Reference Material for
Louisiana Medicaid Ownership Disclosure Information
For an Entity/Business

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address: **http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl**

1) Section 100 – Purpose:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.1&idno=42

2) Section 101 – Definitions:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.2&idno=42

3) Section 102 - Determination of ownership or control percentages:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.3&idno=42

4) Section 103 – State plan requirement
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.4&idno=42

5) Section 104 – Disclosure by Medicaid providers: Information on ownership and control:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.5&idno=42

6) Section 105 - Disclosure by providers: Information related to business transactions:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.6&idno=42

7) Section 106 – Disclosure by providers: Information on persons convicted of crimes:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.7&idno=42

Notice Regarding Disclosure of Social Security Numbers

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. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a – 3: http://www.law.cornell.edu/uscode/42/1320a-3.html

Social Security Act 1128 a: http://www.ssa.gov/OP_Home/ssact/title11/1128A.htm

MAPIL Louisiana R.S., Title 46:437.1-14. http://www.legis.state.la.us/lss/lss.asp?doc=100852

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://www.doa.louisiana.gov/osr/reg/register.htm

Louisiana Update January/February 2009: http://www.lamedicaid.com/ProviderUpdate/provider_update0109.pdf

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. Every field on the Disclosure of Ownership Form must be completed, and every question must be answered. Failure to complete the form in its entirety will result in a rejection.

Please refer to the web sites listed on the previous page for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

Note: Please enter your Provider Name at the top of each page which provides a space for that purpose.

SECTION I – ENROLLING PROVIDER INFORMATION

Louisiana Medicaid Provider Number – Enter your seven- (7) digit Medicaid provider number, if known. 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, Re-Enroll, or Change of Ownership (CHOW). If CHOW, provide the date of the CHOW and the current Louisiana Medicaid Provider number in the spaces provided.
Provider Type – Enter the Louisiana Medicaid Provider Type for this entity/business.
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 in the space labeled "Legal Name of Entity/Business." Enter the DBA Name in the space labeled "Doing Business As (DBA) Name." If a license is required, the name entered must match the operating name on the entity/business license.
Entity/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
Email Address to receive official DHH Notices - Enter the email address at which official DHH notices are to be sent.
Entity/Business Website – Enter URL of the entity/business website.
Is this enrolling entity/business publicly traded? A publicly traded company is one which is traded on the open market, also called publicly held or public company. Check either the Yes box or the No box.
Privately owned or Non-profit Providers Only – Identify the type of entity/business as it is registered with the Internal Revenue service. Check only one box from among Sole Proprietorship, Partnership/Limited Liability Partnership, Corporation, Limited Liability Corporation (LLC), or Non-profit. Answer any questions associated with the type of entity/business in the space(s) provided. Optional: Check the Comments box and write in any comments in the space provided. Continue to Section II.
Louisiana Government Providers Only – Identify the type of entity/business if Louisiana government owned. Select only one from among City and/or Parish, LEA (Local Education Agency), LSU, OBH, OPH, OAAS, OCDD, Villa, Other DHH agency, or Other State-owned entity. Check the appropriate box, and fill out the blank with the appropriate information as needed. Print the Name and Title of the person authorized to enroll the agency in Louisiana Medicaid, and then go to Section VIII.

SECTION II – 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 III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. Is this Tax ID currently enrolled in a Federal/State funded healthcare program? Check the Yes box or the No box. If yes, check off the plan or plans (Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program. In each instance checked, provide the Doing Business As (DBA) Name, the Plan Numbers for Louisiana Enrollments, and the Plan Numbers for Other State Enrollments.
B. Is the enrolling entity/business located out of the state of Louisiana? Check the Yes box or the No box. If yes, has this out-state entity/business been issued any Medicaid or Medicare provider numbers by the domicile state? Check the Yes box or the No box. If yes, provide the domicile state name, the domicile state Medicaid Provider Number, and the domicile state Medicare Provider Number in the spaces provided.

SECTION IV – PREPARER INFORMATION – INDIVIDUAL COMPLETING DISCLOSURE OF OWNERSHIP INFORMATION

List the full name (including maiden name and hyphenated last name if applicable), social security number, date of birth, and job title. Check one box to identify whether the person completing the form is staff, owner, third party/independent agent, or other. If you check other, please specify by writing the relationship in the space provided. List the entity/business address, entity/business telephone number, and the entity/business email address of the person completing this form. Finally, enter any additional entity/business telephone number(s) and entity/business email address(es).

