



## **Provider Enrollment Disclosure Statement of Ownership and Control Interest** for Entities, Agencies, Facilities and Organizations

**Individual Providers or Individuals in a Group of Practitioners: Do not use this form.**  
Instead, use the [DHS 3973](#) (Disclosure Statement for Individuals).

### **PURPOSE**

The primary use of the Disclosure of Ownership and Controlling Interest Statement is to comply with 42 CFR Part 455 Subpart B and to facilitate monitoring of providers sanctioned by the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS), DHHS Office of Inspector General, and/or the Oregon Department of Human Services (DHS).

- Payment cannot be made to any entity in which these providers serve as employees, administrators, operators, or in any other capacity.
- Payment will not be made for any services furnished by, at the medical direction of, or on the prescription of the provider, on or after the effective date of exclusion.

We believe this disclosure statement will assist participating providers in their efforts to ensure that they do not do business with parties currently excluded from participation in federal and state health care programs.

Completion and submission of this form is a condition of participation under any of Oregon's medical assistance or public assistance programs or as a condition of approval or renewal of a contractor agreement between the disclosing entity (Provider) and the appropriate division of DHS under any of the above-titled programs. Failure to submit requested information may result in a refusal by DHS to enroll the provider for encounter purposes or to enter into a provider agreement or contract with any such entity, agency, facility or organization or in termination of existing contracts.

### **INSTRUCTIONS**

The following instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. See 42 CFR 455.100 for additional definitions. No instructions have been given for questions considered self-explanatory.

**IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.** Answer **all** questions as of the current date. If additional space is needed, attach a sheet referencing the part and question being completed.

*Detailed Instructions (for pages 4 through 6)*

<b>Part 1: Identifying Information</b>	
A.	Specify name of the Provider entity, agency, facility or organization submitting the Provider Enrollment Application and Agreement.
B.	Specify in what capacity the entity is doing business. For example: The name of trade or corporation under which they are doing business. This name must match the license name, if applicable.
C.	<p>Federal Employer Identification Number (EIN). Enter Provider’s nine-digit employer identification number (EIN) assigned by the IRS in the following format: XX-XXXXXXX.</p> <ul style="list-style-type: none"> <li>• An EIN is used to identify the accounts of employers and certain others who have no employees.</li> <li>• For more information about an EIN, please check <a href="https://www.irs.gov">https://www.irs.gov</a> for “Employer Identification Numbers” or “EIN”. Whenever this Disclosure Statement requests an employer identification number (EIN) about an individual or entity, it has the same meaning.</li> </ul>
D.	<p>Check the entity type that best describes the structure of your organization.</p> <ul style="list-style-type: none"> <li>• <u>“Government” or “Tribal” Agencies or Organizations</u> If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicaid payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. In this Disclosure Statement, the provider should identify as having “Ownership or control interests” the key authorized officials of the government or tribal organization responsible for management decisions of the provider with the authority to legally and financially bind the provider/government or tribal agency or organization to the laws, regulations, and program instructions of the Medicaid program.</li> </ul>
<b>Part 2: Ownership and Control Interests.</b> Use the following definitions to identify the individuals you should enter in parts <b>A, B and D</b> of this section. See 42 CFR 455.100 for additional definitions.	
	<ul style="list-style-type: none"> <li>• <u>“Direct ownership interest”</u> is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. See 42 CFR 455.102 to calculate ownership or control percentages.</li> <li>• <u>“Disclosing entity”</u> is defined as the Medicaid provider (other than an individual practitioner or group of practitioners) requesting enrollment with Oregon medical assistance program, or a fiscal agent.</li> <li>• <u>“Indirect ownership interest”</u> 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. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A’s interest equates to an 8 percent indirect ownership and must be reported. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the stock of the disclosing entity, B’s interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.</li> <li>• <u>“Controlling interest”</u> is defined as the operational direction or management of a 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</li> </ul>

*Detailed Instructions (for pages 4 through 6)*

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

- “Group of Practitioners” means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
- “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 title V, XVLL, or XX of the Act. This includes hospitals, skilled nursing facilities, health maintenance organizations that participate in Medicare (title XVLL) and any entity (other than an individual practitioner or group of practitioners) that furnished 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.
- “Subcontractor” means an individual, agency, or organization to which a disclosing entity has contracted or delegated part of its management functions or responsibilities of providing medical care to its patients; or an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

**Part 3: Criminal Offenses.** This section asks about criminal offenses and exclusions. Complete this section for any of the individuals listed in Part 2 of this form.

**Part 4: Status Changes:** Respond to all applicable questions.

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| D. | <ul style="list-style-type: none"> <li>• “<u>Management company</u>” is defined as any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.</li> </ul>  |
| F. | <ul style="list-style-type: none"> <li>• A “<u>chain affiliate</u>” is any freestanding health care facility that is either owned, controlled or operated under lease or contract by an organization consisting of two or more freestanding health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital-based home health agencies are not considered chain affiliates.</li> </ul> |

**Part 5: Board of Directors:** For organizations that are corporations, this section asks for information about each person on the Board of Directors.

**Provider Enrollment Disclosure Statement  
of Ownership and Control Interest**  
for Entities, Agencies, Facilities and Organizations

**1. Identifying Information**

A. Name of Provider Entity, Facility or Organization

Street Address:

Telephone number:

B. DBA Name registered with Oregon Secretary of State, if any:

C. Federal Employer Identification Number (EIN):

**Attach a copy** of the IRS confirmation letter showing your Tax ID number and the associated name. DHS will also accept a copy of your Federal Tax Deposit Coupon (Form 941-V).

