Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name	Federal Tax ID or SSN

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. *See* Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: ☐ Yes or ☐ No

Group of Individual Practitioners ☐ Yes or ☐ No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all ***individuals*** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of your organization if you are organized as a corporation; or
f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

a) has an ownership interest totaling five percent or more in you;
b) has an indirect ownership interest equal to five percent or more in you;
c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
e) is an officer or director of you if organized as a corporation; or
f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? ☐ Yes or ☐ No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

☐ Yes or ☐ No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means 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 or 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 established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? ☐ Yes or ☐ No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

   ☐ None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

   ☐ None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

   ☐ None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

☐ None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

☐ None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory	
Signature of Authorized Signatory	Date