Louisiana Medicaid Ownership Disclosure Information

Please note: It is recommended that the Internet be used to report ownership information instead of filling out the form that follows.

- **Using the Provider Ownership Enrollment web application to report ownership data eliminates rejection of enrollment application due to improperly reported ownership data.**

To use the Provider Ownership Enrollment web application, please go to www.lamedicaid.com and click on the "Provider Enrollment" link on the left-hand sidebar. Then click on the "Applications for New Enrollments, Reactivations, and Change of Ownership" link.

- **If you use the web application to register ownership information, DO NOT complete or submit the form.**

After reporting your ownership information on the Louisiana Medicaid web site, you must print and sign the signature page that the application provides for you, and submit the signature page along with the other enrollment documents identified on the appropriate checklist to:

Molina Medicaid Solutions Provider Enrollment
P.O. Box 80159
Baton Rouge, LA 70898-0159

State of Louisiana
Instructions for Louisiana Medicaid Ownership Disclosure Information
Entity/Business

Please note: This is a multi-page form. All of the pages must be completely filled out and submitted or the application cannot be accepted. Please review the instructions in their entirety before completing the form. The following fields MUST be completed:

SECTION I – ENROLLING PROVIDER INFORMATION

Information - Please read the provided information regarding disclosure, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).
Louisiana Medicaid Provider Number – Enter your seven- (7) digit Medicaid provider number. If this application is for a new Medicaid provider number, leave this field blank.
Tax-Payer ID Number – Enter the nine- (9) digit Tax ID number for this provider.
National Provider Identifier – Enter your ten- (10) digit National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov
This enrollment packet is for a – Check the appropriate box from among New Enrollment, Currently Enrolled, or Re-Enroll.
Provider Type – Enter the Louisiana Medicaid Provider Type for this entity/business.
Area Code and Telephone Number(s) of Enrolling Entity/business - Enter the area code and telephone number(s) at the street address of this enrolling entity/business.
Name of Enrolling Entity/Business – Enter the legal name of the entity/business.
Doing Business As: If a license is required for this entity/business, enter the DBA Name or Operating Name so that it matches the name on the entity/business license.
Business Street Address - Enter the physical business street address of the entity/business requesting enrollment
City, State, Zip - Enter the city, state and zip code of the physical business street address
E-Mail Address - Enter the entity/business email address.
Publicly Traded Definition - A company which has issued securities through an offering, and which are now traded on the open market, also called publicly held or public company,

SECTION II – INDIVIDUAL COMPLETING DISCLOSURE OF OWNERSHIP INFORMATION

List the full name, social security number, date of birth, job title, address, telephone number, and email address of person completing this form. Also, check one box specifying the position of the person completing the form for the enrolling entity/business (Staff, Third Party Independent Agent, other). If you check other, please specify by writing the relationship in the space provided.

SECTION III – ENROLLING ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

A - D. Read all questions carefully and respond by checking the appropriate boxes. If yes to any question, complete or attach the required documentation.

SECTION IV – GOVERNMENT-FUNDED HEALTH CARE INFORMATION

A. Has the Tax ID given in Sections I and III been used to enroll in any other Federal/State funded programs located in Louisiana? If yes, provide requested information.
B. Is the enrolling entity/business located out of the state of Louisiana? If yes, provide requested information.

SECTION V – OWNER INFORMATION

List all owners of this entity/business. Be sure to make a photocopy of the form before you fill it out the first time; you need one page for each owner. For more information, please see the guide on the page just before Section V.
For the entity/business identified in Section I, list all owners with 5% or greater ownership interest in this entity/business, including each shareholder, partner, or any subcontractor (an individual, agency or organization which any owner has contracted with or delegated some of it management functions or responsibilities of providing medical services to patients).
A. - F. Read all questions carefully and respond by checking the appropriate boxes. If yes to any question, attach the required documentation.
G. Does the above-named entity/business have ownership in any other entity/business that is currently enrolled in a federal/state program? If yes, in the table provided, list the appropriate names and TAX ID or NPI for these entities/businesses.
H. Does this owner reside out of the state of Louisiana? If yes, provide requested information.

