STATE OF KANSAS
Disclosure of Ownership and Control Interest Statement

The Kansas Medical Assistance Program (KMAP) is required to collect disclosure of ownership, control interest and management information from providers who participate in Medicaid or the Children's Health Insurance Program (CHIP) and the federal regulations set forth in 42 CFR Part § 455. Required information includes:

1) The identity of all owners and others with a control interest of 5% or greater as described in 42 CFR § 455.104;
2) The identity of managing employees, agents and others in a position of influence or authority as described in 42 CFR § 455.104
3) Certain business transactions as described in 42 CFR § 455.105; and
4) Criminal conviction information for the provider, owners, agents and managing employees. The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN) as described in 42 CFR § 455.106.

Completion and submission of this Disclosure of Ownership and Control Interest Statement is a condition of participation in KMAP. The Disclosure of Ownership and Control Interest Statement must be submitted upon enrollment; upon executing a provider agreement/contract; upon request of the Medicaid agency during revalidation; and within 35 days after any change in ownership of the disclosing provider entity.

Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement/contract, or termination of existing provider agreement/contract.

Fill in each section. Every field must be complete. If fields are blank or the form is unreadable (e.g. due to illegible handwriting), the form will be returned for corrections/completeness and not processed.

Instructions for Disclosure of Ownership and Control Interest Statement

If additional space is needed, please note on the form the answer is being continued, and attach a sheet referencing the question number being continued. (For example: Question 1 Ownership Information, continued). Please see Glossary for definitions of bolded terms.

Providing the SSN and TIN (as applicable) is required under 42 CFR § 455.104; Any Statement without the required SSN and TIN (as applicable) is incomplete and will not be processed.

Question 1 - 2 Ownership Information:
List the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Control Interest. If the Owner is a corporation, the primary business address must be listed and every business location and P.O. Box address.

Question 3 Ownership in Other Providers & Entities:
Please identify all other providers or entities owned or controlled by the individual(s) or organization(s) identified in question 1. This information is to identify shared and interconnected ownership and control interests.

Question 4 Familial Relationships of All Owners:
Only group providers answer this question. Report whether any of the persons listed in Questions 1, 2, 5, and 6 are related to each other and identify the parties and their relationship.

Question 5 Business Transactions with any Subcontractor:
Identify all subcontractors the provider entity had business transactions with totaling more than $25,000 during the preceding 12-month period.

Question 5a Subcontractor Ownership:
List the Ownership of all Subcontractors the provider entity had business transactions totaling more than $25,000 within the last twelve (12) month period.

Question 6 Significant Business Transactions with any Wholly Owned Supplier or Subcontractor Information:
List any ***Significant Business Transactions*** between provider entity and any Wholly Owned Supplier or Subcontractor during the past 5 years.

Question 7 Managing Employees
List information for all managing employees such as general manager, business manager, president, vice-president, CEO, CFO, administrator, director, board of directors, 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. CMS requires the identification of officers and directors of a provider entity organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

Question 8 Outstanding Debt
Provide information on family or household members of individuals listed in questions 1-7 who have outstanding debt with any state Medicaid program or any other Federal agency or program.

Questions 9-11 and 12a Criminal Convictions, Adverse Legal Actions, Sanctions, Exclusions, Debarment, and Terminations:
List your own criminal convictions, adverse legal actions, exclusions, sanctions, debarments, and terminations, ***and*** for any person who has an ownership or control interest, or is an agent or managing employee of the provider entity. List all offenses related to each person's or provider entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs.

Question 12 Participation in Medicaid or Medicare
List the provider entities or individuals who have participated, previously or currently, in KMAP, any other state's Medicaid program, or Medicare regardless of the timeframe.

Question 13 Provider Entity subject to Section 6032 of the Deficit Reduction Act
Provider entities receiving payments in any federal fiscal year (October 1 to September 30) of at least $5 million from the KMAP and KanCare managed care organizations (MCOs) are subject to the provisions contained within Section 6032 of the Deficit Reduction Act of 2005 (Pub. L.109-171).

Question 14 Contact Person
This question is self-explanatory.

Question 15 Address for Location of Records
This question is self-explanatory.

STATE OF KANSAS
Disclosure of Ownership and Control Interest Statement

Name of Provider Entity/Individual		EIN/SSN	
Date of Birth (for individual)	NPI	Taxonomy	
Physical Address	City/State	Zip Code	

Fiscal agents and all providers must answer each question except where noted. If more space is needed, provide the information on a separate piece of paper and attach to this document.

