# OWNERSHIP/CONTROLLING INTEREST AND CONVICTION INFORMATION

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1168 (8-2020)

Clear Fields

**The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is mandatory for participation in this program by the Centers for Medicare and Medicaid Services, Department of Health and Human Services. (Citation: 42 CFR 455.104, 455.105, and 455.106) [to participate in the North Dakota Medical Assistance Program (Medicaid) as mandated.] Failure to provide the social security number may result in a delay in processing the application. Disclosure must be made at the time of enrollment or contracting with the Department at time of survey, or within 35 days of a written request from the Department. Any change in ownership shall be reported within 35 days after any change.**

## I. Identifying Information

The address for corporate entities must include, as applicable, primary business address, every business location, and PO Box address.

| | | | |
|---|---|---|---|
| Legal Name (Must Match Line 1 of W-9) | | Doing Business As (Must match Line 2 of W-9) | |
| Service Address (required) | City | State | ZIP Code |
| Mailing Address (required) | City | State | ZIP Code |
| Billing Address | City | State | ZIP Code |
| List any PO boxes and corresponding address information associated with this facility | | Facility Telephone Number (required) | |
| FAX Number | ND Medicaid Provider Number | NPI Number | E-Mail Address (required) |

## II. Direct/Indirect Ownership Information - All Owners with 5% or more Ownership - Per CFR 42 CFR 455.436

Any Owner (Individual or Company) with 5% or more Ownership must be listed:
-Individual as an Owner - List your Social Security Number (SSN) and birth date
-Company as an Owner - List the Tax Identification Number (TIN) of the company that is an owner
-No Ownership: The group that is enrolling/enrolled would be considered its own owner and that information should be listed here.
-For providers enrolled with Medicare and Medicaid, any discrepancies noted in 5% or more ownership will be reported to Medicare.

| | | | | |
|---|---|---|---|---|
| Name | % Ownership | Relationship | SSN/TIN (required) | Date of Birth (required for individual) |
| Physical Address (required) | City | State | ZIP Code | |
| Billing Address | City | State | ZIP Code | |
| List Any PO Box Information | City | State | ZIP Code | |
| Name | % Ownership | Relationship | SSN/TIN (required) | Date of Birth (required for individual) |
| Physical Address (required) | City | State | ZIP Code | |
| Billing Address | City | State | ZIP Code | |
| List Any PO Box Information | City | State | ZIP Code | |
| Name | % Ownership | Relationship | SSN/TIN (required) | Date of Birth (required for individual) |
| Physical Address (required) | City | State | ZIP Code | |
| Billing Address | City | State | ZIP Code | |
| List Any PO Box Information | City | State | ZIP Code | |

Additional ownsers attached? ☐ Yes ☐ No

## III. Managing Employee/Control Interest - Per CFR 42 CFR 455.436

The following individuals are to be listed here:
- Managing Employees (CFE, CIO, CEO, office manager, PIC, DON, etc. -Individuals who have signed any legal documents
- Board of Directors Board members are required for corporate entities only) for this application
- Trustee Members
- Personnel Authorized to sign on behalf of the organziation

| Name | Title | DOB (required) | SSN (required) | Address | Work Telephone Number |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Additional managing employees/persons with controlling interest attached? ☐ Yes ☐ No

## IV. Ownership/Controlling Interest Information

**A BOX MUST BE CHECKED**

Does any person, business or organization with an ownership or controlling interest in the provider listed in Section I have an ownership or controlling interest of five percent (5%) or more in any other Medicaid provider? ☐ Yes ☐ No

Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest 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 (or fiscal agent or managed care entity) has a 5% or more interest in any other disclosing entity, fiscal agent (FA), or managed care entity (MCE).

If yes, indicate the name(s) that have the ownership or controlling interest and include the contact information for the other Provider(s). If additional space is needed, attach a separate document.

| | | | |
|---|---|---|---|
| Name of Other Disclosing Entity, FA, or MCE | North Dakota Medicaid Provider Number (if applicable) | | |
| Relationship | SSN/TIN (required) | Date of Birth (required for individual) | |
| Physical Address (required) | City | State | ZIP Code |
| Billing Address | City | State | ZIP Code |
| List Any PO Box Information | City | State | ZIP Code |

Additional Ownership/Controlling Interest information attached? ☐ Yes ☐ No

## V. Conviction Information

Are there any directors, officers, agents, managing employees, or subcontractors of the institution, agency, or organization who have been convicted of or plead guilty to a criminal offense related to programs under Medicare, Medicaid, or Title XX Services Program?

☐ Yes ☐ No **A BOX MUST BE CHECKED**

List the identity of any person who has ownership, controlling interest or is an agent or managing employee in the provider listed Section I and has been convicted of a criminal offense related to that persons involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

| | | | |
|---|---|---|---|
| Name | SSN/TIN (required) | Date of Birth (required for individual) | |
| Physical Address (required) | City | State | ZIP Code |
| Billing Address | City | State | ZIP Code |
| List Any PO Box Information | City | State | ZIP Code |

Additional conviction information attached? ☐ Yes ☐ No

## VI. Signature

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 entity already participates, a termination of its agreement or contract with the state agency as appropriate. It is the provider's responsibility to ensure all information is accurate and to report any changes as required by law by completing a new SFN 1168 Ownership/Controlling Interest and Conviction Information form.

| Name of Authorized Representative (Please Print) | Date of Birth (required) | Social Security Number (required) |
|---|---|---|
| Title | | |
| Signature | | Date |

# INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP/CONTROLLING INTEREST FORM

Completion and submission of this form is a condition of participation, certification, or decertification under any of the programs established by titles XIX, XX, and XXI, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and North Dakota Medicaid. A full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in termination of existing agreements.

**General Instructions**

For definitions, procedures and requirements, refer to the appropriate 42 Code of Federal Regulations, Subpart B, 455.100 - 455.106:
Title XIX - 42 CFR 455.106
Title XXI - 42 CFR 457.900

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information. If additional space is needed, attach an additional sheet. Return the original, and retain a copy for your files.

This form is to be completed when changes occur that alter what is reported on this form or when the provider is required to re-enroll.

**Detailed Instructions**

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

**Item I: Identifying Information**

Specify in what capacity the entity is doing business as, example, name of the facility or practice. Be sure to list any PO boxes and corresponding address information associated with this facility. Include a separate document if needed.

**Item II: Direct/Indirect Ownership Information and Item IV Managing Employee Information**

Definitions follow:
***Agent*** means any person who has been delegated the authority to obligate or act on behalf of a provider.
***Disclosing entity*** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.
***Other disclosing entity*** means 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.
***Fiscal agent*** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.
***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).
***Health insuring organization*** *(HIO)*) means a county operated entity, that in exchange for capitation payments, covers services for beneficiaries (1) Through payments to, or arrangements with, providers; (2) Under a comprehensive risk contract with the State; and (3) Meets the following criteria (i) First became operational prior to January 1, 1986; or (ii) Is described in section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990).
***Indirect ownership interest*** means 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.
***Managed care entity*** *(MCE)* means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.
***Managing employee*** means 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 operation of an institution, organization, or agency.
***Ownership interest*** means the possession of equity in the capital, the stock, or the profits of the disclosing entity. *Person with an* ***ownership or control interest*** means a person 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. This includes **Board of Directors** and Trustees of Nonprofit and For profit **corporations**, Members of LLC and partners of partnerships and Joint Ventures.

**Item III: Managing Employee/Control Interest**

Reference the definitions provided in Item III.

**Item IV: Ownership/Controlling Interest Information**

***Ownership interest*** means the possession of equity in the capital, the stock, or the profits of the disclosing entity. *Person with an* ***ownership or control interest*** means a person 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. This includes **Board of Directors** and Trustees of Nonprofit and For profit **corporations**, Members of LLC and partners of partnerships and Joint Ventures.

**Item V: Conviction Information**
This section is for exclusion and/or sanction information. Please provide accurate information regarding previous and current exclusions and sanctions. All YES answers require additional documentation in the space provided.

In order for providers to ensure that persons with ownership or control interest in the provider or an agent or managing employee of the provider have not been convicted of a criminal offense specific to the areas cited under VI, they must perform the same screening functions that State Medicaid Agencies are required to perform. Per 42 CFR 455.436- The State Medicaid Agency must do all of the following: (a) confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases (b) Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe. (c)(1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and (2) Check the LEIE and EPLS (now known as SAM) no less frequently than monthly.

**Item VI: Signature**
This section must be signed by an authorized agent of the disclosing entity.

**Title 42: Public Health**
**§455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.**

(a) *Who must provide disclosures.* The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) *What disclosures must be provided.* The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:(1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest 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 (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) *When the disclosures must be provided.*

(1) *Disclosures from providers or disclosing entities.* Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under §455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

(2) *Disclosures from fiscal agents.* Disclosures from fiscal agents are due at any of the following times:

(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

(ii) Upon the fiscal agent executing the contract with the State.

(iii) Upon renewal or extension of the contract.