D. Check the entity type that best describes the structure of the enrolling provider entity, agency, facility or organization: Check **only one** box.

For-profit Corporation

Non-profit Corporation

Partnership

Government-owned

Sole Proprietorship

Tribal-owned

**2. Ownership or control interests**

A. List the name, and address for individuals and the EINs for organizations having direct or indirect ownership or controlling interest in the provider entity (see instructions for definition of ownership and controlling interest).

Attach additional pages as necessary to list all officers, owners, management and ownership individuals and entities.

Name	Title	Address	EIN	Entity Type*

**\*Entity Type:** In the “Entity Type” field, enter one of the codes listed below for each individual listed.

1: Sole proprietorship

2: Partnership

3: Unincorporated Associations

4: Corporation

5: Government or tribal

6: Other (specify):

- B. List the name, address and employer identification number of each person or entity with an ownership or controlling interest **in any subcontractor** in which the disclosing entity has direct or indirect ownership of 5 percent or more.

Name	Title	Address	TIN	Percentage

- C. List those persons named in A or B that are related to each other (spouse, parent, child, sibling, or other family members by marriage or otherwise).

Name	Relationship	Address

- D. List the name, address, EIN and DHS provider number of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or control interest of at least 5% or more.

For example, are any owners of the disclosing entity also owners of Medicare or Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.)

Name	Address	EIN	DHS Provider Number

### 3. Criminal Offenses

- A. List the name, title, and address for any person or entity with an ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity that has been convicted of a criminal offense related to that person's or entity's involvement in any program under Medicare, Medicaid or the Title XX services program.

Name	Title	Address

- B. List the name, title, and address of any individual or entity with an ownership or controlling interest in the disclosing entity that has been suspended or debarred from participation in Medicare, Medicaid or Title XX program.

Name	Title	Address

## Status Changes

A. Has there been a change in ownership or control within the last year?

No                       Yes                      If Yes, give date:

B. Do you anticipate any change of ownership or control within the year?

No                       Yes                      If Yes, when?:

C. Do you anticipate filing for bankruptcy within a year?

No                       Yes                      If Yes, when?:

D. Is this facility is operated by a management company or leased in whole or in part by another organization? Has there been a change in management within the past year?

No                       Yes                      If Yes, give date of change in operations:

Name, address and EIN of new management organization:

E. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? *If "yes", please check box below and list date.*

Administrator                       Director of Nursing                       Medical Director                      Date:

Name of new Administrator, Director of Nursing or Medicaid Director:

F. Is this facility chain-affiliated? If yes, list name, address of Corporation and EIN.

Name	EIN	Address

If the answer to (F) is No, was the facility ever affiliated with a chain? If yes, list name, address of Corporation and EIN.

Name	EIN	Address

G. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last two years?  No  Yes

If Yes, when?                                      Current beds                                      Prior beds

## 5. Board of Directors

If the disclosing entity is a corporation (for example, for profit, non-profit, limited liability, or other corporate form), list the name, title, and address of the Directors.

Name	Title	Address

## PROVIDER SIGNATURE

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to enroll or contract, or if the Provider already is enrolled, a termination of its agreement or contract.

By signing this Disclosure Statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform DHS or its designee, in writing, within 30 days of any changes or if additional information becomes available.

\_\_\_\_\_  
Name of Authorized Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## REMARKS

Provide any additional information concerning any item or statement on this Disclosure Statement.

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## Privacy Policy and Disclosure Notice

This privacy policy and disclosure notice explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security Numbers (SSNs), may be requested and used in connection with Provider enrollment and the administration of DHS medical assistance programs. Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the program. Any information may also be provided to the Oregon Secretary of State, the Oregon Department of Justice including the Medicaid Fraud Unit, or other state or local

agencies as appropriate, the Internal Revenue Service, U.S. DHHS Centers for Medicare and Medicaid Services or Office of the Inspector General, or other authorized federal authority. Disclosures for other purposes must be authorized by law, including but not limited to the Oregon Public Records Act. For more information about access to information maintained by the department, contact the Provider Services Unit.

The Department limits its request for and use of taxpayer identification numbers, including SSNs, to those purposes authorized by law and as described in this notice. The Oregon Consumer Identity Theft Protection Act permits DHS to collect and use SSNs to the extent authorized by federal or state law.

Providers must submit the provider's SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, whichever is required for tax reporting purposes on an IRS Form 1099. Billing providers must submit the performing provider's SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, in connection with payments made to or on behalf of the performing provider. Providing this number is mandatory to be eligible to enroll as a provider with the Department of Human Services, pursuant to 42 CFR 433.37, the federal tax laws at 26 USC 6041, and OAR 407-120-0320 and 410-141-0120 for purposes of the administration of tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities. Taxpayer identification numbers for the provider, and individuals or entities other than the provider, are also subject to mandatory disclosure for purposes of the Disclosure of Ownership and Control Interest Statement, as authorized by OAR 407-120-0320(5)(c) and OAR 410-141-0120.

Failure to submit the requested taxpayer identification number(s) may result in a denial of enrollment as a provider and issuance of the provider number, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from DHS or for encounter purposes.

**Complete and return this form with the following forms and any requested documentation:**

- [DHS 3972](#) (Provider Enrollment Request)
- [DHS 3975](#) (Provider Enrollment Agreement)
- Required Provider Enrollment Attachment (if applicable)

**Send all completed provider enrollment material to:**

DMAP Provider Enrollment  
500 Summer St NE, E44  
Salem OR 97301-1079