



**OWNERSHIP/CONTROL INTEREST  
DISCLOSURE STATEMENT**

**This form must be completed by an Authorized Representative, defined as an individual with designated authority to act on behalf of the individual, Disclosing Entity or Provider. The signature on this form must be the written signature of the authorized representative and may not be a signature stamp.**

<b>Item I. Identifying Information</b>					
(a) Do you provide services/functions as: <input type="checkbox"/> a Disclosing Entity <input type="checkbox"/> a Provider <input type="checkbox"/> a County					
(b) Name of Disclosing Entity or Provider:					
(c) DBA Name					
(d) Address:					
(e) Federal Tax Identification Number (TIN):					
<b>Item II. Ownership and Control Interest Information for Disclosing Entity 42 C.F.R. §§ 455.100-104</b>					
(a) List following information for each <b>person, organization, corporation or other entity</b> who has any Ownership or Controlling Interest of 5% or more in your entity. Attach additional pages as necessary. See instruction page for definitions.					
Name	Title	Address	SSN/TIN		% owned
(b) List those persons named in Item II (a) that are related to each other (spouse, parent, child or sibling). 42 C.F.R. § 455.104					
Name		Relationship			SSN
(c) List the following information for each person with an Ownership or Control Interest in any Subcontractor that your entity has a direct or indirect ownership of 5% or more of. 42 C.F.R. § 455.104					
Name	Title	Address	SSN		% owned
(d) List the following information for any other Disclosing Entity in which a person with an Ownership or Controlling Interest in your entity, has an Ownership or Control Interest of at least 5% or more. 42 C.F.R. § 455.104					
Name	Title	Address	TIN		% owned

**Item III. Criminal Offenses and Exclusions 42 C.F.R. §§ 455.100, 106**

(A) Have you or any other individual or organization who has an Ownership or a Control Interest in this entity been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs?  No  Yes

If you answered yes above, please provide the following information for each person convicted of a criminal offense.

Name	Address	Title	SSN or TIN

(B) Do you have any agreements for the provision of items or services related to Medicare or Medicaid with an individual or entity who has been excluded from participation in Medicare, Medicaid or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?  No  Yes

If you answered yes above, please provide the following information for each individual or entity.

Name	Address	Title	SSN or TIN

**South Country Health Alliance may refuse to enter into, renew, or terminate an agreement with this Disclosing Entity if it is determined that this entity did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106**

**Item IV. Attestation and Signature**

Note: Authorized Representative means an individual with designated authority to act on behalf of the Individual, Disclosing Entity or Provider.

By signing this form, based on best knowledge, information and belief, I certify that the above information is true and correct. I will notify SCHA of any changes to this information. By signing this form, I also attest that I, or this Disclosing Entity or Provider has also requested or will be requesting this information from our Subcontractors and Providers, and that such information will be received and reviewed by myself or this Disclosing Entity or Provider. I also give consent for this information to be disclosed to DHS or any other appropriate government agency.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Phone

# Instructions and Definitions for Ownership/Control Interest Disclosure Statement

Completion and submission of this statement is a condition of participation in the Medicare or Medicaid program and is also/will be a contractual obligation with South Country Health Alliance (SCHA). Failure to submit the requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

## **Who should complete this form?**

You should complete this form if you are a Disclosing Entity, Subcontractor, or Provider.

## **When to complete and submit this statement:**

This form should be submitted with your initial contract or agreement with SCHA. After becoming a participating provider you must submit a new statement:

- When any information in your initial Disclosure of Significant Business Transactions Statement has changed – AND –
- Every year. **This form should be submitted to SCHA by August 1, 2011.**

## **INSTRUCTIONS**

### **Item II: Ownership and Control Interest Information on Disclosing Entity:**

- (a) Here, you will need to list information about EACH PERSON who owns or controls 5% or more of your entity.
- (b) You also need to report whether any of the persons listed in (a) are related to each other.
- (c) Here, you list people that have an Ownership or Control Interest in a Subcontractor that your entity owns at least 5% of. (Note the definition of subcontractor)
- (d) Here, you list other entities that are owned or controlled at least 5% by someone with an Ownership or Control Interest in your entity.

### **Item III: Criminal Offenses:**

Before SCHA enters into or renews a provider or delegation agreement, each Disclosing Entity or Provider must disclose to SCHA the identity of any person who has Ownership or Control Interest in your entity AND has been convicted of a criminal offense related to an involvement in any program under Medicare, Medicaid or Title XX services program since the inception of those programs.

- (A) Should be filled out if you are an Individual, providing information about yourself.
- (B) Should be filled out if you are an authorized representative filling this out for a Disclosing Entity or Provider.
- (C) Must be filled out by all.

## **DEFINITIONS**

### **Disclosing Entity:**

A Medicare or Medicaid provider (other than an individual practitioner or group of practitioners) or supplier, or a fiscal agent (a contractor that processes or pays vendor claims on behalf of SCHA). This definition includes Counties and Third Party Administrators (TPAs).

### **Ownership or Control Interest:**

Questions that ask for information about ownership or control interest are asking for information about persons, businesses or organizations that have either:

- Direct ownership of 5% or more in the disclosing entity – OR –
- 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) – OR –
- A combination of direct and indirect ownership interest equal to 5% or more in the disclosing entity – OR –
- Owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity – OR –

- 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

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.

Controlling interest is defined as the operational direction or 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, (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity or the sale or dissolution of that entity; 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.

**Provider:**

An Individual or entity that 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.

**Subcontractor:**

- (1) 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; or
- (2) 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 Medicare or Medicaid agreement.

**Supplier:**

An individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicare or 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 a provider or by a person(s) or other entity with an ownership or control interest in a provider.

Mail to: SCHA – Attn: Rhonda Seefeld, 110 W. Fremont Street, Owatonna, MN. 55060

Fax to: SCHA – Attn: Rhonda Seefeld, (507)-444-7774

Email to: [rseefeld@mnscha.org](mailto:rseefeld@mnscha.org)