1. Do you have an ***ownership or control interest*** in the provider/fiscal agent/managed care entity or in any ***subcontractor*** in which the provider/fiscal agent has ***direct or indirect ownership*** of five percent or more? If Yes, give their information below.
42 CFR 455.104(b)(1)(i); 42 CFR 455.104(b)(1)(ii); 42 CFR 455.104(b)(1)(iii)

Yes ☐
No ☐

#	Name (individual or corporation)	Primary Address	Email Address	Date of Birth (for individual)	Social Security Number (for individual) or Tax Identification Number (for corporation)	% of ownership
1A.						
1B.						
1C.						
1D.						
1E.						

2. Are any persons named in question #1 related to each other? If yes, give the name(s) of person(s) and relationship(s) such as spouse, parent, child, or sibling.
NOTE: Designate relationship to each person listed in question #1 by using 1A, 1B, 1C, etc.
42 CFR 455.104(b)(2)

Yes ☐
No ☐

#	Name	Relationship

3. Does any person (individual or corporation) named in question #1 have an ***ownership or control interest*** in any other Medicaid provider or in any provider 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? If yes, give the name(s), address(es), and tax ID(s) of the Medicaid provider or provider entity. *NOTE: Designate association to each person listed in question #1 by using 1A, 1B, 1C, etc.* *42 CFR 455.104(b)(3)*	Yes ☐ No ☐

#	Name	Address	Tax Identification Number

Question 4 answered by group providers only.	
4. Are any provider members of the group related to the listed owners or those with an ***ownership or control interest*** listed in question #1? *NOTE: Designate relationship to each person listed in question #1 by using 1A, 1B, 1C, etc.*	Yes ☐ No ☐

#	Name	Relationship	Date of Birth	Social Security Number

5. Has the provider entity had business transactions with any ***subcontractor*** totaling more than $25,000 during the preceding 12-month period? If yes, give the information below for each ***subcontractor***. *42 CFR 455.104(b)(1)(iii); 42 CFR 455.105(b)(1)*	Yes ☐ No ☐

#	Name	Address	Date of Birth (if individual)	Social Security Number (if individual) or Tax Identification Number
5A.				
5B.				
5C.				
5D.				
5E.				

5a. Provide the following for all provider entities or persons with an ***ownership or control interest*** in each

subcontractor named in question #5.
*Note: Designate association to **subcontractor** listed above by using 5A, 5B, 5C, etc.*

42 CFR 455.104(b)(1)(iii); 42 CFR 455.105(b)(1)

#	Name	Address	Date of Birth	Social Security Number or Tax Identification Number

6. Has the provider entity had any ***significant business transactions*** with any ***wholly owned supplier*** or with any ***subcontractor*** during the preceding five year period? If yes, give the information below for each ***wholly owned supplier*** or ***subcontractor***.

42 CFR 455.105(b)(2)

Yes ☐
No ☐

Name	Address	Description of Business Transaction

7. Provide the following information on all ***managing employees*** of the provider entity.
NOTE: This question cannot be blank.

42 CFR 455.104(b)(4)

Name	Address	Date of Birth	Social Security Number
A.			
B.			
C.			
D.			
E.			

8. Does any family or household members of <u>any</u> of the provider entities or individuals listed under any question in this Statement have any outstanding debt

Yes ☐
No ☐

with any state Medicaid program or any other Federal agency or program? If yes, provide the following information below and attach documentation of the arrangements made to repay the debt. *NOTE: Designate association to each person listed in this question by using 1A, 1B, 5A, 5B, etc.*						
#	Name	Address	Date of Birth	Social Security Number	Program	Amount of Debt

9. Has the provider entity, or any person who has ***ownership or control interest*** in the provider, or any person who is an ***agent*** or ***managing employee*** of the provider been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? If yes, provide the following information below. *42 CFR 455.106(a)(2)*	Yes ☐ No ☐

Name	Description	Date

10. Have any of the provider entities or individuals listed under any question in this Statement had any of the following healthcare related adverse legal actions imposed by any state Medicaid program or any other Federal agency or program: • Criminal Conviction • Administrative Sanction • Program Exclusion	Yes ☐ No ☐

• Suspension of Payment • Civil Monetary Penalty • Assessment • Program Debarment • Criminal Fine • Restitution Order • Pending Civil Judgment • Pending Criminal Judgment • Judgment Pending Under False Claims Act If yes, provide the following information below and attach copy of the adverse legal action notification(s).	

