SUPPLEMENTAL OWNERSHIP & CONTROLLING INTEREST DISCLOSURE FORM

To supplement applications for SD Medicaid Group, FAOIP, 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.

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: 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 _____/_____/_____

Name: _____ Date of Birth _____/_____/_____

Name: _____ Date of Birth _____/_____/_____

Name: _____ Date of Birth _____/_____/_____

Name: _____ Date of Birth _____/_____/_____

Provider NPI: _____ **Page _____ of _____**

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.

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:_____

Provider NPI: ___________________　　　**Page _____ of _____**

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:_______________________________________