Current Status: *Active* **PolicyStat ID:** *2652518*

Origination:	*12/2016*
Last Approved:	*12/2016*
Last Revised:	*12/2016*
Next Review:	*12/2017*
Owner:	*Rolf Lowe: Assistant General Counsel/HIPAA Privacy Officer*
Policy Area:	*Legal*
References:	

Disclosure of Control and Ownership Interest

POLICY

It is the policy of the Detroit Wayne Mental Health Authority (DWMHA) that organizations and individuals who provide services to Medicare and/or Medicaid eligible individuals comply with all applicable federal, state and local statutes and regulations.

PURPOSE

Federal regulations require Pre-Paid Inpatient Health Plans ("PIHP") and Community Mental Health Service Programs ("CMHSP") to disclose information about individuals with ownership or control interests in the respective entity. These regulations also require PIHPs and CMHSPs to identify and report any additional ownership or control interests by those individuals in other entities, as well as identify when any of the individuals with ownership or control interests have spousal, parent-child, or sibling relationships with each other. Additionally, these same Federal regulations require providers or other individuals/organizations having a contractual arrangement with a PIHP or CMHSP to disclose this information on a regular basis.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWMHA Board, DWMHA Staff, Contractual Staff, Access Center, MCPN Staff, Network Providers, COPE, Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adult, Children, I/DD, SMI/SEI, SED,SUD, Autism
3. This policy impacts the following conracts/service lines: MI-HEALTH LINK, Medicaid, Autism, SUD, General Fund, Block Grants

KEY WORDS

1. Agent
2. Managing Employee
3. Person with an Ownership or Control Interest
4. Provider
5. Subcontractor

STANDARDS

1. Disclosure Statement - The DWMHA/MCPN provider/contractor disclosure statement will include the following information:
    a. Name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity (DWMHA, MCPN, provider or contractor). The address for corporate entities must include primary business address, every business location, and P.O. Box location.
    b. Date of Birth and Social Security Number of each person with an ownership or control interest in the disclosing entity (DWMHA, MCPN, provider or contractor).
    c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (DWMHA, MCPN provider or contractor) or in any subcontractor in which the disclosing entity (DWMHA, MCPN, provider or contractor) has a five percent or more interest.
    d. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with an ownership in the disclosing entity as a spouse, parent, child, or sibling, or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent or more interest, is related to another person with an ownership or control interest as a spouse, parent, child, or sibling.
    e. The name of any other DWMHA/MCPN provider or contractor in which the owner of the disclosing entity has an ownership or control interest.
    f. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity.
    g. The identity of any individual who has an ownership or control interest in the provider/contractor, or is an agent or managing employee of the provider/contractor and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XX services program since the inception of those programs.
2. Time of Disclosure – DWMHA and MCPNs will obtain disclosure statements from its providers and contractors at any of the following times:
    a. When the provider submits a provider application;
    b. Upon execution of the provider agreement or contract;
    c. During re-credentialing, re-contracting or impaneling;
    d. Within 35 days of any change in the ownership of a disclosing entity.
3. Monitoring – DWMHA and MCPNs shall monitor their provider network and all contractors providing work funded by Medicare and/or Medicaid dollars via monthly OIG Exclusion Database searches to capture exclusions since the last search. DWMHA and MCPNs will also conduct an OIG Exclusion database search at any time a provider/contractor submits new disclosure information. The OIG database search will be performed monthly on all disclosing entities and any individuals with ownership or control interest identified on the disclosure form. MCPNs will communicate all OIG database search findings to the DWMHA using the naming conventions and tools required by the DWMHA.
4. Reporting Criminal Convictions – DWMHA will notify the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation, and Contracts when any disclosures are made by providers/ contractors and DWMHA officers, directors and employees with regard to criminal offenses described

under sections 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act. Additionally, DWMHA will inform the credentialing department. The covered offenses include convictions of program-related crimes, patient abuse, healthcare fraud, and controlled substances.

5. Failure to Comply – Failure to fully complete the disclosure form when requested or the submission of false or misleading information to the DWMHA or MCPNs will be subject to contractual sanctions up to and including immediate suspension of funding and termination of the contractual agreement.

