Disclosure of Ownership Instructions

Field #	Description
1	Enter name of individual or entity depending on who the Disclosure is in regards to.
2	Enter the KY Medicaid provider number.
3	Do you plan to have a change in ownership, management company or control within the next year? If so, when?
4	Do you anticipate filing bankruptcy? If so, when?
5	Enter the Federal Tax Identification Number (**if there is an affiliation with a chain**) along with name, address, city, state and zip code.
6	List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. ***If no one owns 5% or more of provider, check box.*** If you are enrolled as an individual and do not own a FEIN, please enter **your** name and information. Corporate entities disclosed in this question must disclose every business location. ** IF A CORPORATE ENTITY IS DISCLOSED IN THIS QUESTION, THE BUSINESS LOCATIONS OF THE CORPORATE ENTITY MUST BE DISCLOSED. PLEASE ATTACH A SHEET TO DISCLOSE THIS INFORMATION.
Indirect Ownership Interest - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. **Ownership interest** - means the possession of equity in the capital, the stock, or the profits of the disclosing entity. **Person with an ownership or control interest** - means a person or corporation that: • Has an ownership interest totaling 5% or more in a disclosing entity; • Has an indirect ownership interest equal to 5% or more in a disclosing entity; • Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity; • Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity; • Is an officer or director of a disclosing entity that is organized as a corporation; or, • Is a partner in a disclosing entity that is organized as a partnership	
7	List officers' and board members' information of the disclosing entity. In the event, a sanction is returned for any names listed on this question, a SSN of the board member will be required.
8	If individuals disclosed in questions #6, #7, and #17 are related, please list the relationship.
9	List name of management company. If not applicable, enter N/A. In the event, a sanction is returned for any names listed on this question, a FEIN will be required.
10	List names of the disclosing entities in which persons have ownership of other disclosing entities.
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 of the Act. This includes: • 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). • Any Medicare intermediary or carrier. • 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 or the Act.	
11	If entity engages with subcontractors (such as physical therapist, pharmacies, etc.,) which exceeds the lesser of $25,000 or 5% of applicant's operating expense, list subcontractor's name and address.
Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5% of applicant's operating expense.	
12	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. In the event, a sanction is returned for any names listed on this question, a SSN/FEIN will be required.
13	List name, SSN, address of any immediate family member who is authorized to prescribe drugs, medicine, devices or equipment.
14	List anyone disclosed in question #8 who has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act (SSA) or any criminal offense in this state or any other state. Please also indicate any KY Medicaid provider number(s) associated with individual or organization.

15	List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the SSA or any criminal offense in this state or any other state. Indicate any KY Medicaid provider number(s) associated with individual or organization. In the event, a sanction is returned for any names listed on this question, a SSN/FEIN will be required.
Agent- means any person who has been delegated the authority to obligate or act on behalf of a provider. **Managing Employee**- means 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.	
16	List the name, title, SSN, and address of all managing employees as defined in 42 CFR 455.101.
17	List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.
Subcontractor- means 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 an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement	
18	Please indicate which number you will be using for reporting monies to you from Medicaid for 1099 purposes. *Example: If you are an individual completing this question, please input your Social Security Number unless you are own a FEIN 100%. An individual provider can bill under his/her individual provider number even if they are working in a group setting. The individual must complete a Map-347 in order to be linked to the group setting under which they are reporting. **IRS verification letter or Social Security Card must be attached verifying FEIN/SSN.*
19	Enter your initials if you maintain electronic medical records and are HIPAA compliant. Check the box if you do not keep electronic medical records.
20	Please enter the contact information for DMS to contact should there be any questions regarding this form.
21	Signature: Enter original signature from the individual provider, owner, or officer/board member if the provider does not have an owner. If you are an individual provider, *your* signature is required. Printed Name: The individual signing this form must enter their printed name. Date: Enter the date this disclosure is signed. Title: Must be title of person signing this form. EXAMPLE: individual provider, owner, etc.
22	For Internal Purposes Only: DMS Authorized Signature

Please return form to:

KY Medicaid
P.O. Box 2110
Frankfort, KY 40602-2110

Disclosure of Ownership

THIS FORM IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.101, 455.104, 455.105 AND 455.106 and KRS CHAPTER 205, AS AMENDED).

Note: See the instructions of this form for definitions of underlined terms according to 42 CFR 455.101, 455.104, 455.105, and KRS Chapter 205, as amended. ***Any attachments must be labeled referencing the question. Changes in ownership pursuant to 907 KAR 1:671 Section 6(11) requires new enrollment under the new ownership structure. Enrollment requirements can be found at http://www.chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm. If you are uncertain whether a change applies to the aforementioned regulation, please submit details of the change for advisement.***

1. Individual Provider Name or Entity Name that this Disclosure pertains to:

2. List KY Medicaid provider number that this DISCLOSURE pertains to:
KY Medicaid Provider Number: **(One KY Medicaid provider number per form.)**

3. If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. ☐ ***Check here for N/A***

Date: **Change:**

4. If you anticipate filing for bankruptcy within the year, enter anticipated date of filing. Date: ☐ ***Check here for N/A***

5. If this facility is a subsidiary of a parent corporation, enter corporate FEIN #: ☐ ***Check here for N/A***

Name:		
Address:		
City:	State:	Zip:

