OWNERSHIP/CONTROLLING INTEREST AND CONVICTION INFORMATION

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1168 (6-2018)

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.

I. Identifying Information

The address for corporate entities must include, as applicable, primary business address, every business location, and PO Box address.				
Name of Provider		Doing Business As		
Physical Address (required)		City	State	ZIP Code
Mailing Address		City	State	ZIP Code
List any PO boxes and corresponding address information associated with this facility			Telephone Number	
FAX Number	Provider Number (ND Medicaid)	NPI Number	E-Mail Address	

II. Certification

Check the applicable certification that your facility has: ☐ Joint ☐ Centers for Medicare and Medicaid Services (CMS) ☐ Other _____		
Name of Authorized Representative (Please Print)		
Certification Dated	Signature	Date

III. Direct/Indirect Ownership Information

List name, address, Tax Identification Number (TIN), Social Security Number (SSN) and Date of Birth (DOB) of each person or entity with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. 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. Please include the primary business location and all business locations. All addresses must contain both the physical address and the mailing address. *If additional space is needed attach a separate document.*

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

III. Direct/Indirect Ownership Information Continued

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

IV. Managing Employee/Control Interest

List current agents and managing employees by name, title, Date of Birth (DOB), Social Security Number (SSN), and work telephone number. The individual who signs the W-9, Provider Agreement, and this form MUST be listed here. Refer to page 4 for definitions. If additional space is needed, attach a separate document.

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

V. 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 percent or more 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

Name of Other North Dakota Medicaid Provider	North Dakota Medicaid Provider Number		
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

VI. Changes in Provider Status

A BOX MUST BE CHECKED FOR EACH QUESTION

		Date
Has there been a change in ownership or control within the last year? If yes, provide date.	☐ Yes ☐ No	
Do you anticipate any change of ownership or control within the year? If yes, provide date.	☐ Yes ☐ No	
Is this facility operated by a management company or leased in whole or part by another organization? If yes, give date of change of operations.	☐ Yes ☐ No	

VII. 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 or control interest in the provider, or is an agent or managing employee of the provider; 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.

If this does not apply to any person falling within the guidelines listed above, check the “no” box and attest that your facility is conducting the federal database checks that State Medicaid Agencies are required to perform. Those requirements are listed in the instructions section.

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

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

VIII. Multiple Owner Information

Do any owners of the disclosing entity have ownership interest in any other facilities enrolled with Medicare?

☐ Yes ☐ No **A BOX MUST BE CHECKED**

If yes, complete the requested information below. If additional space is needed, attach a separate document.

Owner Name	Facility Name	Medicare Number	
Physical Address (required)	City	State	ZIP Code
Billing Address	City	State	ZIP Code
List Any PO Box Information	City	State	ZIP Code

Owner Name	Facility Name	Medicare Number	
Physical Address (required)	City	State	ZIP Code
Billing Address	City	State	ZIP Code
List Any PO Box Information	City	State	ZIP Code

IX. Chain Affiliations

Chain Home Office Information

Name of Home Office as Reported to the Internal Revenue Service		
Business Street Address Line 1 (Street Name and Number)		
Business Street Address Line 2 (Street Name and Number)		
City/Town	State	ZIP Code + 4
Tax Identification Number	Cost Report Year-End Date (mm/dd)	
Fee-For-Service Contractor	Chain Number	

Type of Business Structure (check one)

Voluntary:

- ☐ Non-Profit - Religious Organization
- ☐ Non-Profit - Other (specify): _____

Proprietary:

- ☐ Individual
- ☐ Corporation
- ☐ Partnership
- ☐ Other (specify): _____

Government:

- ☐ Federal
- ☐ State
- ☐ City
- ☐ County
- ☐ City-County
- ☐ Hospital District
- ☐ Other (specify): _____

Provider's Affiliation to the Chain Home Office (check one)

- ☐ Joint Venture/Partnership
- ☐ Managed/Related
- ☐ Leased
- ☐ Operated/Related
- ☐ Wholly Owned
- ☐ Other (specify): _____

X. 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.

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: Certification

Specify what entity is responsible for your facility certification (if applicable).

Item III: 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 IV: Managing Employee/Control Interest

Reference the definitions provided in Item III.

Item V: 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 VI: Changes in Provider Status
Changes in provider status is defined as any change in management control. Examples of such changes would include: a change in the Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any changes of ownership.

If there has been a change in ownership within the last year or if you anticipate a change indicate the date in the appropriate space. If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for the operation of the facility.

Item VII: 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 VIII: Multiple Owner Information
This section is for any owners of the disclosing entity that are also owners of other Medicare facilities. All YES answers require additional documentation in the space provided.

Item IX: Chain Affiliations
A chain provider is one that is owned by the same entity that owns another provider or providers. Chain affiliates may include facilities that are publuc, private, charitable, or proprietary. They may also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based clinics, are not chain affiliates.

Item X: 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.