SUPPLEMENTAL OWNERSHIP & CONTROLLING INTEREST DISCLOSURE FORM

To supplement applications for SD Medicaid Tribal/IHS 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.

Part B. Ownership and Controlling Interest

Each enrolled provider 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. 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% x 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% x 80% = 8% indirect ownership interest and must be reported.

Instructions: Circle or populate the requested data below. Complete this page for each organization or individual who has 5% or greater ownership or control interest in the provider noted above.

Owner Type (circle one): Individual Ownership Organization Ownership

If Organization Owner:

FEIN:_____ Organization Name:_____

Percent Owned (In whole number): _____%

Ownership Start Date: ____/____/_____Ownership End Date: ____/____/_____

Relationship To Provider: Spouse Parent Child Sibling Self None

Street Address: _____

City:_____State: _____ ZIP:_____

Provider NPI: _____

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In the case of organizational interests, confirm the following by noting an "X":

☐ Any business location for the given organization ownership interest is listed above, is in the online enrollment record or is attached to this form.

If Individual Owner:

SSN _____ Date of Birth_____/_____/_____

First Name:_____Middle Name:_____ Last Name:_____

Percent Owned (In whole number): _____%

Ownership Start Date: ____/____/_____Ownership End Date: ____/____/_____

Relationship To Provider: Spouse Parent Child Sibling Self None

Street Address: _____

City:_____State: _____ ZIP:_____

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 below with the appropriate status circled. Use additional copies of this page as needed to list all individuals. Any person who has an ownership or control interest in the disclosing entity (provider), or is an agent or managing employee of the disclosing entity (provider) who has ever been convicted of a criminal offense related to the involvement in any program under Medicare, Medicaid, Title XXI or the Title XX program should be noted as "Managing-Convicted" and requires supporting details regarding the conviction. To enter convicted employees that are not managing employees, select "Non-Managing Convicted." Managing employees without convictions should be noted as "Managing Non-Convicted."

First Name:_____Middle Name:_____ LastName:_____

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

Status: Managing Non-Convicted Non-Managing Convicted Managing Convicted

Street Address: _____

City:_____State: _____ ZIP:_____

Provider NPI: _________________

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First Name:________________________Middle Name:____________________ LastName:_______________________

Date of Birth:_____/______/_____ SSN: ___________________________ End Date: _____/______/_____

Status: Managing Non-Convicted Non-Managing Convicted Managing Convicted

Street Address: ____

City:___________________________________State: _______ ZIP:__________

First Name:________________________Middle Name:____________________ LastName:_______________________

Date of Birth:_____/______/_____ SSN: ___________________________ End Date: _____/______/_____

Status: Managing Non-Convicted Non-Managing Convicted Managing Convicted

Street Address: ____

City:___________________________________State: _______ ZIP:__________

First Name:________________________Middle Name:____________________ LastName:_______________________

Date of Birth:_____/______/_____ SSN: ___________________________ End Date: _____/______/_____

Status: Managing Non-Convicted Non-Managing Convicted Managing Convicted

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:_________________________________