QUALITY ASSURANCE/IMPROVEMENT

The DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of MCPNs, their subcontractors and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWMHA staff, MCPNs, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. 42 CFR 455 Subpart B
2. 42 CFR 455.104-106
3. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Programs Social Security Act, Sections 1128(a) and 1128(b)(1)(2), and (3)

RELATED POLICIES

RELATED DEPARTMENTS

1. Administration
2. Claims Management
3. Clinical Practice Improvement
4. Compliance
5. Customer Service
6. Information Technology
7. Integrated Health Care
8. Managed Care Operations
9. Management & Budget
10. Personnel
11. Purchasing

12. Quality Improvement
13. Utilization Management
14. Recipient Rights
15. Substance Use Disorders

CLINICAL POLICY

No

INTERNAL/EXTERNAL POLICY

EXTERNAL

EXHIBIT(S)

Authority Disclosure Statement

Attachments:

Authority Disclosure Statement.pdf

Approval Signatures

Approver	Date
Ronald Hocking: Chief Operating Officer	12/2016
Dana Lasenby: Deputy Chief Operating Officer	11/2016
Allison Smith: Project Manager, PMP	09/2016
Rolf Lowe: Assistant General Counsel/HIPAA Privacy Officer	08/2016

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Disclosure Statement

Detroit Wayne Mental Health Authority (DWMHA) is required to collect disclosure of ownership, controlling interests, and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid program and/or the Pre-paid Inpatient Health Plan (PIHP). This requirements is pursuant to a Medicaid and/or PIHP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455. Required information includes: 1) the identity of all owners and others with a controlling interest of 5% or greater; 2) certain business transactions as described in 42 CFR §455.105; 3) the identity of managers and others in a position of influence or authority; and 4) criminal convictions, sanctions, exclusions, debarment or termination information for the provider, owners or managers. The information required includes, but is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Completion and submission of this Statement is a condition of participating as a credentialed or enrolled provider in the DWMHA for services to members under Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Wavier Program. Failure to submit the requests information may result in a refusal of participation in DWMHA or denial of a claim.

This statement should be submitted at any of the following times: upon the submission of an application; upon execution of an agreement; during re-credentialing or re-contracting; within 35 days after any change in ownership of the disclosing entity. A Statement must be provided to DWMHA within 35 days of a request for information by the US Department of Health and Human Services (HHS) or the State Agency. DWMHA maintains policies and practices that protect the confidentiality of personal information, including Social Security numbers, obtained from its providers and associates in the course of its regular business functions. DWMHA is committed to protecting information about its providers and associates, especially the confidential nature of their personal information.

Detailed instructions and a glossary for capitalized terms can be found at the end of this form. If attachments are included, please indicate to which section those attachments refer.

Provider/Provider Entity Information

*Please fill out the entire section. Every field must be complete. If fields are left blank, the form will be returned for corrections/completeness. *These fields cannot be left blank; check appropriate box or use 'N/A'.*

Please choose appropriate category: ☐ Provider Entity ☐ Licensed Independent Practitioner ☐ Managing Employee ☐ HCBS Provider ☐ Other: **Group Affiliation?** ☐ Yes ☐ No **If yes,** do you have a private practice as well? ☐ Yes ☐ No	**Name of Provider/Provider Entity:** **Name of Person Completing this Form:** **Title:** **Phone Number:** **Fax:** **Email:** **In which state(s) do you participate in Medicaid?**
Additional Addresses (list all Practice Locations) **Attaching list?** ☐ Yes ☐ No	

***SSN (if Individual Provider):** ☐ N/A ***Federal Tax ID# (if Entity):** ☐ N/A	☐ ***Medicaid ID#**: ☐ *Applied for Medicaid ID ☐ *Not applicable	☐ ***NPI#**: ☐ *Applied for NPI# ☐ *Not applicable

Section I: Individual Provider Ownership Information

1. Are there any individuals or organizations with a Direct or Indirect Ownership Interest of 5% or more in your entity/practice? ☐ Yes ☐ *No-Skip to #2* ☐ *N/A-Skip to #2*

See instructions for more information and examples

If yes, list the name, primary address, date of birth (DOB), and Social Security Number (SSN) for each person having an Ownership Interest in the disclosing entity of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership Interest of 5% or greater. (42 CFR §455.104). Attach additional sheets as necessary - ☐ Yes ☐ No

Name of Owner	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)			**SSN or TIN or both as applicable	% Interest
		Street:				
		C:	S:	Z:		
		Street:				
		C:	S:	Z:		
		Street:				
		C:	S:	Z:		