SECTION V – OWNERSHIP INFORMATION

Carefully read the Louisiana Medicaid policy statements and definitions of ownership so that you can properly fill out Sections V(a), V(b), and V(c).

SECTION V(A) – INFORMATION ON ALL OWNERS

Make a photocopy of Section V(a) in case more space is needed. List all owners with a direct or indirect stake/shareholding/ownership/etc. of 5% or greater in the enrolling entity/business named in Section I. In the top table, list individuals. Note that for each individual listed, a two-page Section V(b) must be filled out. In the bottom table, list entities/businesses that have an ownership interest in the entity/business named in Section I. Note that for each entity/business listed, Section V(c) must be filled out. In the bottom table, space is also provided to list individuals who have at least a 5% interest or greater in the entities/businesses listed on the left-hand part of the lower table. For each of these individuals as well a Section V(b) must be filled out.

SECTION V(B) – INFORMATION ON INDIVIDUAL OWNER

An entire Section V(b) (consisting of two pages) must be completed for each and every individual owner, whether the individual owns a direct stake in the enrolling entity or owns a stake in an entity that owns a stake in the enrolling entity. Make a copy of the blank form for each owner you report.

A. OWNER – person with 5% or greater direct or indirect ownership as a stakeholder – Enter the First Name, Middle Name, Maiden Name, Last Name and Hyphenated Last Name (if applicable) in the spaces provided. Enter the Title/Job Position within this entity/business, the Social Security Number, and Date of Birth in the spaces provided. Check the Yes or No box to indicate whether this owner is a U.S. citizen. Enter the current address of the owner in the spaces provided. Enter the Telephone Number and Email address of the owner in the spaces provided.
B. Are any individual 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? – Check the Yes or No box. If yes, list all individuals and how they are related in the spaces provided.
C.- E. Has the owner named above ever – Read the questions carefully and check the Yes or No boxes. If yes to any question, attach the requested documentation.

F. **Has the owner named above ever** – Read the question carefully and check the Yes or No box. If yes, enter the name(s) in the spaces provided.

G. **Is this individual owner currently enrolled in a Federal/State funded healthcare program? –or – Does this individual owner have controlling interest in an entity/business that participates in a Federal/State funded healthcare program? –** Check the Yes or No box. If yes, check off the plans, list the DBA Name(s), the Tax ID(s) or SSN(s), and the plan number(s) in the spaces provided.

H. **Does this owner reside out-of-state (not in Louisiana)?** – Check the Yes or No box. If yes, has this out-of-state owner been issued any Medicaid or Medicare provider numbers by the domicile state? Check the Yes or No Box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided.

SECTION V(C) – INFORMATION ON THE ENTITY/BUSINESS OWNER

A. **OWNER – an entity/business with 5% or greater direct or indirect ownership** – Enter the Entity/Business Name, the DBA Name, and the Tax ID Number in the spaces provided. Enter the current address of the Entity/Business in the spaces provided. Enter the Telephone Number and Email address of the entity/business contact person in the spaces provided.

B-D. **Has the owner named above ever –** Read the questions carefully and check the Yes or No boxes. If yes to any question, attach the requested documentation.

E. **Has the owner named above ever** – Read the question carefully and check the Yes or No box. If yes, enter the DBA name(s) in the spaces provided.

F. **Does this owner have ownership or controlling interest in any other entity participating in a Federal/State Funded healthcare program?** -- Check the Yes or No box. If yes, check off the plans, list the DBA Name(s), the Tax ID(s), and the plan number(s) in the spaces provided.

G. **Does this owner reside out-of-state (not in Louisiana)?** – Check the Yes or No box. If yes, has this out-of-state owner been issued any Medicaid or Medicare provider numbers by the domicile state? Check the Yes or No Box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided.

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

Carefully read the Louisiana Medicaid policy statements and definitions of managers/agents so that you can properly fill out Sections VI(a) and VI(b).

SECTION VI(A) – INFORMATION ON ALL MANAGERS/AGENTS

Make a photocopy of Section VI(a) if more space is needed to list individuals.