SECTION VI – MANAGEMENT/AGENT INFORMATION

List all persons who are part of the management/agent structure for this entity/business. Be sure to make a photocopy of the form before you fill it out the first time; you need one page for each manager/agent. For more information, please see the guide on the page just before Section VI.
Information - Please read the provided information regarding disclosure, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL) which is located at the beginning of Section I.
Manager – defined under 42 §CFR 455.101 as "a general manger, business manager/agent, administrator, director, or other individual who exercises operational or manager/agential control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency".
Agent - Defined under 42 §CFR 455.101 as any person who has been delegated the authority to obligate or act on behalf of a provider.
Manager/t/Agent Information: Complete the title/Job Position, social security number, First, Middle, Maiden (if applicable), and Last Name, current address of manager/agent, and telephone number with area code.
A. – E. Read all questions carefully and respond by checking the appropriate boxes. If yes to any question, complete and attach the required documentation.
F. Does the above-named person have ownership or controlling interest in any entity/business that is currently enrolled in a government-funded program? If yes, in the table provided, check off the plans and list all plan numbers assigned to the Taxpayer ID Number.
G. For an out-of-state entity/business enrolling in Louisiana Medicaid, please provide the Medicaid and Medicare provider numbers issued to this entity/business by the domicile state.

SECTION VII – INFORMATION ON SUBCONTRACTORS

For the entity/business identified in Section I, list any subcontractor (whether individual, agency, or organization) which the entity/business has contracted with or delegated some its manager/agential functions or responsibilities for providing medical services to patients. For more information please see the guide on the page just before Section VII.
A. & B. Read all questions carefully and respond by checking the appropriate boxes. If you checked yes on any boxes, you shall provide requested information for each subcontractor.
If you had more than two subcontractors, make a photocopy of the form first, and submit as many pages as you need.

SECTION VIII – PROVIDER SIGNATURE

Carefully review all sections of the Disclosure of Ownership. Requires original signature of the authorized representative (no stamps or initials) and the date.

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION ENTITY/BUSINESS

Under Federal Regulations, a provider or disclosing (applying) entity must disclose to the Medicaid agency, prior to enrolling:

- The name and address of each person, entity or business with an ownership or control interest in the disclosing entity as well as any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more; *(See Federal Regulations* 42 CFR § 455.104(a)(1)

- Whether any person, entity or business with an ownership or control interest in the disclosing entity and any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more each subcontractor is related to another as spouse, parent, child, or sibling; *(See Federal Regulations 42 CFR § 455.104(a)(2)),* and

- The name of any other disclosing entity in which a person with an ownership or controlling interest in the provider or disclosing entity also has an ownership or control interest. *(See Federal Regulations* 42 CFR § 455.104(a) (3)). http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

NOTICE REGARDING DISCLOSURE OF SOCIAL SECURITY NUMBERS: As part of the application for enrollment in Louisiana Medicaid, social security numbers are required for each individual with Direct or Indirect Ownership or Control Interest of 5% or more, each individual Corporate Officer, Board of Director, Partner or Shareholder, and each individual Managing Employee or Agent who exercises operation or manager control or who directly or indirectly manages the conduct of day to day operations, pursuant to Louisiana Medicaid rules and regulations and 42 U.S.C. § 1320(a)(3). Social security numbers are required and the application will be returned if the social security numbers are not provided. Failure to provide social security numbers will be a basis to refuse to enroll you as a Medicaid provider.

In addition, Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (**MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A**) and Administrative Rules, (***Louisiana Register***, **Vol. 29, No. 4, April 20, 2003**), as well as **Louisiana Provider Update January/February 2009** (available at LAMEDICAID.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers.

