Ownership and Control Interest Disclosure Statement

South Country Health Alliance, along with other Minnesota health plans, is required by the Centers for Medicare & Medicaid Services (CMS) and the Minnesota Dept. of Human Services (DHS) to collect this information from you.

You are required to complete this form in its entirety:

- As a condition of South Country Health Alliance participation;
- Upon credentialing and re-credentialing with South Country Health Alliance;
- When any information on your Ownership and Control Interest Disclosure Statement changes; and
- When contracting with South Country Health Alliance to provide services related to its medical programs.

Disclosing Entity Identifying Information/Formation Structure

ENTITY'S LEGAL NAME ACCORDING TO IRS:		ENTITY'S DOING BUSINESS AS (DBA) NAME:	
PROVIDER TYPE Other-Enter Value	NPI/UMPI #:	OFFICE PHONE NUMBER:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
FEDERAL EMPLOYER ID NUMBER (FEIN):		MN TAX ID NUMBER:	

CHECK THE ENTITY TYPE THAT BEST DESCRIBES YOUR ORGANIZATION:

☐ Sole Proprietorship ☐ Partnership ☐ Corporation (LLC) ☐ Non-Profit
☐ Hospital-Based ☐ State Agency ☐ County Agency ☐ Professional Association
☐ Other Municipal agency (please specify) : _____
☐ Other Partnership (LP, LLP, LLLP, etc) Specify Type: _____

All disclosing entities must complete the following sections for all persons and businesses or organizations that meet any of the following criteria:

- Have an ownership or control interest of 5% or more in this disclosing entity
- Have an ownership or control interest in a subcontractor in which this disclosing entity has a direct or indirect ownership interest of 5% or more
- Are a managing employee (see definitions on pages 4 and 5)

For a Person: If you list a person, you must include the person's date of birth, social security number (SSN) and residential (home) address.

For a Business: If you list a business, you must include the business' federal tax ID (FEIN) and primary business address for every business location (including street address) and every PO Box address.

Individual Person(s) With Ownership or Control Interest

List all individual owners, managing employees, and persons with control interest

ARE YOU A(N):
☐Subcontractor (If person/entity is listed because of ownership/control interest in a subcontractor, name subcontractor): ______________________
☐Managing Employee ☐Owner – List % of Ownership Interest if 5% or more: _____________________
☐Board Member or Officer ☐Authorized Agent ☐Other – specify ___________________________________

FULL LEGAL NAME (LAST)	FIRST	MI	SOCIAL SECURITY NUMBER

HOME RESIDENCE ADDRESS (DO NOT LIST BUSINESS ADDRESS)	DATE OF BIRTH (MM/DD/YY)

CITY	COUNTY	STATE	ZIP CODE

☐Hire Date ☐Termination Date __________(mm/dd/yy)
RELATIONSHIP TO ANY OTHER PERSON LISTED
☐Spouse ☐Child ☐Parent ☐Sibling

ARE YOU A(N):
☐Subcontractor (If person/entity is listed because of ownership/control interest in a subcontractor, name subcontractor): ______________________
☐Managing Employee ☐Owner – List % of Ownership Interest if 5% or more: _____________________
☐Board Member or Officer ☐Authorized Agent ☐Other – specify ___________________________________

FULL LEGAL NAME (LAST)	FIRST	MI	SOCIAL SECURITY NUMBER

HOME RESIDENCE ADDRESS (DO NOT LIST BUSINESS ADDRESS)	DATE OF BIRTH (MM/DD/YY)

CITY	COUNTY	STATE	ZIP CODE

☐Hire Date ☐Termination Date __________(mm/dd/yy)
RELATIONSHIP TO ANY OTHER PERSON LISTED
☐Spouse ☐Child ☐Parent ☐Sibling

ARE YOU A(N):
☐Subcontractor (If person/entity is listed because of ownership/control interest in a subcontractor, name subcontractor): ______________________
☐Managing Employee ☐Owner – List % of Ownership Interest if 5% or more: _____________________
☐Board Member or Officer ☐Authorized Agent ☐Other – specify ___________________________________

FULL LEGAL NAME (LAST)	FIRST	MI	SOCIAL SECURITY NUMBER

HOME RESIDENCE ADDRESS (DO NOT LIST BUSINESS ADDRESS)	DATE OF BIRTH (MM/DD/YY)

CITY	COUNTY	STATE	ZIP CODE

☐Hire Date ☐Termination Date __________(mm/dd/yy)
RELATIONSHIP TO ANY OTHER PERSON LISTED
☐Spouse ☐Child ☐Parent ☐Sibling

Attach additional sheets as necessary.

