Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SUPPORT ADMINISTRATION
DEVELOPMENTAL DISABILITIES ADMINISTRATION
BEHAVIORAL HEALTH AND SERVICE INTEGRATION ADMINISTRATION

# Medicaid Provider Disclosure Statement

Completion and submission of this form is a federal and state requirement and a condition of participation in Medicaid reimbursement (see instructions for specific citations). Full and accurate disclosure of ownership as well as financial, managerial, and controlling interests is required. Submission of this form to DSHS is also required for changes in ownership, managing employees, or controlling interests. Any failure to submit the requested information may cause the Department to refuse to enter into an agreement or contract with the individual or entity, or to terminate existing agreements. See the instructions for definitions of the terms used in this form.

Please answer all questions as of the current date. If additional space is needed use an attached sheet.

**Sections:**



## I. Enrolling Provider's Information (see instructions)

| PROVIDER NAME (LEGAL NAME) | FEDERAL TAX ID: SSN / FEIN |
|---|---|
| DOING BUSINESS AS (DBA) | NATIONAL PROVIDER IDENTIFIER (NPI) |

## II. Individuals with Ownership Interest (see instructions)

List each individual who has direct or indirect ownership, separately or in combination, amounting to an ownership interest of 5% or more of the provider listed in Section I. Attach additional pages as necessary.

| FIRST NAME | LAST NAME | DATE OF BIRTH |
|---|---|---|
| SOCIAL SECURITY NUMBER | START DATE | OWNERSHIP PERCENTAGE |

STREET NAME AND NUMBER, SUITE, ROOM, ETC. CITY STATE ZIP CODE

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

| FIRST NAME | LAST NAME | RELATIONSHIP |
|---|---|---|
| FIRST NAME | LAST NAME | RELATIONSHIP |

List each individual who has direct or indirect ownership, separately or in combination, amounting to an ownership interest of 5% or more of the provider listed in Section I. Attach additional pages as necessary.

| FIRST NAME | LAST NAME | DATE OF BIRTH |
|---|---|---|
| SOCIAL SECURITY NUMBER | START DATE | OWNERSHIP PERCENTAGE |

STREET NAME AND NUMBER, SUITE, ROOM, ETC. CITY STATE ZIP CODE

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

| FIRST NAME | LAST NAME | RELATIONSHIP |
|---|---|---|
| FIRST NAME | LAST NAME | RELATIONSHIP |

## II. Individuals with Ownership Interest (continued)

List each individual who has direct or indirect ownership, separately or in combination, amounting to an ownership interest of 5% or more of the provider listed in Section I. Attach additional pages as necessary.

| FIRST NAME | LAST NAME | DATE OF BIRTH |
|---|---|---|
| SOCIAL SECURITY NUMBER | START DATE | OWNERSHIP PERCENTAGE |

STREET NAME AND NUMBER, SUITE, ROOM, ETC. CITY STATE ZIP CODE

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

| FIRST NAME | LAST NAME | RELATIONSHIP |
|---|---|---|
| FIRST NAME | LAST NAME | RELATIONSHIP |

List each individual who has direct or indirect ownership, separately or in combination, amounting to an ownership interest of 5% or more of the provider listed in Section I. Attach additional pages as necessary.

| FIRST NAME | LAST NAME | DATE OF BIRTH |
|---|---|---|
| SOCIAL SECURITY NUMBER | START DATE | OWNERSHIP PERCENTAGE |

STREET NAME AND NUMBER, SUITE, ROOM, ETC. CITY STATE ZIP CODE

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

| FIRST NAME | LAST NAME | RELATIONSHIP |
|---|---|---|
| FIRST NAME | LAST NAME | RELATIONSHIP |

## III. Managing Employees and other Controlling Interests (see instructions)

List each managing employee and other controlling interests (e.g. members of a board of directors or an officer) of the provider listed in Section I. Attach additional pages as necessary.