In the spaces provided, 1 through 10, list each individual or agent who is a part of management. For each individual, check the Yes or No box to indicate whether the person is also an owner. If the manager is also an owner and was reported in Section V, then it is not necessary to fill out Section VI(b); otherwise, Section VI(b) is required for each manager listed in VI(a).

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

Make a photocopy of Section VI(b) for each manager/agent you report.

MANAGER or AGENT – Check the box for Manager or Agent. Enter the title/job position within this entity/business, the social security number, and the full name (including maiden name and hyphenated last name if applicable) in the spaces provided. Check the Yes box or the No box to specify whether this owner is a U.S. citizen. Enter the current address of the manager, street, city and Zip Code in the spaces provided. Enter the email address, telephone number, and date of birth of the manager in the spaces provided.

A-C. **Has the manager/agent named above ever –** Read the questions carefully and check the Yes or No boxes. If yes to any question, attached the requested documentation.

D. **Has the manager/agent named above ever –** Read the question carefully and check the Yes or No box. If yes, enter the name(s) in the spaces provided.

E. **Does this manager/agent have ownership or controlling interest in any other entity currently participating in a Federal/State Funded healthcare program?** -- Check the Yes or No box. If yes, check off the plans, list the DBA Name(s), and the plan number(s) in the spaces provided.

F. **Does this manager/agent reside out-of-state (not in Louisiana)?** – Check the Yes or No box. If yes, has this out-of-state manager/agent been issued any Medicaid or Medicare provider numbers by the domicile state? Check the Yes or No Box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided.

SECTION VII – SUBCONTRACTOR INFORMATION

Read Federal Regulations 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2). Read Section VII carefully, as you are entering into an agreement with the Louisiana Department of Health and Hospitals by which you agree to and may be requested to provided the specified subcontractor information.

SECTION VIII – AUTHORIZED REPRESENTATIVES

List the individuals who are authorized to sign into legal, binding documents on behalf of this provider, such as direct deposit forms and/or changes to the disclosure of ownership forms. Every person listed here must be either an owner or a manager as disclosed in the Disclosure of Ownership forms. Check one box for each person to indicate whether the individual is an owner, a manager, or other (specify the title in the space provided).

SECTION IX – 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. Please sign in colored ink (not black).

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION—ENTITY/BUSINESS

SECTION I – ENROLLING PROVIDER 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 of Enrolling Entity/Business** - -	
Name of Enrolling Entity/Business:	**Legal Name of Entity/Business**	**Doing Business As (DBA) Name**	
	Entity/Business Street Address	**City**	**State** / **Zip**
	Provider's FAX Number - -	**Provider's telephone number to request medical records** - -	
	Email Address to receive official DHH Notices	**Entity/Business Website**	

Is this enrolling entity/business publicly traded? See instructions. ☐ Yes ☐ No

Privately owned or Non-profit Providers Only
Identify Type of Entity/Business – as registered with the Internal Revenue Service
Select only one (1) – multiple selections may result in a rejection for clarification

☐ **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 stakeholders/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? _____ **(Must attach IRS verification showing the non-profit status)
☐ **Comments:** _____

Privately owned or Non-profit – continue on to Section II

-- OR --

Louisiana Government Providers Only
Identify Type of Entity/Business if Louisiana Government owned
Select only (1) – multiple selections may result in a rejection for clarification

☐ **CITY and/or PARISH**	**DHH**	**Other State-owned entity:**
☐ **LEA (Local Education Agency)**	☐ OBH ☐ OPH	
☐ **LSU**	☐ OAAS ☐ OCDD	_____
Hospital -_____	☐ Villa	
	Other _____	

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

Print Name **Print Title**

Louisiana Government ONLY (including LSU) – move on to Section VIII – the Signature page.

Provider Name: _____

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

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 any 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, terminated from participation, 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, terminated from participation, 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 enrollment rejection, suspension, termination from participation, 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 previously 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 III - ENROLLMENT IN HEALTHCARE PROGRAMS

A. Is the Tax ID in Section I currently enrolled in a Federal/State funded healthcare program? ☐ Yes ☐ No

If yes, check off the plans, list the DBA Name(s), the Tax ID(s), and the plan number(s):

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

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. ****

Provider Name: _____

SECTION IV - 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)			

Please Read before proceeding to
SECTION V – OWNERSHIP INFORMATION

Be sure to make a photocopy of the following form (Section V(b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT) 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(b) 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).

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/or 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.

