Provider Disclosure Information Request

Provider & Subcontractor Disclosure of Ownership & Controlling Interest Statement Attestation of Criminal convictions, Sanctions, Exclusions, Debarment or Termination

Prepaid Inpatient Health Plans (PIHPs) must comply with federal regulations (42 CFR 455.100-106) to collect disclosure of ownership, controlling interest and management information including information from providers that are credentialed or otherwise enrolled to participate in the Medicaid and/or the Children's Health Insurance Program (CHIP) by Macomb County Community Mental Health PIHP or by a delegate of Macomb County Community Mental Health (MCCMH) PIHP, pursuant to a Medicaid contract with the MDCH and federal regulations. 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 conviction, sanction, exclusion, debarment or termination information for the provider, owners and managers. The information required includes, but is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN) information for the provider, owners and managers. The Centers for Medicaid and Medicare Services and the State Medicaid agency require MCCMH to obtain this information to demonstrate that it is not contracting with an entity that has been excluded from Federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid. This form is required if you wish to participate or continue to participate with MCCMH.

This Statement should be submitted at the time of initial appointment or re-appointment, updated yearly, within 35 days of any change in information, or within 35 days of a request for updated information. Use additional blank sheets of paper if you need space to continue your responses. If you have questions, please contact MCCMH Business Management Division.

In the event the practice group with which the Provider belongs has completed this form within the previous 180 days and can certify that no information on the previously submitted form has changed, you may initial below and may leave the "Disclosure of Ownership & Control Interest" Section of this Worksheet blank; otherwise, all fields must be completed.

☐ **I hereby certify that the information in the ownership and controlling interest worksheet submitted by the practice group within the previous 180 days is still complete and accurate.**

Identifying Information of Provider/Subcontractor:

Name of Provider/Subcontractor: ______________________________

Type of Provider/Subcontractor: ______________________________

Tax ID #: ____________________ NPI #: ___________________ Medicaid Provider ID #: _________________

Primary Business Address: ______________________________

Additional business locations, including P.O. Boxes, if applicable: ______________________________

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☐ **If the provider is no longer affiliated with this Tax ID#, please check this box and sign and date the second page.**

Type of Ownership: ______________________________

(examples may include: partnership, corporation, government, limited partnership, corporate-owned, investor-owned, etc.)

Disclosure of Ownership & Control Interest (Use & Attach Additional Sheets of Paper if Necessary)

a) List any individual or organization (hereinafter referred to as "Person") & their address that has a direct or indirect ownership or control interest of 5% or more in your entity (hereinafter referred to as "Interest"). If the Person with the Interest is a corporation, please include (i) the primary business address, (ii) every business location; (iii) P.O. Box addresses, if applicable; and (iv) the tax identification number. If the Person with the Interest is an individual (this includes Officers and Directors of the corporation; or Partners in the case of a partnership), list the individual's name, date of birth and SSN.

_______________________________ _______________________________

_______________________________ _______________________________

b) For any person disclosed above in (a) with an ownership or control interest, list whether such person is related to another person with ownership or control interest in your entity as a spouse, parent, child, or sibling.

_______________________________ _______________________________

_______________________________ _______________________________

c) For any person disclosed above in (a), list the name(s) of any other disclosing entity (defined as a Medicaid/Medicare provider, other than an individual practitioner or group of practitioners, or any entity that is otherwise required to disclose certain ownership and control information because of participation in a Federal health care program) in which such person has an ownership or control interest.

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For each service location:

d) List any managing employees & their address, date of birth, and SSN. Managing employees are individuals such as general managers, business managers, administrators, or directors who exercise operational or managerial control over the entity or part thereof, or directly/indirectly conduct the daily operations of the entity, or part thereof.

Primary Service Address: ____

_______________________________ _______________________________

_______________________________ _______________________________

Second Service Address: ____

_______________________________ _______________________________

_______________________________ _______________________________

Third Service Address: ____

____________________ ____________________

____________________ ____________________

Repeat section for all service addresses covered under this provider/Tax id#. Any service address not listed will be considered non-participating for Medicaid.

e) Has there been a change in ownership or control within the last year? Yes ☐ No ☐

   If yes, provide date of change: ____________________

f) Has any person listed on this form ever been excluded, sanctioned, debarred or terminated from any Federal health programs, had civil monetary penalties imposed against them, or been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs? Yes ☐ No ☐

   If yes, list those persons below in addition to the exclusion type, date of exclusion, and date the exclusion ended, as applicable:

____________________ ____________________

____________________ ____________________

____________________ ____________________

☐ **CHECK IF YOU HAVE LISTED ADDITIONAL INFORMATION ON ADDITIONAL PAGES**

I certify that the information contained above is true, complete, and accurate. Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate.

Signed: ____________________ Print: ____________________

Date: ____________________ Title: ____________________