

Mississippi Division of Medicaid Provider Disclosure Form

This provider disclosure form is for:			
<input type="checkbox"/> Provider Application/Enrollment		<input type="checkbox"/> Re-validation	
<input type="checkbox"/> Change of Disclosing Information		<input type="checkbox"/> Request of Division of Medicaid	
<input type="checkbox"/> Change of Ownership (CHOW)			
Date of CHOW: _____			
SECTION A Disclosing Provider Information			
Legal Business Name			
EIN/SSN:		NPI:	
Address (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and P O Box addresses.)			
Address	City	State	Zip
If the disclosing entity is an existing MS Medicaid provider, please enter the current Medicaid provider number.			
Type of Business - Privately Owned or Non-profit Providers only			
<input type="checkbox"/> Individual/Sole Proprietorship		<input type="checkbox"/> Corporation	
<input type="checkbox"/> Partnership/Limited Liability Partnership		<input type="checkbox"/> Limited Liability Company (LLC)	
<input type="checkbox"/> Non-Profit (Must attach IRS verification showing non-profit status)			
SECTION B Ownership and Control			
NOTE: ONLY REPORT ORGANIZATIONS IN THIS SECTION. INDIVIDUALS WITH OWNERSHIP/MANAGING CONTROL MUST BE REPORTED IN SECTION B-2. The disclosing entity <u>MUST</u> have at least ONE owner and at least one managing employee. If there is more than one business entity with ownership/control interest that should be reported, copy and complete this section for each.			
SECTION B-1 Business Entity with Ownership Interest and/or Managing Control Identification Information			
Check all that apply:			
[] 5 Percent (5%) or More Ownership Interest [] Partner [] Managing Control			
Legal Business Name as Reported to the Internal Revenue Service			

Doing Business As Name (if applicable)		Tax Identification Number (required)	
Primary Business Address Line 1 (Street Name and Number)			
Address Line 2 (Suite, Room, etc.)			
City		State	Zip Code
Mailing Address (P.O. Box)	City	State	Zip Code
Business Location			
Address Line 1			
Address Line 2			
City		State	Zip Code
Business Location			
Address Line 1			
Address Line 2			
City		State	Zip Code
Business Location			
Address Line 1			
Address Line 2			
City		State	Zip Code

**SECTION B-2
Individuals with Ownership Interest and/or Agents/
Managing Control**

The following individuals must be reported in Section B-2:

- All individual owners with 5% or more direct/indirect ownership
- All officers and directors of the disclosing provider (whether for profit or non-profit)
- All managing employees of the disclosing provider
- All Authorized and delegated officials noted in the Mississippi Medicaid Enrollment application

If there is more than one individual with ownership/control interest that should be reported, copy and complete this section for each individual.

First Name	MI	Last Name	Jr., Sr., etc.
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Social Security Number (required)	Date of Birth (MM/DD/YYYY)
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Home Address	City	State	Zip Code
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What is the above noted individual's relationship with the enrolling provider? (Check all that apply.)

[] 5 Percent (5%) or Greater Direct/Indirect Owner [] Director/Officer

[] Partner [] Contracted Managing Employee

[] Managing Employee (W-2) [] Agent

Are any individuals or legal entities (**disclosed in Section B**) as having an ownership or control interest, officer, agent, managing employee, director, or shareholder related to each other as spouse, parent, child, or sibling? Yes No

If so, provide the requested information for each:

Name	Relationship
Name	Relationship
Name	Relationship

Section C – Criminal Convictions and Other Sanctions

Provide the requested information in this section or any person who:

(1) Has an ownership or control interest in the disclosing provider OR is an agent or managing employee of the disclosing provider

AND

(2) Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs,

OR

(3) Has been convicted of a crime referenced in Miss. Code Ann. § 43-13-121(7)(c) – (h),

(4) Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c-h),

- (5) Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program,
- (6) Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program,
- (7) Has had his/her/its license or certification revoked, or
- (8) Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.

Identify the person and each convictions/sanction, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Attach a copy of any documentation.