Business Ownership or Control Interest

List all individual owners, managing employees, and persons with control interest

ARE YOU A(N):
☐ Subcontractor (If person/entity is listed because of ownership/control interest in a subcontractor, name subcontractor): ____________________
☐ Owner – List % of Ownership Interest if 5% or more: ____________________
☐ Other – specify ____________________

FULL LEGAL NAME (Taxpayer name of FEIN or on W-9 from IRS)			FEIN
BUSINESS ADDRESS	CITY	STATE	ZIP CODE
COUNTY	OWNERSHIP OR CONTROL INTEREST ☐ Begin Date ☐ End Date ______________(mm/dd/yy)		

ARE YOU A(N):
☐ Subcontractor (If person/entity is listed because of ownership/control interest in a subcontractor, name subcontractor): ____________________
☐ Owner – List % of Ownership Interest if 5% or more: ____________________
☐ Other – specify ____________________

FULL LEGAL NAME (Taxpayer name of FEIN or on W-9 from IRS)			FEIN
BUSINESS ADDRESS	CITY	STATE	ZIP CODE
COUNTY	OWNERSHIP OR CONTROL INTEREST ☐ Begin Date ☐ End Date ______________(mm/dd/yy)		

ARE YOU A(N):
☐ Subcontractor (If person/entity is listed because of ownership/control interest in a subcontractor, name subcontractor): ____________________
☐ Owner – List % of Ownership Interest if 5% or more: ____________________
☐ Other – specify ____________________

FULL LEGAL NAME (Taxpayer name of FEIN or on W-9 from IRS)			FEIN
BUSINESS ADDRESS	CITY	STATE	ZIP CODE
COUNTY	OWNERSHIP OR CONTROL INTEREST ☐ Begin Date ☐ End Date ______________(mm/dd/yy)		

Attach additional sheets as necessary.

☐ Check this box if your business has no business ownership or control interest

Complete the following information for each person, business or organization previously listed that has an ownership or control interest in any other Medicaid disclosing entity or for any entity that is otherwise required to disclose ownership and control information because of participation in Title V, XVIII or XX programs.

FULL LEGAL NAME (Person: last, first, MI; Business: Taxpayer name as listed with IRS)			% OF OWNERSHIP INTEREST
FULL LEGAL NAME OF OTHER PROVIDER		ADDRESS OF OTHER PROVIDER	
CITY	COUNTY	STATE	ZIP CODE

Check the appropriate box for each of the following questions.

Has any person having an ownership or control interest ever:

- Been convicted of a criminal offense related to that person's involvement in any Medicare, Medicaid, Title XX or Title XXI program in Minnesota or any other state or jurisdiction? ☐Yes ☐No
- Had civil monetary penalties or assessments imposed under section 1128A of the Social Security Act? ☐Yes ☐No
- Been excluded from participation in Medicare or other State health care program? ☐Yes ☐No

Has any Managing Employee or Agent ever:

- Been convicted of a criminal offense related to that person's involvement in any Medicare, Medicaid, Title XX or Title XXI program in Minnesota or any other state or jurisdiction? ☐Yes ☐No
- Had civil monetary penalties or assessments imposed under section 1128A of the Social Security Act? ☐Yes ☐No
- Been excluded from participation in Medicare or other State health care program? ☐Yes ☐No

Complete the following for any "Yes" answer:

FULL LEGAL NAME (Person: last, first, middle)	SOCIAL SECURITY NUMBER
REASON FOR ANSWERING "YES" (conviction, monetary penalty, exclusion from program(s))	

PCA Providers only: Complete the following information for all residential properties you own, lease, or manage that could be or are used for providing home care services.

FULL LEGAL NAME OF RESIDENCE/PROVIDER (Taxpayer name of FEIN or on W-9 from IRS)			
ADDRESS OF PROPERTY	CITY	STATE	ZIP CODE
DO YOU OWN, LEASE OR MANAGE THE PROPERTY ☐ Own ☐ Lease ☐Manage	COUNTY		

Signature

By signing below, I, an authorized officer (CEO, president, etc) with authority to bind the entity, certify that the information on this form is true and correct, and that I will notify South Country Health Alliance of any changes to this information.

NAME (PRINT)	TITLE	PHONE NUMBER
SIGNATURE		DATE (mm/dd/yy)

Clear Form

Use this button to erase the current form contents.

Submit

Use this button to submit the form via email.

DEFINITIONS

Agent means any person who has been delegated the authority to obligate or act on behalf of an entity.

Managing Employee means a person who exercises operational or managerial control over, or who directly or indirectly conducts or manages the day-to-day operations of an institution, organization, agency or school, such as a general manager, business manager, administrator, director.

Ownership or Control Interest means any person, business or organization to which any one or more of the following apply:

- Direct ownership of 5% or more in the disclosing entity
- Indirect ownership interest equal to 5% or more in a disclosing entity (meaning ownership in another entity that has an ownership interest in the disclosing entity)
- A combination of direct and indirect ownership interest equal to 5% or more in the disclosing entity
- Owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity
- Is an officer or director of a disclosing entity that is organized as a corporation
- Is a partner in a disclosing entity that is organized as a partnership

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity.

Indirect ownership interest is defined as ownership interest in an equity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5% or more in the disclosing entity. Example: If C owns 10% of the stock in a corporation that owns 80% of the stock of the disclosing entity, C's interest equates to an 8% indirect ownership and must be disclosed.

Subcontractor means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services.

Title V – Maternal and Child Health Services Block Grant

Title XVIII – Health Insurance for the Aged and Disabled (Medicare)

Title XX – Block Grants to States for Social Services and Elder Justice

Title XXI – State Children's Health Insurance Program