***SSN and TIN required under §455.104; See Sect 4313 of the Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No 22*

Section II: Ownership in Other Providers & Entities

2. Does the *Owner identified in Section I* have an Ownership or Controlling Interest in *any other* provider or entity?

☐ Yes ☐ *No-Skip to #3* ☐ *N/A-Skip to #3*

If yes, list the name and the SSN or TIN of the other provider or entity in which the *Owner identified in Section I* also has an Ownership or Controlling Interest (42 CFR §455.104(b)(3)). Attach additional sheets as necessary - ☐Yes ☐ No

Name of Owner from Section I	Name of Other Provider or Entity	Other Provider or Entity's SSN (indiv.) or TIN (entity)

Section III: Subcontractor Ownership

3. Do you, as the Provider Entity, have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor? ☐ Yes ☐ *No-Skip to #4* ☐ *N/A-Skip to #4*

If yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor?

☐ Yes ☐ No

If yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you *also have* Direct or Indirect Ownership Interest of 5% or more (42 CFR §455.104). Attach additional sheets as necessary - ☐Yes ☐ No

Legal Name of Subcontractor:		
Name of Subcontractors *Other Owner*:		*Other Owner's*:
Other Owner's Address:		City, State, Zip:
Other Owner's TIN:	*Other Owner's* SSN:	% Interest:

Section IV: Familial Relationships of All Owners

4. Are any of the individuals identified in Sections I, II, or III related to each other? ☐ Yes ☐ *No – Skip to #5* ☐ *N/A-Skip to #5*

If yes, list the individuals identified and the relationship to each other (e.g. spouse, domestic partner, sibling, parent, child) (42 CFR §455.104(b)(2). Attach additional sheets as necessary - ☐ Yes ☐ No

Name of Owner 1	Name of Owner 2	Relationship

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment, or Terminations

5. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Provider Entity ever been indicted or convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, CHIP or Title XX program? ☐ Yes ☐ *No-Skip to #6* ☐ *N/A-Skip to #6*

If yes, list those persons and the required information below. (42 CFR §455.106). Attach additional sheets as necessary - ☐ Yes ☐ No

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**State and Date of Conviction:**
Matter of the Offense:	**Date of Reinstatement:**

6. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Provider Entity ever been sanctioned, excluded, or debarred from Medicaid, Medicare, CHIP or Title XX program? ☐ Yes ☐ *No-Skip to #7* ☐ *N/A-Skip to #7*

If yes, list those persons and the required information below. (42 CFR §455.436). Attach additional sheets as necessary - ☐ Yes ☐ No

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**List all States where currently excluded:**
Reason for Sanction, Exclusion, or Debarment:	
Date(s) of Sanctions, Exclusions, or Debarments:	**Date of Reinstatement:**

7. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? ☐ Yes ☐ *No-Skip to #8* ☐ *N/A-Skip to #8*

If yes, list those person and the requirement information below. (42 CFR §455.416). Attach additional sheets as necessary - ☐ Yes ☐ No

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**Terminated from Medicare?** ☐ Yes ☐ No
Reason for Termination:	**Date of Termination:**
State that originated Termination:	**Date of Reinstatement:**

**At any time during the Contract period, it is the responsibility of the Povider/Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (see Fed. Register, Vol. 44, No. 138)*

Section VI: Business Transaction Information

8. **Business Transactions – Subcontractors:** Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? ☐Yes ☐ *No-Skip to #9* ☐ *N/A-Skip to #9*

If yes, list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) Attaching additional sheets as necessary - ☐Yes ☐ No

Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

9. **Significant Business Transactions – Wholly Owned Suppliers:** Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? ☐Yes ☐ *No-Skip to #10* ☐ *N/A-Skip to #10*

If yes, list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (43 CFR §455.105(b)(2)). Attach additional sheets as necessary - ☐Yes ☐ No

See Glossary for definition.

Name of Supplier:	**Suppliers SSN or TIN:**
Suppliers Address:	**City, State, Zip:**

10. **Significant Business Transactions – Subcontractors:** Has the Provider Entity had any Significant Business Transactions with a Subcontractor totaling more than $25,000 in the past five (5) year period?