Provider Name: _____

SECTION V(a) – INFORMATION ON ALL OWNERS

List all owners with a direct or indirect stake/shareholding/ownership/etc. of 5% or greater in the enrolling entity/business named in Section I.

Individuals/members/stockholders/stakeholders with ownership
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
Make a photocopy of this page if more space is needed to list individuals.
Fill out Section V(b) for each individual listed above.

– and/or –

List all entity/business owners with a direct or indirect stake/shareholding/ownership/etc. of 5% or greater in the enrolling entity/business named in Section I.

Note: The enrolling entity/business cannot be listed as an owner below.

Entities/Businesses with an ownership stake	Individual owners of the entity/business identified on the left.
1.	a.
	b.
	c.
	d.
2.	a.
	b.
	c.
	d.
3.	a.
	b.
	c.
	d.
4.	a.
	b.
	c.
	d.
5.	a.
	b.
	c.
	d.
Make a photocopy of this page if more space is needed to list entities/businesses and/or individuals.	
Fill out Section V(c) for each entity/business listed above.	

Provider Name: _____

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

Complete Section V(b) (2 pages) for each individual owner. Make a copy of the blank form for each owner you report.

A. OWNER – a person with 5% or greater direct or indirect ownership as a stakeholder					
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Title/Job Position within this entity/business			Social Security Number - -		Date of birth / /
Is this owner a U.S. citizen? ☐ Yes ☐ No					
Current Address of Owner					
City					
State		Zip Code			
Telephone Number - -		Email address			

B. Are any **individual 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 other 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.

Provider Name: _____

SECTION V(b) – INDIVIDUAL OWNER INFORMATION, continued

Name of Individual Owner: _____

Has the owner named above ever:

E. Been denied enrollment, suspended, terminated from participation, 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, terminated from participation, 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 enrollment rejection, suspension, termination from participation, 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, or alias? ☐ Yes ☐ No

If yes, enter name(s) below:

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. Is this individual owner currently enrolled in a Federal/State funded healthcare program? ☐ Yes ☐ No

– or –

Does this individual owner have controlling interest in an entity/business that participates in a Federal/State funded healthcare program? ☐ Yes ☐ No

If yes, check off the plans, list the DBA Name(s), the Tax ID(s) or SSN(s), and the plan number(s):

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

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:

Provider Name: _____

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER

Complete Section V(c) for each entity/business owner. Make a copy of the blank form for each owner you report.

A. OWNER – an entity/business with 5% or greater direct or indirect ownership

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

Current Address of Entity/Business	
City	
State	Zip Code
Telephone Number - -	Email address of entity/business contact person

Has the owner named above ever:

B. Been convicted of a felony or convicted of any other 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.

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, 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.

D. Been denied enrollment, suspended, terminated from participation, 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, terminated from participation, 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 enrollment rejection, suspension, termination from participation, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals//entities/businesses involved. Reinstatement letter required.

E. Used or been known by any other name or Doing Business As (DBA) name(s)? ☐ Yes ☐ No

If yes, enter name(s) below:

DBA Name:	DBA Name:

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

If yes, check off the plans, list the DBA Name(s), the Tax ID(s), and the plan number(s):

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

G. 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 – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Be sure to make a photocopy of the following form (Section VI(b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT) 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 VI(b) 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-inclusive, and other activities and titles that imply or assume similar powers or responsibilities may apply.

Provider Name: _____

SECTION VI(a) – INFORMATION ON ALL MANAGERS/AGENTS

List each individual or agent who is part of management.

Managers/Agents	Is this manager also an owner?
1.	☐ Yes ☐ No
2.	☐ Yes ☐ No
3.	☐ Yes ☐ No
4.	☐ Yes ☐ No
5.	☐ Yes ☐ No
6.	☐ Yes ☐ No
7.	☐ Yes ☐ No
8.	☐ Yes ☐ No
9.	☐ Yes ☐ No
10.	☐ Yes ☐ No
Make a photocopy of this page if more space is needed to list individuals.	
Fill out Section VI(b) for each individual listed above unless the manager is also an owner and was reported in Section V.	

Provider Name: _____

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

Complete Section VI(b) for each manager/agent. Make a copy of the blank form for each manager you report.

☐ **MANAGER – or –** ☐ **AGENT**	Title/Job Position within this entity/business	Social Security Number (required)

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

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

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

Has the manager/agent named above ever:

A. 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

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, 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.

