

SUPPLEMENTAL OWNERSHIP & CONTROLLING INTEREST DISCLOSURE FORM

For Existing SD Medicaid FAOIP, Group, and Regular Individual Enrollment Types

Provider Name: _____

Provider NPI (only 1 per form): _____

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The online enrollment record does not currently capture all necessary information. This form is an extension of the online enrollment record and does not replace the online enrollment data under the ownership step.

Part A. Disclosure Questions

Instructions: Circle “Y” for each “yes” response and “N” for each “no” response. Any “Yes” response requires additional documentation explaining the situation by item number, the name(s) of involved individual(s), the resolution if any, and any related timeframes.

1. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had an assessment taken against them? Y N
2. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had an administrative sanction taken against them? Y N
3. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had a suspension of payment taken against them? Y N
4. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had a restitution order taken against them? Y N
5. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had a program exclusion taken against them? Y N
6. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had program debarment taken against them? Y N
7. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had a pending criminal judgment taken against them? Y N
8. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had a pending civil judgment taken against them? Y N
9. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had a judgment pending under the False Claims Act? Y N
10. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had a criminal fine taken against them? Y N

11. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever had a civil monetary penalty taken against them? Y N
12. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever been placed on the MED, LEIE, SAM, or other exclusionary database? Y N
13. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever been charged with or convicted of any theft or fraud type crime(s)? Y N
14. Has any state or federal health care program ever taken any type of administrative action against you, any agent or employee of the provider, or any person with an ownership or control interest in the provider? Y N
15. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever been charged with or convicted of any health related crime(s)? Y N
16. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever been charged with or convicted of a crime involving the abuse of a child or an elderly adult? Y N
17. Have you, any agent or employee of the provider, or any person with an ownership or control interest in the provider ever 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? Y N

Provider NPI: _____

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Part B. Ownership and Controlling Interest

The ownership step of the online enrollment record must list the provider’s direct and indirect ownership percentages in accordance with 42 CFR 455.102. Any amounts 5% or greater must be captured in the online enrollment record. Individuals with 5% or greater interest must be entered as an individual owner with their SSN. Entities with 5% or greater interest must be entered as an organization owner with the entity’s FEIN. The total of all ownership cannot exceed 100%.

Direct ownership is an actual ownership interest in the provider such as stock ownership. The percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation.

Ex: If A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets: $10\% \times 60\% = 6\%$ and must be reported.

Indirect ownership is an ownership interest in an entity that in turn has ownership interest in the provider. Multiply the percentages of ownership in each entity.

Ex: If A owns 10% of the stock in a corporation which owns 80% of the stock of the disclosing entity (provider noted above), A's interest: $10\% \times 80\% = 8\%$ indirect ownership interest and must be reported.

Instructions: Populate the online enrollment record in accordance with the definitions noted above and check the boxes below to confirm that the information is accurate. In the case of individual ownership interest records, the individual(s) listed in the individual record must also be listed in this form below with that individual’s date of birth.

The online enrollment record has been updated to reflect the current ownership interests.

In the case of individual ownership interests:

Name: _____ Date of Birth ____/____/____

In the case of organizational interests:

The applicable primary business address is captured in the ownership step of the online enrollment record. Any business location for the given organization ownership interest is listed in the online record or attached to this form.

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Part C. Managing Interest

Under 42 CFR 455.101, a managing employee is defined as "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 operations of an institution, organization or agency". The "other individual" reference generally includes, but is not limited to, members of board of directors or other governing bodies.

Instructions: All individuals currently meeting the above definition of "managing employee" must be populated on the online enrollment record. In addition, populate the name(s), date of birth, and address for ALL individuals meeting the definition of managing employee in the same order as found on the online enrollment record. If a listed individual on the online enrollment is no longer a managing employee with the disclosing provider, provide an end date on the form below. Use additional copies of this page as needed to list all individuals.

First Name: _____ Middle Name: _____ LastName: _____

Date of Birth: ____/____/____ SSN: _____ End Date: ____/____/____

Street Address: _____

City: _____ State: _____ ZIP: _____

First Name: _____ Middle Name: _____ LastName: _____

Date of Birth: ____/____/____ SSN: _____ End Date: ____/____/____

Street Address: _____

City: _____ State: _____ ZIP: _____

First Name: _____ Middle Name: _____ LastName: _____

Date of Birth: ____/____/____ SSN: _____ End Date: ____/____/____

Street Address: _____

City: _____ State: _____ ZIP: _____

First Name: _____ Middle Name: _____ LastName: _____

Date of Birth: ____/____/____ SSN: _____ End Date: ____/____/____

Street Address: _____

City: _____ State: _____ ZIP: _____

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First Name: _____ Middle Name: _____ LastName: _____

Date of Birth: ____/____/____ SSN: _____ End Date: ____/____/____

Street Address: _____

City: _____ State: _____ ZIP: _____

First Name: _____ Middle Name: _____ LastName: _____

Date of Birth: ____/____/____ SSN: _____ End Date: ____/____/____

Street Address: _____

City: _____ State: _____ ZIP: _____

First Name: _____ Middle Name: _____ LastName: _____

Date of Birth: ____/____/____ SSN: _____ End Date: ____/____/____

Street Address: _____

City: _____ State: _____ ZIP: _____

First Name: _____ Middle Name: _____ LastName: _____

Date of Birth: ____/____/____ SSN: _____ End Date: ____/____/____

Street Address: _____

City: _____ State: _____ ZIP: _____

I declare and affirm under the penalties of perjury that this document has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I further declare and affirm under the penalties of perjury that any claim to be submitted pursuant to this document will be examined by me, and to the best of my knowledge and belief, will be in all things true and correct. Failure to appropriately disclose information is reason to deny an application to be a provider with South Dakota Medicaid or terminate an existing provider agreement with South Dakota Medicaid.

Completed by: _____ Date: _____

(Signature of Authorized Official)

Printed Name: _____