SECTION I – Enrolling Entity/Business Information

Louisiana Medicaid Provider Number (7 digits)
(Leave blank if applying for new number)

Taxpayer ID Number (9 digits)

National Provider Identifier (NPI) (10 digits)

This enrollment packet is for a
☐ New Enrollment ☐ Currently Enrolled ☐ Re-Enroll ☐ Change of Ownership (CHOW) _____ _____
Date of CHOW Current Medicaid Provider Number

Provider Type:		**Telephone Number(s) of Enrolling Entity/Business** _____ - _____ - _____		
Name of Enrolling Entity/Business:	**Legal Name of Entity/Business**	**Doing Business As (DBA) Name of Entity/Business**		
	Entity/Business Street Address	**City**	**State**	**Zip**
	Entity/Business Email Address	**Entity/Business Website**		
Is this enrolling entity/business publicly traded? See instructions. ☐ Yes ☐ No				

Identify Type of Entity/Business if Privately owned or Non-profit
☐ **Sole Proprietorship** ☐ **Partnership/Limited Liability Partnership:** How many members are identified with this partnership?_____ ☐ **Corporation:** Revenue greater than or equal to $5M annually _____ Revenue less than $5M annually _____ In the Articles of Incorporation: How many individual owners are identified? _____ How many Board of Director members are identified? _____ How many officers are identified? _____ ☐ **Limited Liability Company (LLC)** In the Articles of Organization: How many members are identified? _____ How many managers are identified? _____ ☐ **Non-profit:** How many members are appointed to the governing board? _____ ☐ **Other** (Specify) _____

Identify Type of Entity/Business if Government owned (Louisiana Government Providers Only)		
☐ **CITY and/or PARISH** ☐ **SCHOOL BOARD** ☐ **LSU Hospital -_____**	**DHH** ☐ OBH ☐ OPH ☐ OAAS ☐ OCDD ☐ Villa Other _____	**Other State-owned entity:** _____

Print the Name and Title of the person authorized to enroll in Louisiana Medicaid on behalf of this Governmental Agency	
Print Name	Print Title

SECTION II - PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Social Security Number	Date of Birth	Job Title

The person completing this form is (please check one):

☐ Staff ☐ Owner ☐ Third Party/Independent Agent ☐ Other (explain) _____

Entity/Business Address	Entity/Business City	Business State	Business Zip

Entity/Business Telephone Number	Entity/Business Email Address
Additional Entity/Business Telephone Number(s)	Additional Entity/Business Email Address(es)

ATTENTION

If you are a Louisiana government-owned Entity/Business (including LSU), proceed to Section VII

All other Entities/Businesses must continue to Section III.

SECTION III – ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

Taxpayer ID Number of this enrolling entity/business

Has this enrolling entity/business or any entity/business affiliated with the above tax ID, ever:

A. Been convicted of a healthcare related felony or other criminal offense, State and/or Federal, under this name or any other name in any state or U.S. Territory, regardless of a post trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program? ☐ Yes ☐ No

If yes, attach explanation details of conviction or plea, including date of occurrence and state in which conviction occurred. Court documentation is required.

B. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification? ☐ Yes ☐ No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and state in which this action occurred, regarding the disciplinary action for all individuals/entities/agents/subcontractors, managing employees and/or businesses involved. Reinstatement letter required.

C Been denied enrollment, suspended, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory? ☐ Yes ☐ No

If yes, attach documents (notice of rejection, suspension, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals//entities/businesses involved. Reinstatement letter required.

D. Used or been known by any name other than the legal name or the Doing Business As (DBA) name documented in this application? ☐ Yes ☐ No

If yes, list all names and Tax IDs below:

Name	Tax ID
Name	Tax ID
Name	Tax ID

SECTION IV - ENROLLMENT IN HEALTHCARE PROGRAMS

A. Has the Tax ID given in Sections I and III been used to enroll in any other Federal/State funded programs **located in Louisiana** such as those listed below? ☐ Yes ☐ No

If yes, check off the plans, list the DBA Name(s), and Tax ID or NPI .