| FIRST NAME | LAST NAME | |
|---|---|---|
| DATE OF BIRTH | SOCIAL SECURITY NUMBER | START DATE |

STREET NAME AND NUMBER, SUITE, ROOM, ETC. CITY STATE ZIP CODE

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or controlling interest of the provider listed in Section I, list related individual(s):

| FIRST NAME | LAST NAME | RELATIONSHIP |
|---|---|---|
| FIRST NAME | LAST NAME | RELATIONSHIP |

List each managing employee and other controlling interests (e.g. members of a board of directors or an officer) of the provider listed in Section I. Attach additional pages as necessary.

| FIRST NAME | LAST NAME | |
|---|---|---|
| SOCIAL SECURITY NUMBER | START DATE | DATE OF BIRTH |

STREET NAME AND NUMBER, SUITE, ROOM, ETC. CITY STATE ZIP CODE

## III. Managing Employees and Other Controlling Interests (continued)

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or controlling interest of the provider listed in Section I, list related individual(s):

| FIRST NAME | LAST NAME | RELATIONSHIP |
|---|---|---|
| FIRST NAME | LAST NAME | RELATIONSHIP |

List each managing employee and other controlling interests (e.g. members of a board of directors or officers)of the provider listed in Section I. Attach additional pages as necessary.

| FIRST NAME | LAST NAME | |
|---|---|---|
| SOCIAL SECURITY NUMBER | START DATE | DATE OF BIRTH |
| STREET NAME AND NUMBER, SUITE, ROOM, ETC. | CITY | STATE ZIP CODE |

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or controlling interest of the provider listed in Section I, list related individual(s):

| FIRST NAME | LAST NAME | RELATIONSHIP |
|---|---|---|
| FIRST NAME | LAST NAME | RELATIONSHIP |

## IV. Organizations with Ownership or Management Interest (see instructions)

List each office, organization, corporation or entity that has a management interest or direct/indirect ownership separately or in combination, amounting to an ownership interest of 5% or more in the provider listed in Section I. Attach additional pages as necessary.

| ORGANIZATION NAME (LEGAL NAME) | FEDERAL TAX ID - FEIN | CHECK ONE<br>☐ Ownership Interest<br>☐ Management Interest |
|---|---|---|
| DOING BUSINESS AS (DBA) | START DATE | OWNERSHIP PERCENTAGE |
| PRIMARY BUSINESS STREET ADDRESS | CITY | STATE ZIP CODE |

**Mailing Address (PO Box) for the disclosed organization, if different from Primary Business Address**

| MAILING ADDRESS | CITY | STATE ZIP CODE |
|---|---|---|

**Business Locations for the disclosed organization, if different from the Primary Business Address**

| STREET NAME AND NUMBER, SUITE, ROOM, ETC. | CITY | STATE ZIP CODE |
|---|---|---|
| STREET NAME AND NUMBER, SUITE, ROOM, ETC. | CITY | STATE ZIP CODE |

List each office, organization, corporation or entity that has a management interest or direct/indirect ownership separately or in combination, amounting to an ownership interest of 5% or more in the provider listed in Section I. Attach additional pages as necessary.

| ORGANIZATION NAME (LEGAL NAME) | FEDERAL TAX ID - FEIN | CHECK ONE<br>☐ Ownership Interest<br>☐ Management Interest |
|---|---|---|
| DOING BUSINESS AS (DBA) | START DATE | OWNERSHIP PERCENTAGE |
| PRIMARY BUSINESS STREET ADDRESS | CITY | STATE ZIP CODE |

**Mailing Address (PO Box) for the disclosed organization, if different from Primary Business Address**

| MAILING ADDRESS | CITY | STATE ZIP CODE |
|---|---|---|

## IV. Organizations with Ownership or Management Interest (continued)

**Business Locations for the disclosed organization, if different from the Primary Business Address**

| STREET NAME AND NUMBER, SUITE, ROOM, ETC. | CITY | STATE | ZIP CODE |
|---|---|---|---|
| STREET NAME AND NUMBER, SUITE, ROOM, ETC. | CITY | STATE | ZIP CODE |

## V. Subcontractor Information (see instructions)

List each person with an ownership or controlling interest in any subcontractor in which the provider listed in Section I has direct or indirect ownership of 5% or more. Attach additional pages as necessary.