6. List name, date of birth, SSN#/FEIN#, and address of each person or entity that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider. (Attach extra page if necessary.) **If you are enrolled as an individual, list *your* information.** *N/A Not Acceptable*. ☐ ***Check here if no one owns 5% or more.***

Name:	SSN:	
Business Address:	FEIN:	DOB:
City:	State:	Zip:
P.O. Box:		
City:	State:	Zip:

****IF A CORPORATE ENTITY IS DISCLOSED IN QUESTION #6 ABOVE, THE BUSINESS LOCATIONS OF THE CORPORATE ENTITY MUST BE DISCLOSED. PLEASE ATTACH A SHEET TO DISCLOSE THIS INFORMATION.**

7. List officers' and board members' information of disclosing entity. (Attach extra sheet if necessary listing same details below.) ☐ ***Check here for N/A*** ****The entire first name is required. Initials are not accepted.***

Name(a):	Title:	
Address:	SSN:	
City:	State:	Zip:
Name(b):	Title:	
Address:	SSN:	
City:	State:	Zip:

8. If any individuals listed in questions #6, #7, and #17 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.) ☐ ***Check here for N/A***

Name(a):	SSN:
Relationship:	FEIN:
Name(b):	SSN:
Relationship:	FEIN:

9. If this facility employs a management company, please provide following information: ☐ ***Check here for N/A***

Name:		
Address:		
City:	State:	Zip:

10. List the name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest. ☐ ***Check here for N/A***

Name:	FEIN:	
Address:		
City:	State:	Zip:

11. List the names and addresses of all other Kentucky Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (Attach extra page if necessary.) ☐ ***Check here for N/A***		
Name:		
Address:		
City:	State:	Zip:
12. List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. (Attach extra page if necessary.) ☐ ***Check here for N/A***		
Name:		
Address:		
City:	State:	Zip:
13. List the name, SSN, and address of any immediate family member who is authorized under Kentucky Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment in accordance with KRS 205.8477. ☐ ***Check here for N/A***		
Name (a):		Credential (M.D., etc.):
Address:	DOB:	SSN:
City:	State:	Zip:
Name (b):		Credential (M.D., etc.):
Address:	DOB:	SSN:
City:	State:	Zip:
14. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) **If individual or organization is associated with a KY Medicaid provider number(s), please indicate below.** (Attach extra page if necessary.) ☐ ***Check here for N/A***		
NAME (a)/KY Medicaid Provider Number(s):		
NAME (b)/KY Medicaid Provider Numbers(s):		
15. List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) **If individual or organization is associated with a KY Medicaid provider number(s), indicate below.** (Attach extra page if necessary.) ☐ ***Check here for N/A***		
NAME (a)/KY Medicaid Provider Number(s):		
NAME (b)/KY Medicaid Provider Number(s):		
16. List the name, title, SSN, and address of all managing employees below as defined in 42 CFR 455.101 and pursuant to 42 CFR 455.104(b)(4). ☐ ***Check here for N/A*** **(**Attach extra sheet if necessary listing same details below.) **Complete first names are required. First names with initials will not be accepted.***		
Name (a):		Title:
Address:	DOB:	SSN:
City:	State:	Zip:
Name (b):		Title:
Address:	DOB:	SSN:
City:	State:	Zip:
17. List name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. (Attach extra page if necessary.) ☐ **Check here for N/A**		
Name:		SSN:
Address:		FEIN:
City:	State:	Zip:
Name:		SSN:
Address:		FEIN:
City:	State:	Zip:

18. DMS will report all monies paid to you to the IRS. Please indicate which number you use for tax reporting. If enrolled as an individual and you do not own a FEIN, please complete SSN only.

Report DMS payments to my FEIN:_____

Report DMS payments to my SSN:_____

******If the FEIN or SSN above is different than the FEIN or SSN currently on file, verification may be required.******

19. If you keep medical records on an electronic database, you hereby certify by your initials in the space provided that electronic records are confidential and patient privacy is protected (KRS 205.510). Every health care provider, regardless of size, who creates or maintains individual protected health information in any form (written, oral, or electronic) for the purpose of treatment, payment, or operation - or who has someone else perform electronic billing on his behalf –is a covered entity and must comply with HIPAA's Privacy Rule. _____ ☐ I do not keep electronic medical records.

20. Contact Information- This information is used only for questions regarding the information on this form.

Contact Name: _____ Contact Phone Number: _____

Email Address: _____

21. I certify that all the information I have provided on this Department for Medicaid Services Disclosure of Ownership form is accurate. Failure to provide accurate information could result in termination from the Medicaid program. I further acknowledge that changes in name, ownership, and address must be furnished within 35 days of change and that business transactions must be disclosed within 35 days of change or date of request by the Secretary or the Medicaid agency.

Enter original signature from the individual provider if this DISCLOSURE form is for an individual provider. If this DISCLOSURE is for an entity/group, an owner must sign. If the entity/group does not have an owner, an officer or board member (referenced in question #7) must sign.

Signature:_____ Date Signed:_____

Printed Name: _____

Title:_____

22. For Internal Use Only:

Department for Medicaid Services Signature: _____

Title: _____

Date: _____ _____ SAM _____ OIG/HHS

CLEAR FORM