HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

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Oregon Medicaid

(Oregon Health Plan)

Provider Disclosure Statement of Ownership and Control, Business Transactions and Criminal Convictions

All pages of this form must be returned even if pages are blank. This form supersedes any previous form received for this enrolled / enrolling provider.

Please check the box that explains the reason for disclosure:

- ☐ New Enrollment
- ☐ Re-enrollment
- ☐ Revalidation
- ☐ Change in ownership
- ☐ Change in managing employee
- ☐ Removal of owner or managing employee ***see page 12***
- ☐ Removal of director or officer *if organized as a corporation* ***see page 12***

Organization Information (disclosing entity)

Organization legal name:	
Doing Business As (DBA) name *(if applicable)*:	Federal Employer Identification Number (EIN) (## - ########):
National Provider Identifier (NPI):	Existing Medicaid Provider ID (MCD) *(if known)*:
Business address (not mailing) Street: City: State: Zip:	

Business type *(check one)*

- ☐ Corporation
- ☐ Government-owned
- ☐ Limited Liability Corporation (LLC)
- ☐ Limited Liability Partnership (LLP)
- ☐ Limited Partnership
- ☐ Not-for-profit
- ☐ Partnership
- ☐ Professional Corporation
- ☐ Tribally owned
- ☐ Other: *(enter below)* _____

Is the disclosing entity organized as a corporation? ☐ Yes ☐ No
If yes, complete Section II, Question 2 and 3 are also required.

Purpose

Federal law requires a State Medicaid Agency (SMA) to complete Federal database checks on newly enrolling, enrolled, and revalidating providers. This includes any person (individual or organization) with an ownership or control interest or who is a managing employee of the provider (disclosing entity). See 42 CFR § 455.436

Disclosure of Social Security Number (SSN) is ***required*** pursuant to 41 USC 405(c)(2)(C)(i) to establish identification, 42 CFR 455.104 and 455.436 for exclusion verification and 26 CFR 301.6109-1 for the purpose of reporting tax information. OHA may report information to the Internal Revenue Service (IRS) and the Oregon Department of Revenue under the name, Social Security Number (SSN) or Federal Employer Identification Number (FEIN) provided on this application. See 42 U.S.C. § 1320a-3, 42 U.S.C. § 405 (c)(1) and OHA's Privacy Policy and Disclosure Notice to learn more about this requirement.

Agent / Authorized Signer Information *see Glossary for definition.*

Agent name:	Agent email:
Agent phone number (### - ### - ####):	Agent fax number (### - ### - ####):

If the contact person for this request is different than the Agent listed above, list contact person below.

Contact name:	Contact email:
Contact phone number (### - ### - ####):	Contact fax number (### - ### - ####):

Section I: Identification of All Owners

Section I, Question 1:
List all individual(s) and/or organization(s) with a **Direct or Indirect Ownership** of 5% or more. *Refer to glossary to determine who should be listed as an Owner and/or to calculate Ownership Interest.*
Individuals: List the name, primary business address, date of birth (DOB) and Social Security Number (SSN) for each person having a 5% or greater Ownership Interest in the Entity.

Entities: List the name, Tax Identification Number (TIN), primary business address, every business location and PO Box address of each organization, corporation, or entity having 5% or greater Ownership Interest. *Use Section IV to list the other business locations.*
Note: If there are 1 – 7 owners, fill out the chart below. If there are 8 or more owners, attach a list with the required fields labeled, "Section 1, Question 1".
Check this box if you attached a list. ☐

Check box ☐ If there are no owners or if there are owners, but all have less than 5% ownership.

Name of Owner	Complete Address	DOB (Individual) SSN (Individual) TIN (entity)	% Interest
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	

Section II: Identification of All Individuals & Entities with a Controlling Interest

Section II, Question 1: Managing Employee(s) *Refer to glossary for definition.*
List each individual who is a managing employee of the disclosed entity. Information to be disclosed must include name, date of birth (DOB), primary business address and Social Security Number (SSN). If no managing employee(s) is listed, form will be returned as incomplete.

Note: If there are 1 – 8 managing employees, fill out the chart below. If there are 9 or more managing employees, attach a list with the required fields labeled, "Section 2, Question 1".

Check this box if you attached a list. ☐

Name of Managing Employee	Complete Address	SSN *(Individual)*	DOB *(Individual)*
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		

Section II, Question 2: Officers *Refer to glossary for definition.*
This question is required if indicated on page 1 that the disclosing entity is organized as a corporation.

List each individual who is an officer of the disclosing entity. Information to be disclosed must include name, date of birth (DOB), primary business address and Social Security Number (SSN)

Note: If there are 1 – 8 officers, fill out the chart below. If there are 9 or more officers, attach a list with the required fields labeled, "Section 2, Question 2".