Plan	Doing Business As (DBA) Name		Tax ID and NPI Numbers
☐ Louisiana Medicaid			Tax ID #
			NPI #
☐ Medicare Part A			Tax ID #
			NPI #
☐ Medicare Part B			Tax ID #
			NPI #
☐ Medicare Part C			Tax ID #
			NPI #
☐ Medicare Part D (Pharmacies only)			Tax ID #
			NPI #
☐ CHAMPUS			Tax ID #
			NPI #
☐ Other Government Funded Program			Tax ID #
			NPI #
☐ Other Government Funded Program			Tax ID #
			NPI #

B. Is this enrolling entity/business located out-of-state (i.e., out of Louisiana)? ☐ Yes ☐ No

If yes, has this out-of-state entity/business been issued any Medicaid or Medicare provider numbers by the domicile state? ☐ Yes ☐ No

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

**** Attach Additional Sheets as Needed. ****

Please Read before proceeding to Section V – Ownership Information:

Be sure to make a photocopy of the form on the next page before you fill it out the first time; **you need one page for each owner.** If you have a five-person ownership team, you need to submit five completed Section V forms. You may **NOT** submit a list of names; each owner must be reported with a full page of information (**do not attach list—use form provided**).

Section V seeks to identify the owners of this enrolling entity/business.

Medicaid requires that an enrolling entity/business fully disclose **ALL** persons and entities that have an ownership interest (either separately or in combination) of 5% or more of this enrolling entity/business.

Owners are individuals and organizations having direct, indirect, or controlling ownership interest in this disclosing entity/business.

- Direct ownership is defined as the possession of stock, equity in capital, or any interest in the profits of this disclosing entity/business.
- Indirect ownership is defined as an ownership interest in an entity/business that has direct or indirect ownership in this disclosing entity/business.
- Controlling interest is defined as having operational direction or management or the ability and authorization:
    - To amend or change the corporate identity.
    - To nominate or name members of the board, directors, or trustees
    - To amend or change the bylaws, constitution, or other operating or management direction
    - To control the sale of any or all of the assets or property upon dissolution of the entity/business.
    - To dissolve or transfer this disclosing entity/business to new ownership or control.
    - Et cetera.

Owners may also be individuals associated with the enrolling entity/business:

- Whose personal assets are used to satisfy the entity/business creditors.
- Who join together to carry on an entity/business and expect to share in the profits and losses of the entity/business.
- Who report their share of profits and losses of the entity/business on their own personal tax returns.
- Who own corporate stock.
- Who are policy makers.
- Who have veto powers.
- Who have voting power.
- Who have any other responsibilities similar to the ones described above.

Ownership might be implied by titles like the following:

- Founder
- Incorporator
- Member
- Owner
- Shareholder

This list is not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

SECTION V – INFORMATION ON EACH OWNER

Under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(a) (1)), (2).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(a)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.

42 C.F.R. Sec. 455.101 Definitions.
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.

Title XVIII of the Social Security Act, Medicare program [42 U.S.C. 1395 et seq.].
Title XIX of the Social Security Act, Medicaid program [42 U.S.C. 1396 et seq.].
Title XX of the Social Security Act, Social Services block grant [42 U.S.C. 1397 et seq.].
TITLE V—Maternal and Child Health Services Block Grant

(See Federal Regulations 42 CFR § 455.104(a) (3) http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

Under Federal Regulations, a provider or disclosing entity must disclose (at any time upon request) to the Medicaid agency whether any person with ownership, any Agent or any managing employee of the provider or disclosing entity has ever had any criminal conviction related to that individual's involvement in Medicaid, Medicare, or Federally-funded healthcare program since the inception of those programs. (*See Federal Regulations* (~~455.~~ *42 CFR § 455.106 (a) (1) and (2)).

In addition, Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (*Louisiana Register*, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at LAMEDICAID.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers.

Copy and complete a separate form for each owner.

The Owner named on this page is (must check ONE box only per page): Individual ☐ Entity/Business ☐

If you are an individual owner, are you also a manager for this entity/business? Yes ☐ No ☐

Individual OWNER	Title/Job Position within this entity/business	Social Security Number (required) - -

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Current Address of Owner	
City	
State	Email Address
Zip Code	Telephone Number - - / Date of Birth (required) / /

Entity/Business OWNER		
Entity/Business Name	DBA Name	Tax ID Number (required)

Current Address of Owner	
City	
State	Email Address
Zip Code	Telephone Number -

If the owner named above is an individual:

A. Is this owner a U.S. citizen? ☐ Yes ☐ No

If you answered "No" above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States. For assistance, contact the United States Citizenship and Immigration Services (USCIS) at 1-800-375-5283, or visit the website at www.uscis.gov. List the country(s) of the Owner's citizenship below:

1.	2.	3.

