

# INSTRUCTIONS FOR COMPLETING THE FOLLOWING

## OWNERSHIP / CONTROLLING INTEREST

### AND CONVICTION INFORMATION FORM

**Each item on the form must be completed.**

If the item does not pertain to the enrolling provider, indicate NA for Not Applicable.

- Item A: List the name and address of any person or corporation who owns or controls 5% or more of the enrolling provider's business and list the actual % of ownership or controlling interest. Also, list the name, address and % of ownership or controlling interest of any subcontractor in which the enrolling provider owns 5% or more.
- Item B: List the name and relationship of any person indicated in Item A who is related to the enrolling provider as a spouse, parent, child or sibling.
- Item C: List the name, information and ownership % of any person or corporation indicated in Item A who may have ownership or controlling interest of 5% or more in any **other** Medicaid provider's business.
- Item D: List the name, address, controlling interest and relationship of subcontractors and wholly owned suppliers who had business transactions totaling \$25,000 with the enrolling provider.
- Item E: List name and conviction for any person who has an ownership or control interest **OR** is an agent or managing employee of the enrolling provider's business who has ever been convicted of a criminal offense (felony or not) related to the involvement in any program under Medicare, Medicaid, Title XXI or the Title XX Program.
- Item F: List the name(s) of **ALL** managing employees of the enrolling provider. 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".

**Provider Statement:** Print name and title of enrolling provider on the first line

**The enrolling provider signs as authorized signature.**

If enrolling as an individual provider, the actual provider must sign but if enrolling as an entity or organization, the director, administrator, CEO or CFO must sign. **Only actual signatures will suffice - No stamped or administrative signatures will be accepted.**

## OWNERSHIP / CONTROLLING INTEREST AND CONVICTION INFORMATION

To participate in the South Dakota Medical Assistance (Medicaid) Program, completion of this form is required as mandated by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, 42 CFR 455.104 to 106, inclusive, and 42 CFR 455.101 as required under the Social Security Act and per South Dakota Administrative Rule 67:16:33:06. Disclosure of the following information will ensure that South Dakota Medical Assistance continues receiving Federal financial participation.

A. List the name and address of each person or corporation with a direct or indirect ownership or control interest of 5% or more in the disclosing entity (provider) or in any subcontractor in which the disclosing entity (provider) has direct or indirect ownership of 5% or more.

Name	Address	% Of Interest
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Are any of the persons mentioned above related to the enrolling entity (provider) as a spouse, parent, child, or sibling? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please name and show relationship.

Names	Relationship
_____	_____
_____	_____
_____	_____

C. Do any of the persons or corporations with an ownership or control interest have an ownership or control interest of 5% or more in any other disclosing entity (Medicaid provider)? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please name and show information.

Name	Other Provider Name	% Of Interest
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. List the name, address, controlling interest and relationship of subcontractors and wholly owned suppliers who have had business transactions totaling \$25,000 of the disclosing entity (provider).

Name	Address	% Of Interest	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

E. List 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.

Name	Conviction
_____	_____
_____	_____
_____	_____

F. List the name(s) of **ALL** managing employees of the disclosing entity (Medicaid provider).  
 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”.

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**PROVIDER STATEMENT:**

I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Provider Enrollment of any additions/changes to the information.

Provider Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 (please print)

Provider Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_