INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

A full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by Sentara Health Plan to enter into an agreement or contract with any such institution or in termination of existing agreements.

DEFINITIONS:

Direct ownership interest- is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program.

Indirect ownership interest- is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 % or more in the disclosing entity.

Controlling interest- is defined as the operational direction or management of disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

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

SENTARA HEALTH PLAN

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

The federal regulations set forth in 42CFR 455.100-106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the Virginia Department of Medical Assistance Services (DMAS) and managed care organizations, the identity of any individuals and/or entities with ownership or control interest of 5% or greater in the provider, the provider group or disclosing entity.

I. Identifying Information

Legal Name of Entity:	D/B/A:	Provider or Vendor Number:
Telephone Number:	Street Address:	City/County, State, Zip Code:
NPI Number:	EIN/SSN:	DOB:

II. Disclosure Information

a. List names addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest of 5% or more in the disclosing entity.
If more than one individual is reported and any of these persons are related to each other, this must be indicated. Date of Birth (DOB) required for "Individuals only".

Name or EIN:	Address:	NPI#: DOB:__-__-____	Relationship:
Name or EIN:	Address:	NPI#: DOB:__-__-____	Relationship:
Name or EIN:	Address:	NPI#: DOB:__-__-____	Relationship:
Type of Entity: ☐Partnership ☐Corporation ☐Sole Proprietorship ☐Unincorporated ☐Associations ☐Other (Specify): _____			

b. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, XX, or XXI? ☐YES OR ☐NO

c. If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations.

Name or EIN:	Address:
Name or EIN:	Address:
Name or EIN:	Address:

d. Check the appropriate box for each of the following questions.

Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (I.e. Sole Proprietor, Partnership or Members of Board of Directors) If **yes**, list names, addresses of individuals and National Provider Identification Number. ☐**YES** OR ☐**NO**		
Name:	Address:	Provider Number(s):
Name:	Address:	Provider Number(s):
Name or EIN:	Address:	

Has there been a change in ownership or control within the last year? If **yes** when? ☐**YES** OR ☐**NO** **Date: ____-____-____**
Do you anticipate any change of ownership or control within the year? If **yes** when? ☐**YES** OR ☐**NO** **Date: ____-____-____**
Do you anticipate filing for bankruptcy within the year? ☐**YES** OR ☐**NO** **Date: ____-____-____**

Are there any individual or organizations having a direct or indirect ownership or control interest of 5 % or more in the institution, organizations, or agency that have been convicted of a **criminal offense** related to the involvement of such person(s) or organizations in any of the program established by Titles XVIII, XIX, XX, XXI? ☐**YES** OR ☐**NO** **Date: ____-____-____**		
Name:	Address:	Relationship:
Name:	Address:	Relationship:
Name:	Address:	Relationship:

Are there any individuals currently employed by the institution, agency or organization in managerial, accounting, auditing, or similar capacity who were employed by the institution's organizations or agency's fiscal intermediary or carrier within the previous 12 months? **(Title XVIII, providers only)** ☐**YES** OR ☐**NO** **Date: ____-____-____**		
Name:	Address:	Relationship:
Name:	Address:	Relationship:
Name:	Address:	Relationship:

e. Facility (Only)

Is this facility operated by a management company, or leased in whole or part by another organization? ☐**YES** OR ☐**NO**		
Has there been a change in Administrator, Director of Nursing or Medical Director Within the last year? ☐**YES** OR ☐**NO**:		
Is this facility chain affiliated? (If **yes**, list Name, Address of Corporation and EIN) ☐**YES** OR ☐**NO** If **No**, was the facility ever affiliated with a chain? ☐**YES** OR ☐**NO**		
Name:	Address:	EIN:
Name:	Address:	EIN:
Name:	Address:	EIN:

Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?

☐**YES** OR ☐**NO**

If yes, give the year of change: _____

Current Beds:_____ Prior Beds:_____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH SENTARA HEALTH PLAN.

Additional Information (As needed):

I certify that all information provided is current, true, accurate, and complete to the best of my knowledge

Name of Authorized Representative (Typed): _____

Authorized Agent's Signature: _____ **Date**: _____

Title: _____

For Office Use Only

Reviewed by: _____ **Date:** _____

No Issues:_____ **Refer to Contract Manager:** _____