Name	Criminal/ Sanction Information	Date	Agency/Court/ Administrative Body	Resolution

Section D
Relationships to Excluded, Penalized, or Convicted Persons in Accordance with
42 CFR § 1002.3

Identify and provide the requested information in this section regarding any person who:

- (1) has been convicted of a criminal offense as described in Sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act;
- (2) has had civil money penalties or assessments imposed under Section 1128A of the Social Security Act; OR
- (3) has been excluded from participation in Medicare or any of the state health programs AND
- (4) also has one or more of the following relationships to the disclosing provider:
 - i. has a direct or indirect ownership interest (or any combination thereof) of five percent (5%) or more in the entity;
 - ii. is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent (5%) of the total property and assets of the entity;
 - iii. is an officer or director of the entity, if the entity is organized as a corporation;
 - iv. is a partner in the entity, if the entity is organized as a partnership;
 - v. is an agent of the entity;
 - vi. is a managing employee, that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity or part thereof, or directly or indirectly conducts

<p>vii. the day-to-day operations of the entity or part thereof; or was formerly described in subparagraphs (i) through (vi), immediately above, but is no longer so described because of a transfer or ownership or control interest to an immediately family member or a member of the person's household as defined in this section, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.</p>		
<p>NOTE: Please refer to Page 1 of the Instructions for Provider Disclosure Form for applicable definitions.</p>		
Name	Relationship:	<input type="checkbox"/> Current <input type="checkbox"/> Former
Conviction Information (Crime):		Date of Conviction:
Reason for Penalty or Assessment Information:		Date of Penalty or Assessment Imposed:
Reason for Medicare Exclusion Information:		Date Exclusion Imposed:
State Health Care Program Exclusion	State Agency and Reason:	Date of Exclusion:
SECTION E Disclosure of Other Ownership and Control		
<p>Identify individuals or legal entities as having an ownership or control interest who also have an ownership or control interest in any other disclosing entity.</p>		
Name of the Individual/Legal Entity (noted in Section A or B)		
Other Entity Name		
Other Entity Address		
EIN of the Other Entity:		
<p>Are any individuals or legal entities (disclosed in Section B and/or B-2) as having an ownership or control interest, officer, agent, managing employee, director, or shareholder related to the individual/entity (noted in Section C) as a spouse, parent, child or sibling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
If yes, please provide the requested information for each:		
Name	Relationship	Name of Person in Section B-1 and/or B-2

Name	Relationship	Name of Person in Section B-1 and/or B-2
Name	Relationship	Name of Person in Section B-1 and/or B-2

SECTION F
Disclosure of Subcontractor Information

Identify any person (individual or legal entity) with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership of five percent (5%) or more.

Name of the Individual/Legal Entity (noted in Section A or B)

Name of the Subcontractor

Address of the Subcontractor (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and P O Box addresses.)

Address	City	State	Zip

SSN/EIN of the Subcontractor:

Are any individuals or legal entities (disclosed in Section B-1 and/or 2) as having an ownership or control interest, Officer, agent, managing employee, director or shareholder related to the subcontractor (noted in Section D) as spouse, parent, child or sibling? Yes No

If yes, please provide the requested information for each:

Name	Relationship	Name of Person in Section B-1 and/or B-2
Name	Relationship	Name of Person in Section B-1 and/or B-2
Name	Relationship	Name of Person in Section B-1 and/or B-2

**SECTION G
Business Transactions**

(This section should only be completed at the direction of Division of Medicaid (DOM))

Identify the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period before the date of this request. If there are multiple owners or shareholders, list only those with direct or indirect ownership of five percent (5%) or more. If there are no such transactions to report, please respond "None".

Name of Subcontractor

Address

SSN or EIN

Name of Owner	Address
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Name of Owner	Address
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Name of Owner	Address
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Identify any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the five-year period before the date of this request below. If there are no significant business transactions to report, please respond "None".

SECTION H
Attestation and Signature of the Disclosing Provider

I certify that the information on this form, and any attached statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I sign under penalty of perjury, and may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

In addition, I understand that:

- In accordance with 42 CFR § 455.104(e), federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required.
- In accordance with 42 CFR § 455.106(c), DOM may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. Further, DOM may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under 42 CFR § 455.106(a).
- In accordance with Miss. Code Ann. § 43-13-121, Medicaid enrollment may be denied or revoked when providers or their agents, managing employees, or those with minimum ownership interests are convicted of certain crimes and other circumstances. These circumstances include failure to truthfully or fully disclose any and all information required on this form, or making a false or misleading statement to DOM relative to the Medicaid program.
- In accordance with 42 CFR § 455.436, the State Medicaid agency and all Medicaid contractors shall do the following:
 1. Confirm the identity and determine the exclusion status of providers and contractors/subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the provider or contractor/subcontractor through routine checks of federal databases; and,
 2. Consult appropriate databases to confirm identity of the above-mentioned persons and entities by searching the List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) upon enrollment, re-enrollment, credentialing, or re-credentialing, and no less frequently than monthly thereafter, to ensure that the State does not pay federal funds to excluded persons or entities.

NOTE: If the disclosing provider is an individual, the application must be signed by the individual provider.
 If the disclosing provider is a business entity, the signature should that of the person legally authorized to sign on behalf of the entity.

Printed Name:

Signature:

Date:

Title: