Disclosure of Ownership Form
Individual

This form is to be used when applying for network participation as an individual provider or at the time of re-credentialing if contracted on an individual basis with Guardian and/or a Guardian entity. If the addition of an individual provider to an existing entity will change the ownership or control structure of such entity, then a new disclosure form for the entity must be completed to reflect the new ownership or control structure. For example, the new individual provider will be an owner or high-ranking employee of the existing entity.

Please answer all questions as they pertain to the date the form is being completed. If additional space is needed, please note on the form the answer is being continued on a separate attachment and reference the item number on the attachment being continued. Please return the original document to Guardian and retain a copy for your files. Respond to all applicable questions and respond N/A to any question not applicable. NO QUESTIONS CAN BE LEFT BLANK.

Website and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement. Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).

I. IDENTIFYING INFORMATION

Provider's Full Name	SSN	Date of Birth	National Provider Identifier (NPI)	Medicaid Identification Number
Provider's Home Address		**City**	**State**	**Zip Code**

Entity Name (This is whom the Individual Provider is employed by. If Individual Provider is sole proprietor, then list Individual Provider as entity.)		Entity D.B.A Name (Only complete if different from Entity Name)	Entity Federal Tax Identification Number
Entity NPI	**Medicaid Identification Number**	**Entity Address** (If more than one (1) practice location, list all locations)	

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II. Criminal Offense Attestation

A) Have you ever been **convicted** of a criminal offense related to your involvement in any program under Medicare, Medicaid, SCHIP or the Title XX services program since the inception of those programs? "Convicted" means been found guilty by a jury or judge, or pled guilty, nolo contendre, best interest plea or pretrial diversion or suspended sentence.

Yes ☐ **No** ☐

If Yes is checked, provide the following information:

Name on Court Record	SSN	Description of Offense	Date of Conviction	Sanction Period *If Sanctioned by Office of the Inspector General (OIG)*

B) Have you ever been **debarred** from participation in federal government contracts? **Debarred** means you are not allowed to participate in contracts paid for by the federal government, whether or not those contracts are in the health care area.

Yes ☐ **No** ☐

If Yes is checked, provide the following information:

Date Debarred	Length of Debarment	Reason for Debarment

C) Have you ever been **excluded** from participation in federal health care programs (Medicare, Medicaid, SCHIP or TRICARE) in the past? **Excluded** means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded health care program.

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Date Excluded	Date of Reinstatement	Reason for Exclusion

D) Have you ever been **terminated** from a state's Medicaid or SCHIP program for reasons having to do with Program Integrity (fraud or abuse)? **Terminated** means the Provider lost the right to bill a state's Medicaid or SCHIP program for a cause related to fraud or abuse.

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

State Issuing Termination	Date of Termination	Reason for Termination

E) Have you ever had **Civil Monetary Penalties (CMPs)** assessed against you? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal health care program.

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

State Assessing CMP	Date of CMP	Amount of CMP	Reason for CMP

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III. Questions for a Sole Proprietor

A) If you are a sole proprietor, please give the following information for your managing employees and agents. A managing employee is someone who makes day-to-day decisions on the running of your business such as an office manager or billing manager. An agent is someone besides yourself who can legally act for your business.

Managing Employee or Agent Name	SSN	DOB	Complete Home Address (Street, City, State and Zip)

B) Has any person listed in question 3A ever been **convicted** of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? **Convicted** means been found guilty by a jury or judge, or pled guilty, nolo contendre, best interest plea or pretrial diversion or suspended sentence.

Yes ☐ **No** ☐

If Yes is checked, provide the following information:

Managing Employee or Agent's Full Name	Date Convicted	Sanction Period Issued by Office of Inspector General	Explanation of Offense	

C) Has anyone on the list in question 3A ever been **debarred** from participation in federal government contracts? **Debarred** means someone is not allowed to participate in contracts paid for by the federal government, whether or not those contracts are in the health care area.

Yes ☐ **No** ☐

If Yes is checked, provide the following information:

Managing Employee or Agent's Full Name	Date of Debarment	Length of Debarment	Reason for Debarment

D) Has any person on the list in question 3A ever been **excluded** from participation in federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past?

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Managing Employee or Agent's Name	Date Excluded	Date of Reinstatement	Reason for Exclusion

E) Has anyone on the list in question 3A ever been **terminated** from a state's Medicaid or SCHIP program for reasons having to do with Program Integrity (fraud or abuse)?

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Managing Employee or Agent's Name	State Issuing Termination	Date of Termination	Reason for Termination

F) Has any person on the list in question 3A ever had a **Civil Monetary Penalties** (CMPs) assessed against them?

Yes ☐ **No** ☐

If Yes is checked, supply the following information:

Managing Employee or Agent's Name	State Assessing	Date of CMP	Amount of CMP	Reason for CMP

IV. Signature

Guardian and the state or federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106.

THE SIGNATURE BELOW MUST BE THE WRITTEN SIGNATURE OF THE PROVIDER.

In compliance with 42 CFR 455.104c, Provider shall provide a disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement, at the time of re-credentialing/re-enrollment, and within 35-days after any change in ownership of the disclosing entity. In compliance with information outlined in section III, Business Transactions, above.

Name Individual Provider (printed)	Signature of Individual Provider STAMPED SIGNATURE NOT ACCEPTABLE	Date

Authorized Individual Completing Form (printed)	Title of Authorized Individual Completing Form
Phone Number of Authorized Individual	**Email of Authorized Individual**