North Dakota Department of Human Services

SFN 1168
Ownership/Controlling Interest And Conviction Information
Rev 6-2018

Section I – Identifying Information – Required for All Applications

- Provider Number (ND Medicaid) field: Leave blank or write: “Pending”.
- NPI Number: This is the NPI of the Group. DO NOT use the NPI of an individual.
- Fill out all other fields.

Section II – Certification – Required for All Applications

- If it does not apply to you, check the “Other” box and write “N/A” for Not Applicable, and sign and date.
- If it does apply, check the box to indicate your facility’s certification, Print your name, put the certification date, sign, and date.

Section III – Direct/Indirect Ownership Information – Required for All Applications (Government entities are not exempt)

- If the business does not have owners, please add the business’ own information in this section. The business will be treated as its own owner.
- This is for the individuals and businesses who have ownership of 5% or more in the provider who is enrolling with ND Medicaid (Provider that is in Section I). Please read the instructions on Page 5 to see who qualifies as an owner.
- If the owner is a group, write the Tax ID # (also known as a TIN, EIN, or FEIN) in the field labelled “SSN/TIN”. DOB field is not required for a group.
- If the owner is an individual, write the SSN in the field labelled “SSN/TIN”.
- Fill out all other fields for each individual/group.
- If you need more space, you may attach a sheet with the names, DOBs, SSNs/Tax IDs of each individual/group with ownership interest of 5% or more. If attaching, please write “See Attachment” in this section.

Section IV – Managing Employee/Control Interest – Required for All Applications (Government entities are not exempt)

- All persons who are Managing Employees or have a Controlling Interest in the provider must be listed here. This includes all Board Members (Corporations only), Trustees (Corporations only), and Employees that are authorized to sign on behalf of the business (all providers).
- If you need more space, please write “See Attachment” and attach a separate sheet with each person’s first and last name, Date of Birth, and SSN.
- The person/s who signed the W-9, EFT form (SFN 661), and the Provider Agreement (SFN 615) must be included in this section with their first and last name, Date of Birth, and SSN.

Section V – Ownership/Controlling Interest Information – Required for All Applications

- Check either Yes or No.
- If No, move on to the next section.
- If Yes, fill out the rest of the fields in this section.

Section VI – Changes in Provider Status – Required for All Applications

- Check either Yes or No for each question.
- If No, move on to the next question.
- If Yes, fill out the "Date" field with the appropriate date.

Section VII – Conviction Information – Required for All Applications

- Check either Yes or No for each question.
- If No, move on to the next section.
- If Yes, fill out the rest of the fields in this section.

Section VIII – Multiple Owner Information – Required for All Applications

- Check either Yes or No for each question.
- If No, move on to the next section.
- If Yes, fill out the rest of the fields in this section.

Section IX – Chain Affiliations – Required for All Applications for providers who are part of a chain

- Fill out if the provider enrolling is part of a chain.
- Leave blank if not part of a chain.

Section X – Signature – Required for All Applications

- Fill out all fields. Signature must be a wet signature. Electronic signatures not accepted.

If the Group is organized as a Corporation:

Attach a list of your Board of Directors/Trustees if they are not all listed on the SFN 1168. Include each Director/Trustee's first and last name, Date of Birth, and SSN. Please make sure the group's organization type is showing on the W-9.