SECTION V – OWNERSHIP INFORMATION, continued

B. Are any **owners** with direct, indirect or controlling interest, **managing employees**, or **subcontractors** identified for this entity/business related to one another as spouse, parent, child or sibling? ☐ Yes ☐ No

If yes, list all individuals and how they are related below:

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Has the owner named above ever:

C. Been convicted of a felony or convicted of any criminal offense under this name or any other name in any state or U.S. Territory, regardless of a post trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program? ☐ Yes ☐ No

If yes, attach explanation details of conviction or plea, including date of occurrence and state in which conviction occurred. Court documentation is required.

D Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification? ☐ Yes ☐ No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and state in which this action occurred, regarding the disciplinary action for all individuals/entities/agents/subcontractors, managing employees and/or businesses involved. Reinstatement letter required.

E. Been denied enrollment, suspended, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory? ☐ Yes ☐ No

If yes, attach documents (notice of rejection, suspension, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals//entities/businesses involved. Reinstatement letter required.

F. Used or been known by any other name including married, maiden, hyphenated, alias, or Doing Business As (DBA) name(s)? ☐ Yes ☐ No

If yes, enter name(s) below:

DBA Name:			DBA Name:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

G. Does this owner have ownership or controlling interest in any other entity participating in a Federal/State Funded healthcare program? ☐ Yes ☐ No

If yes, in the chart below, provide the appropriate names and TAX ID or NPI for these entity/business.

Plan	Provider Name and Doing Business (DBA) Name	Tax ID or NPI
☐ Medicaid	Name	Tax ID #
	DBA Name	NPI #
☐ Medicare	Name	Tax ID #
	DBA Name	NPI #
☐ Other Federal/State Funded Healthcare Program	Name	Tax ID #
	DBA Name	NPI #
☐ Other Federal/State Funded Healthcare Program	Name	Tax ID #
	DBA Name	NPI #
☐ Other Federal/State Funded Healthcare Program	Name	Tax ID #
	DBA Name	NPI #

H. Does this owner reside out-of-state (not in Louisiana?) ☐ Yes ☐ No

If yes, has this out-of-state owner been issued any Medicaid or Medicare provider numbers by the domicile state? ☐ Yes ☐ No

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

Please Read before proceeding to

Section VI – Management/Agent Information:

Be sure to make a photocopy of the form on the next page before you fill it out the first time; you need one page for each manager/agent. If you have a five-person management team, you need to submit five completed Section V forms. You may **NOT** submit a list of names; each manager/agent must be reported with a full page of information (no attachments—use the form provided).

VI seeks to identify the management structure of this enrolling entity/business.

Manager– defined under 42 §CFR 455.101 as "a general manger, business manager/agent, administrator, director, or other individual who exercises operational or manager/agential control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency".

Agent - Defined under 42 §CFR 455.101 as any person who has been delegated the authority to obligate or act on behalf of a provider.

Medicaid requires that an enrolling entity/business fully disclose **ALL** persons that provide management expertise to the enrolling entity/business.

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Manager/agent
- Officer
- Trustee

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith;* or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

These lists are not all-conclusive, and other activities and titles that imply or assume similar powers or responsibilities may apply.

SECTION VI – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (including a General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) or the name and address of any person who is an Agent of the provider, which is any person with the authority to obligate or act on behalf of the disclosing entity. *(See Federal Regulations 42 CFR § 455.106(a)(1)(2).* http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html

In addition, Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (*Louisiana Register*, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at LAMEDICAID.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers.

Copy and complete a separate form for each individual with management/agent duties.

MANAGER	Title/Job Position within this entity/business		Social Security Number (required)		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Current Address of Manager/Agent					
City					
State	Email Address				
Zip Code	Telephone Number - -		Date of Birth (required) / /		

A. Is this individual with management/agent duties a U.S. citizen? ☐ Yes ☐ No

If you answered "No" above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States. For assistance, contact the United States Citizenship and Immigration Services (USCIS) at 1-800-375-5283, or visit the website at www.uscis.gov. List the country(s) of the Manager/Agent's citizenship below:

1.	2.	3.