Name	Program	State	Action	Date

11. Have <u>any</u> of the provider entities or individuals listed under any question in this Statement had any of the following non- healthcare related adverse legal actions: • Criminal Conviction • Administrative Sanction • Program Exclusion • Suspension of payment • Civil Monetary Penalty • Assessment • Program Debarment If yes, provide the following information below and attach copy of the adverse legal action notification(s).	Yes ☐ No ☐

Name	Program	State	Action	Date

12. Have <u>any</u> of the provider entities or individuals listed under any question in this Statement ever previously participated or currently participate as a provider in Kansas Medicaid or any other states' Medicaid program or Medicare? If yes, provide the following information below.	Yes ☐ No ☐

Name	Program	State

12a. Have any of the provider entities or individuals in question #12 ever had their billing privileges revoked or had their participation in the program terminated for cause? If yes, provide the following information below.	Yes ☐ No ☐

Name	Program	State	Date

12b. Do any of the provider entities or individuals listed in question #12 have any outstanding debt with Kansas Medicaid or any other state's Medicaid program or Medicare? If yes, provide the following information below and attach documentation of the arrangements made to repay the debt.				Yes ☐ No ☐
Name	Program	State	Amount of Debt	Date

13. Is the provider entity part of a provider entity that is subject to the provisions contained in Section 6032 of the Deficit Reduction Act? If yes, provide the following below.		Yes ☐ No ☐
Name of Provider or Provider Entity	Address of Provider or Provider Entity	Tax Identification Number of Provider or Provider Entity

14. Provide the following information for the contact person for audit purposes.	
Name	Title
Phone Number	Email Address

15. Provide the address for the physical location of the records required under K.A.R. 30-5-59. *NOTE: P.O. Boxes and drop boxes are not acceptable.*		
Address	City/State	Zip Code

ANY DOCUMENTATION OR ANSWERS PROVIDED ON THIS APPLICATION, INCLUDING THE LACK OF DOCUMENTATION OR ANSWERS, MAY BE USED IN THE CONSIDERATION OF THIS APPLICATION FOR APPROVAL. THE STATE WILL ONLY CONSIDER APPROVAL OF APPLICANTS THAT IT DETERMINES TO HAVE MET THE FEDERAL, STATE AND AGENCY GUIDELINES FOR PROGRAM INTEGRITY AND PROVIDER ENROLLMENT.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR, WHERE THE PROVIDER ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY OF HEALTH AND HUMAN SERVICES AS APPROPRIATE.

Name of Application Preparer (Typed or Printed) _____

Name of Authorized Agent (Typed or Printed) _____

Signature of Authorized Agent _____

Title of Authorized Agent _____

Date _____

GLOSSARY

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

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

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 provider entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing provider entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing provider 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 provider entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing provider entity and need not be reported. (b) Person with an ownership or control 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 provider 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.

Group of practitioners: means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Group Providers: a provider who has members affiliated to them.

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

Indirect Ownership Interest: an ownership interest in a provider entity that has an ownership interest in the disclosing provider entity. This term includes an ownership interest in any provider entity that has an indirect ownership interest in the disclosing provider entity.

Individual Provider: a healthcare practitioner who is solely practicing or is a member of a group or facility and who is licensed or certified by the state in which he/she delivers services and is credentialed and/or enrolled as a Medicaid participating provider.

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. CMS requires the identification of officers and directors of a provider entity organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation such as president, vice-president, CEO, CFO and board of directors.

Other Disclosing Provider Entity: any other Medicaid disclosing provider entity and any provider 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 (title XV III);
(b) Any Medicare intermediary or carrier; and
(c) Any provider 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 Control Interest: an individual or corporation that—
(a) Has an ownership interest totaling 5 percent or more in a disclosing provider entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing provider entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing provider 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 provider entity;
(e) Is an officer or director of a disclosing provider entity that is organized as a corporation; or
(f) Is a partner in a disclosing provider 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 Provider Entity is the individual or entity identified on this form as the disclosing provider 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 ($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 provider entity with an ownership or control interest in the Provider Entity.