Check this box if you attached a list. ☐

Name of Officer	Complete Address	SSN *(Individual)*	DOB *(Individual)*
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		

Section II, Question 3: Directors *Refer to glossary for definition.*
This question is required if indicated on page 1 that the disclosing entity is organized as a corporation.

List each individual who is a director of the disclosing entity. Information to be disclosed must include name, date of birth (DOB), address and Social Security Number (SSN)

Note: If there are 1 – 8 directors, fill out the chart below. If there are 9 or more directors, attach a list with the required fields labeled, "Section 2, Question 3".

Check this box if you attached a list. ☐

Name of Director	Complete Address	SSN *(Individual)*	DOB *(Individual)*
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		

Section II, Question 4: Controlling Interest
Complete this question if there are any other individuals or organizations with a **Controlling Interest** in the disclosing entity. *Refer to glossary for definition.*

List the name, address, date of birth (DOB) and Social Security Number (SSN) for each person who has a Controlling Interest in the disclosing entity. List the name, Tax Identification Number (TIN), primary business address, every business location and PO Box Address of each organization, corporation, entity having a Controlling Interest.

Note: If there are 1 – 7 individuals/organizations with Controlling Interest, fill out the chart below. If there are 8 or more individuals/organizations with Controlling Interest, attach a list with the required fields labeled, "Section 2, Question 4".

Check this box if you attached a list. ☐

Name of Individual or Organization	Complete Address	DOB (Individual) SSN (Individual) TIN (entity)	Title *(as applicable)*
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	

Section III: Ownership & Controlling Interest in Other Disclosing Entities

Section III, Question 1:
Complete this question if the individuals or organizations *identified in* ***Section I*** as an owner have an Ownership or Controlling Interest in any **Other Disclosing Entity**? *Refer to glossary for definition.*

List the name and SSN or TIN of the Other Disclosing Entity in which the Owner identified in ***Section I*** also has an Ownership or Controlling Interest

Note: If there are 1 – 10 owners, fill out the chart below. If there are 11 or more owners, attach a list with the required fields labeled, "Section 3, Question 1".

Check this box if you attached a list. ☐

Name of Owner Listed in Section I	Name of Other Disclosing Entity	Other Disclosing Entity's SSN (individual) or TIN (entity)

Section IV: Ownership & Controlling Interest in Subcontractors

Section IV, Question 1:
If the disclosing entity has a Direct or Indirect Ownership Interest of 5% or more in any **Subcontractor,** list those below. *Refer to glossary for definition.*

If an individual or organization with an Ownership or Controlling Interest in any Subcontractor in which the disclosing entity ***also has*** Direct or Indirect Ownership Interest of 5% or more, list those below.

Note: If there are 1 – 2 subcontractors, fill out the chart below. If there are 3 or more subcontractors, attach a list with the required fields labeled, "Section 4, Question 1".
Check this box if you attached a list. ☐

Legal Name of Subcontractor:			Subcontract TIN/SSN:
Name of *Other Individual/Organization with Ownership or Controlling Interest*:			
Other *Individual/Organization's* Complete Address (Street/City/State/Zip) Street: City:		State:	Zip:
Other Organization's TIN:	*Other Individual's SSN*:	*Other Individual's DOB*:	% Interest in Subcontractor:

Legal Name of Subcontractor:			Subcontract TIN/SSN:
Name of *Other Individual/Organization with Ownership or Controlling Interest*:			
Other *Individual/Organization's* Complete Address (Street/City/State/Zip) Street: City:		State:	Zip:
Other Organization's TIN:	*Other Individual's SSN*:	*Other Individual's DOB*:	% Interest in Subcontractor:

Section V: Family Relationships

Section V, Question 1:
If any of the individuals identified in Sections I, II, III or IV, are related to each other (e.g., spouse, sibling, parent, child), list the individuals and relationship to each other.

Note: If there are 1 – 4 relationships, fill out the chart below. If there are 5 or more relationships, attach a list with the required fields labeled, "Section 5, Question 1".

Check this box if you attached a list. ☐

Name of Individual #1	Name of Individual #2	Relationship

Section VI: Criminal Convictions, Sanction, Exclusions, Debarment and Terminations

Section VI, Question 1:
If the disclosing entity, or any person who has an Ownership or Controlling Interest in the disclosing entity, or who is an Agent or Managing Employee of the disclosing entity **ever been convicted of a crime** related to that person's involvement in any program under Medicaid, Medicare, CCHIP or Title XX program since the inception of those programs, list those individuals and the required information below.

Note: If providing additional documentation, attach a list with the required fields labeled "Section VI, Question1".

Do you have additional documentation to attach? ☐ Yes ☐ No

Name:		
DOB:	SSN (individual) or TIN (entity):	State of Conviction:
Complete Address (Street/City/State/Zip) Street: City: State: Zip:		
Matter of the Offense:		
Date of Conviction:	Date of Reinstatement *(enter N/A if not reinstated)*:	

Section VI, Question 2:
If the disclosing entity, or any person who has an Ownership or Controlling Interest in the disclosing entity, or who is an Agent or Managing Employee of the disclosing entity has **ever been sanctioned, excluded, or debarred** from Medicaid, Medicare, CCHIP or Title XX program, list those individuals and the required information below.