Has the manager/agent named above ever:

B. Been convicted of a healthcare related felony or any other criminal offense, State or Federal, under this name or any other name in any state or U.S. Territory, regardless of a post trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program? Court documentation required. ☐ Yes ☐ No

If yes, attach explanation of conviction or plea, including date of conviction and state in which it occurred

C. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification? ☐ Yes ☐ No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and State in which this action occurred, regarding the disciplinary action for each individual/entity/agent/subcontractor, managing employees/businesses involved. Reinstatement letter required.

D. Been denied enrollment, suspended, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory? ☐ Yes ☐ No

If yes, attach documents (notice of rejection, suspension, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals//entities/businesses involved. Reinstatement letter required.

E. Ever used or been known by any other name including married, maiden, hyphenated, alias, or Doing Business As (DBA) name(s) ☐ Yes ☐ No

If yes, enter name(s) below:

DBA Name:			DBA Name:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

F. Does this manager/agent have ownership or controlling interest in any other entity participating in a Federal/State Funded healthcare program? ☐ Yes ☐ No

If yes, in the chart below, provide the appropriate names and TAX ID or NPI for these entity/business.

Plan	**Provider Name and Doing Business (DBA) Name**	**Tax ID or NPI**
☐ Medicaid	Name	Tax ID #
	DBA Name	NPI #
☐ Medicare	Name	Tax ID #
	DBA Name	NPI #
☐ Other Federal/State Funded Healthcare Program	Name	Tax ID #
	DBA Name	NPI #
☐ Other Federal/State Funded Healthcare Program	Name	Tax ID #
	DBA Name	NPI #
☐ Other Federal/State Funded Healthcare Program	Name	Tax ID #
	DBA Name	NPI #

G. Does this manager/agent reside out-of-state (not in Louisiana?) ☐ Yes ☐ No

If yes, has this out-of-state manager/agent been issued any Medicaid or Medicare provider numbers by the domicile state? ☐ Yes ☐ No

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

Please Read before proceeding to
Section VII –Subcontractor Information:

Be sure to make a photocopy of the form on the next page before you fill it out the first time; you need one page for each subcontractor. You may **NOT** submit a list of names; each subcontractor or wholly owned supplier must be reported with a full page of information (no attachments—use the form provided).

Section VII seeks to identify the ownership of any **subcontractors or wholly owned suppliers** with whom this enrolling entity has done business within the past 5 years.

Medicaid requires that an enrolling entity/business must disclose ownership information on:

A. Any subcontractor with which the entity had business transactions totaling $25,000 or more within the past 12 months.
B. Any wholly owned supplier or subcontractor with which the entity had significant business transactions of $75,000 or more, within the past 5 years.

DEFINITIONS:

Subcontractor-

1. An individual, agency or organization that you have:
    a. contracted with or
    b. delegated some of your management functions or responsibilities of providing medical care to your patients.

2. An individual, agency or organization with which you have entered into a contract, agreement, purchase order, or lease to obtain:
    a. equipment,
    b. supplies,
    c. space, including real estate, or
    d. services provided under the Medicaid agreement.

Wholly Owned Supplier-

A supplier (i.e., an individual, agency or organization from which a Medicaid provider purchases goods and services used in carrying out its responsibilities under Medicaid, e.g., a commercial laundry, manufacturer of hospital beds, pharmaceutical firm) whose total ownership interest is held by a Medicaid provider or by a person, persons, or other entity with an ownership or control interest in a Medicaid provider.

SECTION VII – INFORMATION ON SUBCONTRACTORS

Under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of any subcontractor in which the provider or disclosing entity has direct or indirect ownership of 5 percent or more. *(See Federal Regulations 42 CFR § 455.104(a)(1)* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether the provider or disclosing entity and any of the disclosed subcontractors are related to one another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(a)(2)*

Copy and complete a separate form for each subcontractor

Does this enrolling entity/business contract with any Subcontractors? ☐ Yes ☐ No
If yes, please complete the following information for subcontractor.
If no, please proceed to the next section.