| NAME AND TITLE | | SSN / TIN | PERCENTAGE |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP CODE |
| NAME AND TITLE | | SSN / TIN | PERCENTAGE |
| ADDRESS | CITY | STATE | ZIP CODE |

Does any owner of the provider listed in Section I also have an ownership or controlling interest of 5% or more in any other entity? Attach additional pages as necessary.

| NAME AND TITLE | | SSN / TIN | PERCENTAGE |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP CODE |

## VI. Criminal Offenses (see instructions)

List each individual who has ownership, controlling interest, is an agent, managing employee, officer, or member of the board of directors of the provider listed in Section I and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XVIII, XIX, or XX, since the inception of those programs. Attach additional pages as necessary.

| NAME AND TITLE | | SSN / TIN | PERCENTAGE |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP CODE |
| NAME AND TITLE | | SSN / TIN | PERCENTAGE |
| ADDRESS | CITY | STATE | ZIP CODE |

## VII. Suspension or Debarment (see instructions)

Federal statutes and regulations clearly prohibit states from paying for items or services furnished, ordered or prescribed by excluded parties. States are required to search the exclusions databases by the name of a provider entity seeking to participate in the program and also by the name of any owner, managing employee, or controlling interests including officers and members of a board of directors.

Have you, any of your managing employees, or any individual who has an ownership or controlling interest of the provider listed in Section I ever been placed on the federal Office of the Inspector General, Health and Human Services (OIG/HHS) exclusions list or on the System for Award Management (SAM), or otherwise been suspended or debarred from participation in Medicare, Medicaid, or Title XVIII, XIX, or XX services programs. If yes, list each person below. Attach additional pages as necessary. The lists of excluded individuals can be found at: http://exclusions.oig.hhs.gov/ and https://www.sam.gov.

| NAME AND TITLE | | SSN / TIN | DATE OF BIRTH |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP CODE |
| NAME AND TITLE | | SSN / TIN | DATE OF BIRTH |
| ADDRESS | CITY | STATE | ZIP CODE |

## VIII. Status Changes (see instructions)

Is a change of ownership anticipated within the next year? ☐ Yes ☐ No

Is this facility operated by a management company or leased in whole or partly by another organization? ☐ Yes ☐ No

If yes, list date of change in operations: _____

Has there been a past bankruptcy or do you anticipate filing for bankruptcy within the next year? ☐ Yes ☐ No

If yes, when?

## IX. Signature (see instructions)

Anyone who 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 appropriate state agency. By signature I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.

NAME OF INDIVIDUAL COMPLETING THIS FORM

TITLE OF INDIVIDUAL COMPLETING THIS FORM

SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM DATE

## Instructions for the Medicaid Provider Disclosure Statement

These instructions are for use with the Medicaid Provider Disclosure Statement. Definitions of the terms used in this form are included at the end of this document. Please answer all questions as of the current date.

Completion and submission of this form is a federal and state requirement, and a condition of participation in Medicaid reimbursement. Full and accurate disclosure of ownership as well as financial, managerial, and controlling interests is required. Completion of this form is also required to notify the DSHS of changes to ownership, managing employees, and controlling interests. Failure to submit the requested information may cause the Department to refuse to enter into an agreement or contract with the individual and/or entity or to terminate existing agreements. These disclosures are required under 42 CFR §455.104, 42 CFR §455.105, and 42 CFR §455.106.

**Instructions by Section:**

**I. Enrolling Provider's Information**

Complete this section with information about the provider entity. Specify the provider's name, (legal name reported to the IRS), the Federal Tax ID associated with the provider (FEIN or SSN), the National Provider Identifier (NPI), and the Doing Business As (DBA) name, if applicable.

**II. Individuals with Ownership Interest**

Complete this section with information about individuals who have direct or indirect ownership interest of 5% or more of the provider listed in Section I. Report organizational owners in Section IV. See the definitions section at the end of this document for instructions on how to compute ownership percentage.

For each owner, specify the name, date of birth, Social Security number, percentage of ownership, street address, and the start date of ownership interest with the provider.