Note: If providing additional documentation, attach a list with the required fields labeled "Section VI, Question2".

Do you have additional documentation to attach? ☐ Yes ☐ No

Name:	
DOB:	SSN (individual) or TIN (entity) :
Complete Address (Street/City/State/Zip) Street: City: State: Zip:	
Reason for Sanction, Exclusion or Debarment:	
Date(s) of Sanctions, Exclusions or Debarments:	Date of Reinstatement *(enter N/A if not reinstated)*:
List all States where currently excluded:	

Section VII: Removal of Owner(s) or Managing employee(s)

If additional space is needed to list the name(s) of previous owners or managing employees who need to be removed from the enrollment record, please enclose a separate page listing the name(s), DOB, SSN or TIN.

If removing owner(s), complete section I, question 1 to either update ownership percentage for existing owner(s) or to add new 5% or more owner(s).

Name of Owner	**SSN (*Individual*)** **TIN (*entity*)**	**DOB (*Individual*)**

Complete the corresponding section(s) above if adding individuals to replace those removed.

Name of Managing Employee	**SSN *(Individual)***	**DOB *(Individual)***

Name of Director or Officer	**SSN *(Individual)***	**DOB *(Individual)***

Section VIII: Business Transaction Information

Section VII is not required at the time of supplying this form but may be required upon request of CMS or the State Medicaid Agency (SMA). By signing this form, you are acknowledging that you will supply the following information within 35 days if requested by the Secretary of Health and Human Services or the SMA.

Section VII, Question 1: Business Transactions – Subcontractors

List the information for Subcontractors with whom the disclosing entity has had business transactions totaling more than $25,000 during the previous 12-month period ending on the date of the request.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractors Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN (individual) or TIN (entity), and Subcontractor Owner's Address

Section VIII, Question 2: Significant Business Transactions – Wholly Owned Suppliers

List the information of any Wholly Owned Supplier with whom the disclosing entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period.

- Name of Supplier, Supplier's SSN (individual) or TIN (entity), and Supplier's Address

Section VIII, Question 3: Significant Business Transactions – Subcontractors

List the information for Subcontractor with whom the disclosing entity has had any Significant Business Transactions exceeding the lesser or $25,000 or 5% of operating expensed during any one fiscal year in the past 5-year period.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractors Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN (individual) or TIN (entity), and Subcontractor Owner's Address

Disclosing entity's attestation, signature and date

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 by knowingly providing false information on this form or in connection with any claim for payment from the State of Oregon, which may include federal funds, I may be liable for a false claim under the Oregon False Claims Act (ORS 1807.750 to 180.785) and the federal False Claims Act (31 USC 3279 to 3733). I agree to inform OHA or its designee, in writing, within 30 days of any changes or if additional information becomes available.

Print name of Provider Agent / Authorized Signer	Title
Signature of Provider Agent / Authorized Signer	Date

Glossary – many of these definitions have been sourced from **42 CFR § 455.101.**

Agent: means any person who has been delegated the authority to obligate or act on behalf of a provider. This individual also acts as an authorized signer for the entity.

Direct Ownership Interest: An individual or entity that possesses equity in the capital, the stock, or the profits of the disclosing entity. Ownership Interest also includes an interest in any mortgage, deed of trust, note, or other obligations.

In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported (42 CFR §455.102).

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Indirect Ownership Interest: An individual or entity that has an ownership interest in an entity that has a direct or indirect ownership interest in the disclosing entity.

The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported (42 CFR §455.102).

Managing Employee: 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 operation of an institution, organization, or agency.

Managed Care Entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Officers and directors: All officers and directors must be disclosed if the disclosing entity is organized as a corporation. *See question on page 1*. This includes board members, board of directors, volunteers, and if a non-profit corporation has "trustees" instead of officers or directors, these trustees must be disclosed. To clarify further on "director" this would not be the Finance Director unless the Finance Director is also on the Board of Directors. However, if the Finance Director meets the definition of a managing employee, then the Finance Director should be disclosed as a managing employee.

Other Disclosing Entity: 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, XV III, or XX of 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
(b) (title XV III);
(c) Any Medicare intermediary or carrier; and

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.

Person with an ownership or control interest means a person or corporation that;

(a) Has an ownership interest totaling 5 percent of more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct or indirect ownership interests equal to 5 percent of more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant Business Transaction: means any business transaction or series of related that, during any one fiscal year, exceeds the lesser of $25,000 or five percent (5%) of a providers total operating expenses.

Subcontractor:

(a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier: means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Provider Enrollment at provider.enrollment@odhsoha.oregon.gov or 1-800-336-6016 (voice). We accept all relay calls.