C. Been denied enrollment, suspended, terminated from participation, 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, terminated, 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 enrollment rejection, suspension, termination from participation, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals/entities/businesses involved. Reinstatement letter required.

D. Ever used or been known by any other name including married, maiden, hyphenated, or alias? ☐ Yes ☐ No

If yes, enter name(s) below:

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)

Provider Name: _____

SECTION VI(b) - Manager Information, continued

Manager Name: _____

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

If yes, check off the plans, list the DBA Name(s), and list Plan Numbers.

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

F. 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:

SECTION VII – SUBCONTRACTOR INFORMATION

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.

– or –

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.

Provider Name: _____

SECTION VII – SUBCONTRACTOR INFORMATION

Subcontractor information may be found in Federal Regulations 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2)

Pursuant to 42 CRF § 455.105, by enrolling in the Medicaid program, you are entering into an agreement with the Louisiana Department of Health and Hospitals by which you agree to and may be requested to provide the following information within 35 calendar days within the date of the request by the Department or the Secretary of Health and Human Services.

1. The ownership of any subcontractor with whom you have had business transactions totaling more than $25,000 during the 12 month period ending on the date of the request; and

2. Any significant business transactions between you and any wholly owned supplier, or between you and any subcontractor, during the 5 year period ending on the date of the request.

3. Any wholly owned supplier or subcontractor with which the entity had significant business transactions of $75,000 or more, within the past 5 years.

Louisiana State Medicaid regulations allow the Department 90 calendar days after receipt of a complete application to determine whether to enroll an applicant in the program.

Provider Name: _____

SECTION VIII – AUTHORIZED REPRESENTATIVES

THE FOLLOWING INDIVIDUALS ARE AUTHORIZED TO SIGN INTO LEGAL, BINDING DOCUMENTS ON BEHALF OF THIS PROVIDER, SUCH AS DIRECT DEPOSIT FORMS AND/OR CHANGES TO THE DISCLOSURE OF OWNERSHIP FORMS.

Note: Every person listed here must be either an owner or a manager as disclosed in the Disclosure of Ownership forms.

List each person authorized to sign and identify their position in your practice.	
1.	☐ Owner ☐ Manager ☐ Other _____
2.	☐ Owner ☐ Manager ☐ Other _____
3.	☐ Owner ☐ Manager ☐ Other _____
4.	☐ Owner ☐ Manager ☐ Other _____
5.	☐ Owner ☐ Manager ☐ Other _____
6.	☐ Owner ☐ Manager ☐ Other _____
7.	☐ Owner ☐ Manager ☐ Other _____
8.	☐ Owner ☐ Manager ☐ Other _____
9.	☐ Owner ☐ Manager ☐ Other _____
10.	☐ Owner ☐ Manager ☐ Other _____

Please sign in colored ink (not black)

_____ _____
Print Name of Authorized Representative Title/Position

_____ _____
Signature of Authorized Representative Date of Signature

Provider Name: _____

SECTION IX – 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. I understand that 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.
11. 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.
12. 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.
13. 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 terminated from participation 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.
14. 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.
15. 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, terminated from participation, 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.
16. 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." 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 or have been terminated 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.
17. 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.
18. 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
19. 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

Supplemental information requests

1. Provide administrative cost allocation plans for the calendar reporting period. Include detailed assumptions and cost drivers in the plan. Also include the basis (direct/indirect) of each cost allocation and activity used to measure the expenditures. If parent or subsidiary administrative cost allocations are present in the financial statements, the contract agreement and cost allocation schedules for these entities must be provided separately.
2. Provide the current contracts with risk-sharing entities and detailed analysis supporting the risk-sharing agreement and payable or receivable position.
3. Submit a detailed listing of any providers or vendors that are in a credit (accounts receivable) status with amounts bucketed in 30-day increments from date of credit position discovery.
4. Provide a schedule of payments made to providers for non-contract out-of-network services paid at 90% of the Medicaid FFS rate for the audited calendar year. The schedule should include the following columns: Line #, Provider pay-to name, Number of claims processed and Amount of payments.
5. Highest-compensated management: List the names and titles of the 10 highest compensated management personnel, including but not limited to, the Chief Executive Officer, the Chief Financial Officer, Board Chairman, Board Secretary and Board Treasurer.