☐Yes ☐ *No-Skip to #11* ☐ *N/A-Skip to #11*

If yes, list the information for Subcontractors with whom the Provider Entity had any Significant Business Transactions exceeding the $25,000 during the past 5-year period (42 CFR §455.105(b)(2)). Attach additional sheets as necessary - ☐Yes ☐ No

Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

This information must be provided and/or updated within 35 days of a request. Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received (42 CFR §455.105)

Section VII: Management and Control

11. **Managing Employees:** Does the Provider Entity have any Managing Employees?
☐ Yes ☐ *No-Skip to #12* ☐ *N/A-Skip to #12*

If yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of Provider Entity (general manager, business manager, administrator or director), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104). Attach additional sheets as necessary - ☐ Yes ☐ No

Name	DOB mm/dd/yyyy	Complete Address	SSN	Title

12. **Agents:** Does the Provider Entity have any Agents? ☐ Yes ☐ *No* ☐ *N/A*
If yes, list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity, including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104).
Attach additional sheets as necessary - ☐ Yes ☐ No

Name	DOB mm/dd/yyyy	Complete Address	SSN

Through signature below, I hereby certify that any employees or contractors providing services pursuant to a contract with Detroit Wayne Mental Health Authority or one of its Manager of Comprehensive Provider Networks are screened with the applicable background check including, but not limited to, verification against the OIG's List of Excluded Individuals & Entities (https://oig.hhs.gov/exclusions/index/asp) and the System for Award Management (SAM) www.sam.gov and any applicable state, federal or other governmental exclusion or sanction database and that the information provided herein is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of a claim and/or termination of the contract.

Signature_____ Title_____

Print Name_____ Date_____

_____ _____ _____

Phone Number Fax Number Email Address

Disclosure Instructions

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. For example: Section I Ownership Information, continued. Please see Glossary for definition of capitalized terms.

Section I: Provider Entity Ownership Information

Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Controlling Interest in your entity. If the Owner is a corporation: the primary business address must be listed and every business location and PO Box address. Provider members of a group practice who have ownership or a controlling interest in Provider Entity must submit a separate Statement.

Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104; please see Section 4313 of the Balanced Budget Act of 1997, amended Section 1124, and the Federal Register Vol. 76 No. 22. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.

Section II: Ownership in Other Providers & Entities

Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section I that has an Ownership or Controlling Interest in your entity. This information is to identify shared and interconnected ownership and controlling interests.

Section III: Subcontractor Ownership

If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

Section IV: Familial Relationships of All Owners

Report whether any of the persons listed in Sections I, II, and III are related to each other and identify the parties and their relationship. For the definition of domestic partner, refer to your state's laws. Provider members of a group practice who are related to the Provider Entity's owners or those with a controlling interest must submit a separate Statement.

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment, and Terminations

List your own criminal convictions, sanctions, exclusions, debarments, and termination, ***and*** for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information:

1. Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at https://oig.hhs.gov/exclusions/index.asp
2. Sanction information is available in the GSA's SAM (System for Award Management) database www.sam.gov.
3. State specific exclusions/sanction databases may be accessed through the State Agency's website.

Section VI: Business Transaction Information

1. List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2. List any ***Significant Business Transactions*** between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any ***Significant Business Transactions*** between your entity and any Subcontractor during the past 5 years.

Remember that a ***Significant Business Transaction*** is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year.

This information must be made available within 35 days of a request by the US Department of Health and Human Services (HHS), the State Medicaid Agency, and the Medicaid Managed Care Organization responding to an HHS or State request.

Section VII: Management & Control

1. List the required information for all employees that hold a position of Managing Employee within your entity.
2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.
3. List the required information for all individuals on the governing board or board of directors if your entity is organized as a corporation. CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

Glossary

Agent: any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

CHIP: The Federal insurance program for children, Child Health Insurance Program, in Michigan this is known as MIChild.

Controlling Interest: defined as the operational direction or management of a disclosing entity which management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved , to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Determination of ownership or control percentages:

a) *Indirect ownership interest.* 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 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 4 percent indirect ownership interest in the disclosing entity and need not be reported.

b) *Person with an ownership or controlling interest.* 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.

Direct Ownership Interest: the possession of equity in the capital, the stock, or the profits of the disclosing entity.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

Indirect Ownership Interest: 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.

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 operations of an institution, organization, or agency.

Other 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, XVIII, 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 (title XVIII);
b) Any Medicare intermediary or carrier; and
c) 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.

Ownership or Controlling Interest: an individual or corporation that

a) Has an ownership interest totaling 5 percent or 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 and indirect ownership interests equal to 5 percent or 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.

Provider Entity: an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Providing Entity is the individual or entity identified on this form as the disclosing entity.

Significant Business Transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand dollars ($25,000) or five percent (5%) of a Provider Entity's total operating expenses.

Subcontractor: (a) an individual, agency, or organization to which a Provider 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 to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity.