposes of capturing information *about the Provider entity*, such as, whether the business structure is a corporation, partnership or some other type of business organization. It also collects information about non-provider people associated with the entity like members of Boards of Directors, non-provider owners and managing employees. This information must be collected whether the Provider is a profit or not-for-profit entity. All of the sections of the form must be filled out and updated whenever there is a change in the Provider's ownership or control or, upon request by DHCF or appropriate Federal agencies.

Purpose (2): This form is submitted by a new provider in a Group of Practitioners or a Disclosing Entity, whose employment does not change the ownership or control

structure of the Group of Practitioners or Disclosing Entity. The Group of Practitioners or a Disclosing Entity as a whole does not need to submit a new form under Purpose 1 of the form as long as the ownership and control functions of the entity have not been changed by the addition of the new Provider(s). The new Provider(s) are responsible for filling out Items I and IV of the form and signing the form. Please **answer not applicable** for the remainder of the form.

## **DEFINITIONS**

**Agent:** any person who has been delegated the authority to obligate or act on behalf of a Provider. 42 C.F.R. §455.101

**Convicted or Conviction:** a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending. 42 C.F.R. §455.2

### **Convicted of a Criminal Offense (for purposes of this form):**

1. When a judgment of conviction has been entered against the individual or entity by a Federal, State or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;
2. When there has been a finding of guilt against the individual or entity by a Federal, State or local court;
3. When a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State or local court; or
4. When the individual or entity has entered into participation in a first offender, deferred adjudication or other arrangement or program where judgment of conviction has been withheld. 42 U.S.C.A. §1320a-7(i)

**Disclosing Entity:** a Medicaid Provider, such as a Home and Community Based Service (HCBS) Provider (other than an Individual Practitioner or Group of Practitioners) or a fiscal agent.

**Fiscal Agent:** a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

**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). 42 C.F.R. §455.101 Common

location means Providers share physical office space, for example, 101 Main Street, Suite A.

**Indirect Ownership Interest:** an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. 42 C.F.R. §455.101

The amount of indirect ownership in the Disclosing Entity that is held by another entity is determined by multiplying the percentage of ownership interest at each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the Disclosing Entity, A's interest equates to an 8 percent indirect ownership interest in the Disclosing Entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the Disclosing Entity, B's interest equates to a 4 percent indirect ownership interest in the Disclosing Entity and need not be reported.

**Individual Practitioner:** solo physician or non-physician practitioner; who has not reassigned Medicare/Medicaid payments to a Group Practice or Disclosing Entity.

**Managing Employee:** 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. 42 C.F.R. §455.101 For purposes of this form DHCF requires that you list as "managing employees" the following persons: the heads of your entity's operating units or divisions (i.e. inpatient care, finance/billing department, personnel department, ambulatory care center, etc.).

**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:

- (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 under Title V or Title XX of the Act. 42 C.F.R. §455.101

**Ownership Interest:** the possession of equity in the capital, the stock or the profits of the Disclosing Entity. 42 C.F.R. §455.101

In order to determine percentage of ownership, mortgage, deed of trust, note or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the Disclosing Entity's assets used to secure the obligation. For example, if Dr. Smith owns 10 percent of a mortgage secured by 60 percent of Dr. Murray's assets, Dr. Smith's interest in Dr. Murray's assets equates to 6 percent and must be reported. Conversely, if Dr. Brad owns 40 percent of a mortgage secured by 10 percent of Dr. Jolie's assets, Dr. Brad's interest in Dr. Jolie's assets equates to 4 percent and need not be reported. 42 C.F.R. §455.102

**Provider Person:** person who will be billing DHCF for the provision of services to DC Medicaid program beneficiaries.

**Provider Entity:** a business entity, such as, a solo practice, Group of Practitioners or Disclosing Entity.

**Responsible Party:** an individual with legal authority to bind the Provider if the Provider is a Provider Entity - for example, a managing partner or corporate president.

**Significant Business Transaction:** any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a Provider's total operating expenses. 42 C.F.R. §455.101

**Subcontractor:**

- (a) An individual, agency or organization to which a Provider Entity has contracted or delegated some of its management or administrative functions or responsibilities of providing medical care to its patients; i.e. billing, case management, utilization review, etc.; 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 which is paid partially or in full by Medicaid funds. 42 C.F.R. §455.101

**Supplier:** an individual, agency or organization from which your organization purchases goods and services with Medicaid funds used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmaceutical firm). 42 C.F.R. §455.101

**Wholly owned supplier:** 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. 42 C.F.R. §455.101

**The following instructions are intended to clarify certain questions on the form. Instructions are listed in order of question for easy reference.**

**ITEM I**

- a. If you are filling this out as a Provider Person, specify the name of the Provider Person. Do not include a name of a contact person. List the Provider Person's national provider identifier(s) (NPI), social security number (SSN) and Medicaid ID number.
- b. List the Provider Entities' doing business as (DBA) name, NPI(s), federal tax identification number(s) (TIN) and Medicaid ID number. This line is for the name of a Provider Entity (i.e. Family Medical Group of Anytown). This line would also be used for the DBA name of an Individual (i.e. John Smith Pediatrics P.C.).
- c. Specify whether your business is operated as: 1) an Individual by yourself; 2) in a group of Provider Persons at the same location or 3) in any other practice organization.
- d. Enter the address of both the Provider Person and the Provider Entity. P.O. Boxes are not acceptable addresses. All practice locations must be listed.

**ITEM II**

- a. List the name, home address, date of birth (DOB), SSN and percentage owned for each person with a direct or indirect ownership or control interest of five (5) percent or more in the Provider Entity. If you are a Provider Person and own 100 percent of your practice then you would just list yourself. In addition, list the same information for any Subcontractor

in which the Provider Person or Provider Entity has direct or indirect ownership or control interest of 5 percent or more.

- b. List whether any of the persons named in II(a) is related to another as a spouse, parent, child or sibling; and
- c. List the name, address and TIN of any other Provider Entity in which a Person with an Ownership or Control Interest in the Provider Entity also has an Ownership or Control Interest. 42 C.F.R. §455.104

### **ITEM III**

- a. A Provider Entity must list the name, address, DOB, SSN and TIN for any Subcontractor with whom the Provider Entity has had singular business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- b. A Provider Entity must list any significant business transactions between the Provider Entity and any Subcontractor or Wholly Owned Supplier during the 5-year period ending on the date of the request. 42 C.F.R. §455.105

**ITEM IV (if you are a sole Provider you will fill out both parts of this item --- a) is about your employees b) is about yourself**

- a. If you are filling out this form for Purpose 1 (i.e. on behalf of the Provider Entity) please list the following:

1. List the name, home address, DOB and SSN of each Person with an Ownership or Control Interest in the Provider Entity or is an Agent or Managing Employee of the Provider Entity;
2. Please list the name, home address, DOB and SSN of each Person with an Ownership or Control Interest in the Provider Entity that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the title XX services program since the inception of those programs. 42 C.F.R. §455.106 Provider Entities shall search the List of Excluded Individuals/Entities (LEIE) each month for the names of the Providers Entities' employees and contractors.

- b. If you are filling out this form for Purpose 2 (i.e. enrollment of a Provider Person) please fill out this section providing information only about yourself.

**Signature:** If this form is being completed for a Provider Entity, the signature below **MUST** be the written signature of a Responsible Party for the business. If the form is being filled out for a Provider Person the person must sign the form.

**PROVIDER  
DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT AND CRIMINAL INFORMATION FORM**

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. For example, Item 11. (a) continued.

**Item I. Identifying information**

(a) Name of Provider Person, Personal National Provider Identifier(s) (NPI), Social Security Number (SSN), Date of Birth (DOB) and Medicaid ID Number(s)

<b>Provider Name(s)</b>	<b>NPI</b>	<b>SSN</b>	<b>DOB</b>	<b>Medicaid ID Number</b>

*Add more rows if needed.*

(b) Provider Entities' Name and DBA Name, National Provider Identifier(s) (NPI), Federal Tax Identification Number(s) (TIN) and Medicaid Number(s)

<b>Entity Name</b>	<b>DBA Name</b>	<b>NPI</b>	<b>TIN</b>	<b>Medicaid ID Number</b>

*Add more rows if needed.*

(c) Check Business/Organization Type:

- (1)  Are you the only provider person in your practice?
- (2)  Do you all practice with other provider person(s) in all the same location(s)?
- (3)  Are you any other practice type?

(d) Address (P.O. Boxes are not permitted. List all practice locations.):




*Add more rows if needed*

(b) List whether any of the persons named in II(a) is related to another as a spouse, parent, child or sibling.

Name	SSN	Relationship

*Add more rows if needed.*

(c) List the name, address and TIN of any other provider entity in which a person with an ownership or control interest in this provider entity (**named in Item II, section a**) also has an ownership or control interest.

Name	TIN(s)	Address (no P.O. Boxes)	City	State	Zip (5+4)

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*Add more rows if needed.*

**Item III Business Transaction Information** 42 C.F.R. §455.105

(a) List the name, address, DOB, SSN and TIN (if a business) for any subcontractor with whom the provider entity has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.

<b>Name</b>	<b>SSN</b>	<b>DOB</b>	<b>TIN(s)</b>	<b>Address (no P.O. Boxes)</b>	<b>City</b>	<b>State</b>	<b>Zip (5+4)</b>

*Add more rows if needed.*

(b) List any significant business transactions between the provider entity and any subcontractor, or wholly owned supplier, during the 5-year period ending on the date of the request.

<b>Date of Transaction</b>	<b>Person or Entity Name</b>	<b>Amount of Transaction</b>





Add more rows if needed.

**Purpose (2)** On behalf of the provider person have you ever been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of these programs.

Yes       No

If “Yes” is checked, provide the name of the Federal District of conviction for a federal offense(s): \_\_\_\_\_

and/or the County name of conviction for State offense(s): \_\_\_\_\_.

If “Yes” is checked, provide the following information:

Name	Home Address	SSN	DOB	Time Frame of the Offense	Matter of the Offense	Jurisdiction and Date of the Offense	Program Area of the Offense	Sanction Period of the Offense

Add more rows if needed.

The State or Federal Medicaid agency may refuse to enter into, renew or terminate an agreement with a provider if it is determined that a provider did not fully, accurately and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. §455.106

The signature below **MUST** be the written signature of the provider, if being filled out by an individual practitioner. If the form is being filled out for a provider entity the signature below **MUST** be the written signature of a responsible party, an individual with legal authority to bind the provider.

<b>Name of Provider Person or Provider Entities’ Responsible Party – Printed</b>	<b>Title</b>
<b>Signature of Provider Person or Provider Entities’ Responsible Party</b>	<b>Date</b>