If the individual owner is related to another owner, a managing employee, or someone with controlling interest, list the related individual. Report the related individual only if the individual is a spouse, parent, child, or sibling.

**III. Managing Employees and other Controlling Interests**

Complete this section with information about managing employees and controlling interests of the provider listed in Section I. Include the 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. Also list controlling interests including each member of the board of directors, agents with the authority to act on behalf of the provider listed in Section I, and officers or directors of a provider entity that is organized as a corporation.

For each individual listed, specify the name, date of birth, Social Security number, street address, and the start date of controlling or managerial interest with the provider listed in Section I.

If the individual owner is related to another owner, managing employee, or someone with controlling interest of the provider listed in Section I, list the related individual (s). Report the related individual only if the individual is a spouse, parent, child, or sibling.

**IV. Organizations with Ownership Interest or Management Interest**

Complete this section with information about organizations that have direct or indirect ownership interest of 5% or more of the provider listed in Section I. Also include organizations that have management interest in the provider listed in Section I. See the definitions section at the end of this document for instructions on how to compute ownership percentage.

For each organization listed, specify the legal name (as reported to the IRS), Federal Tax ID (FEIN), check whether the organization has ownership or management interest in the provider listed in Section I, Doing Business As (DBA) name, if applicable, the first date the organization started with ownership interest (or management interest), the percentage of ownership (if applicable), and the primary business address.

List mailing address (such as a PO Box) and the address for each business location if different from the Primary Business Address.

**V. Subcontractor Information**

Complete this section with information about each person who has an ownership or controlling interest in any subcontractor in which the provider listed in Section I has direct or indirect ownership of 5% or more.

For each individual listed, specify the name, title, Social Security number, ownership percentage, and address for each individual with an ownership or controlling interest in a subcontractor.

List any individuals with ownership or controlling interest in the provider listed in Section I that also has an ownership or controlling interest of 5% or more in any other entity.

## VI. Criminal Offenses

Complete this section with information about each individual who has ownership, controlling interest, is an agent, managing employee, officer, or member of the board of directors of the provider listed in Section I and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XVIII, XIX, or XX, since the inception of those programs.

For each individual listed, specify the name, Social Security number, ownership percentage (if applicable), and address.

## VII. Suspension or Debarment

Complete this section with information about each individual who is an officer, owner, agent, or managing employee of the provider listed in Section I who has been suspended or debarred from participation in Medicare, Medicaid, or the Title XVIII, XIX or XX services programs. These individuals would have been placed on the federal Office of the Inspector General, Health and Human Services (OIG/HHS) exclusions list, or on the System for Award Management (SAM). The current lists to excluded individuals can be found at: http://exclusions.oig.hhs.gov/search.aspx and https://www.sam.gov.

For each individual listed, specify the name, Social Security number, ownership percentage (if applicable), and address.

## VIII. Status Changes

Indicate any anticipated changes within the next year.

## IX. Signature

Provide the name and title of the individual completing statement, along with the signature and the date the statement is signed.

### Definitions

**Agent:** Any person who has been delegated the authority to obligate or act on behalf of a provider.

**Exclusion:** Items and services furnished, ordered or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid, and all other federal health care programs until the individual or entity is reinstated by the OIG.

**Indirect ownership interest:** 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.

**Managing employee:** 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

**OIG:** Office of Inspector General of the Department of Health and Human Services.

**Ownership interest:** The possession of equity in the capital, stock, or profits of the disclosing entity.

**Person with an ownership or control interest**

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.

(f) Is a partner in a disclosing entity that is organized as a partnership.

**Subcontractor**

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients.

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

**How to calculate ownership percentages:**

(a) **Indirect ownership interest.** The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) **Person with an ownership or control interest**. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government. These regulations can be found at: http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR

Washington Administrative Code (WAC) is the regulations of executive branch agencies issued by authority of statutes.

Like legislation and the Constitution, regulations are a source of primary law in Washington State. The WAC codifies the regulations and arranges them by subject or agency. These regulations can be found at: http://apps.leg.wa.gov/wac/default.aspx