A-1 Has this entity/business contracted with or delegated any management functions or responsibilities for providing medical care to its patients to a Subcontractor (individual, agency or organization? ☐ Yes ☐ No

A-2 If yes, did any of these subcontractor transactions total $25,000 or more within the past 12 months?
☐ Yes ☐ No

If yes, the following information must be provided for each subcontractor:

Individual Subcontractor

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Current Address	
City	
State	Email Address
Zip Code	Telephone Number -
Type of Function Performed:	☐ Health Care Services ☐ Equipment ☐ Supplies ☐ Space or real estate ☐ Other _____

A. Is this individual with subcontractor duties a U.S. citizen? ☐ Yes ☐ No

If you answered "No" above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States. For assistance, contact the United States Citizenship and Immigration Services (USCIS) at 1-800-375-5283, or visit the website at www.uscis.gov. List the country(s) of the contractor's citizenship.

1.	2.	3.

Entity/Business Subcontractor

Full Legal Name		DBA Name		Tax ID Number (required)	
First Name of Owner	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Current Address	
City	
State	Email Address
Zip Code	Telephone Number -
Type of Function Performed:	☐ Health Care Services ☐ Equipment ☐ Supplies ☐ Space or real estate ☐ Other _____

B-1 Has this enrolling entity/business entered into a contract, agreement, purchase order or lease with any Wholly Owned Supplier or Subcontractor to provide health care services or for equipment, supplies, or space used to provide health care services? ☐ Yes ☐ No

B-2 If yes, did any of these subcontractor transactions total $75,000 or more within the past 5 years? ☐ Yes ☐ No

If yes, the following information must be provided for each subcontractor:

Individual Subcontractor

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Current Address of Owner	
City	
State	Email Address
Zip Code	Telephone Number -
Type of Function Performed:	☐ Health Care Services ☐ Equipment ☐ Supplies ☐ Space or real estate ☐ Other _____

A. Is this individual with subcontractor duties a U.S. citizen? ☐ Yes ☐ No

If you answered "No" above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States. For assistance, contact the United States Citizenship and Immigration Services (USCIS) at 1-800-375-5283, or visit the website at www.uscis.gov. List the country(s) of the contractor's citizenship.

1.	2.	3.

Entity/Business Subcontractor

Full Legal Name		DBA Name		Tax ID Number (required)	
First Name of Owner	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Current Address	
City	
State	Email Address
Zip Code	Telephone Number -
Type of Function Performed:	☐ Health Care Services ☐ Equipment ☐ Supplies ☐ Space or real estate ☐ Other _____

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That I have disclosed all necessary information;
2. That I am the authorized representative of this entity/business and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That I have reviewed the information on this entity/business Disclosure form and attest that it is true, accurate and complete;
4. That I understand that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That I understand that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That I understand that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable federal or state laws;
7. That I understand it is my responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That I understand that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9. That I understand if this number is closed due to inaccurate information, I will have to complete a new Provider Enrollment Packet in its entirety for consideration to reactivate this provider number;
10. That I understand that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, I must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
11. I attest that I am a United States citizen or have legal status and work privilege in the US and I understand that it is my responsibility to ensure that all my managers, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
12. I understand that it my responsibility to ensure that I have disclosed on this form if I, or any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Manager, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
13. I understand that I shall report any of the above conditions to the Department of Health and Hospitals (DHH), and once enrolled, I understand that upon discovery of any of the above conditions, it is my responsibility to report them immediately in writing to DHH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
14. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, suspended, or voluntarily withdrawn to avoid disciplinary action from any federally funded healthcare program, I am required to submit this information and the requested documentation.
15. I understand that I am being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs, and I understand that this criminal statute means that if I, or any managers, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program.
16. I also understand that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs.
17. I also understand that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00; and
18. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Please sign in colored ink (not black)

_____	_____
Print Name of Authorized Representative	Title/Position
_____	_____
Signature of Authorized Representative	Date of Signature