Disclosure of Ownership and Control

Completion of the Disclosure of Ownership and Control form is required by *§ 455.104-Disclosure by Medicaid Providers and Fiscal Agents: Information on Ownership and Control*. MVP Health Care® will follow applicable regulatory requirements associated with the disclosure of this information, up to and including termination of any contracts with entities found not to be in compliance with this requirement. Failure to fully respond or to provide accurate and detailed information can result in a delay in the processing of your application. All entities must be included on the Disclosure form.

Return this completed form to your MVP Contract Manager. To submit this form by email, select the *Submit by Email* button on the last page of this form and enter your Contract Manager's email address.

Section 1: Disclosing Entity/Applicant

Entity Name	Federal Employer ID No. (FEIN)	NPI No. *(only if non-exempt)*

Ownership in Applicant *(per 42 CFR § 455.104(b)(1)(i)–Entities and/or Individuals)*

Part A—To be Completed *Only* by Individuals with an Ownership in Applicant

Individual's Name	Title	Date of Birth

Individual's Home Street Address	City	State	Zip Code + 4

Social Security No.	Percentage of Ownership	NPI No or Medicaid ID No.
	% ☐ **0%**	☐ None

Names and Relationship of Other Owners to whom this Individual is related *(parent, child, sibling, spouse)* who have an ownership or controlling interest in the Disclosing Entity/Applicant

Name	*Name*	*Name*
Relationship to Other Owner	*Relationship to Other Owner*	*Relationship to Other Owner*

Individual's Name	Title	Date of Birth

Individual's Home Street Address	City	State	Zip Code + 4

Social Security No.	Percentage of Ownership	NPI No or Medicaid ID No.
	% ☐ **0%**	☐ None

Names and Relationship of Other Owners to whom this Individual is related *(parent, child, sibling, spouse)* who have an ownership or controlling interest in the Disclosing Entity/Applicant

Name	*Name*	*Name*
Relationship to Other Owner	*Relationship to Other Owner*	*Relationship to Other Owner*

Part B—To be Completed *Only* by Entities/Corporations with an Ownership in Applicant

Entity Name	Federal Employer ID No.	Percentage of Ownership	NPI No or Medicaid ID No.
		% ☐ **0%**	☐ None

Entity Primary Street Address	City	State	Zip Code + 4

Additional Business Addresses

Continued on page 2

Entity Name	*FEIN*

Section 1: Disclosing Entity/Applicant, Part B—Continued

Entity Name	Federal Employer ID No.	Percentage of Ownership % ☐ 0%	NPI No or Medicaid ID No. ☐ None

Entity Primary Street Address	City	State	Zip Code + 4

Additional Business Addresses

Section 2: Ownership in Other Disclosing Entities (ODE)

Per 42 CFR § 455.104(b)(3)–Complete Section 2 if any entity identified in Section 1, Part B has an ownership or controlling interest in another disclosing entity.

Entity Name from Section 1	Name of the ODE	NPI No. or Medicaid ID No.
Entity Name from Section 1	Name of the ODE	NPI No. or Medicaid ID No.

Section 3: Ownership in Subcontractors

Complete this Section if the Applicant has an ownership or controlling interest of 5% or more in a subcontractor and the Owner of the Applicant also has an ownership or controlling interest in the subcontractor.

Owner's Name from Section 1	Name of Subcontractor	Tax ID No.
Owner's Name from Section 1	Name of Subcontractor	Tax ID No.

Section 4: Familial Relationship in Subcontractors

Complete this Section if any person identified in Section 3 has a familial relationship (parent, child, sibling, spouse) with a person with ownership or controlling interest in one of the Subcontractors identified in Section 3.

Owner's Name	Name of Subcontractor	Name and Familial Relationship
Owner's Name	Name of Subcontractor	Name and Familial Relationship

Section 5: Managing Employees and Those with a Controlling Interest

Provide information about managing employees and any person with a controlling interest, including, but not limited to: facility administrator, all members of the board of directors, managing employees, compliance officer, laboratory directory, and supervising pharmacist.

Individual's Name	Date of Birth	Social Security No.	Association Type

Individual's Home Street Address	City	State	Zip Code + 4

Familial Relationship ☐ None ☐ Parent ☐ Spouse ☐ Child ☐ Sibling

Continued on page 3

Entity Name *FEIN*

Section 5: Managing Employees and Those with a Controlling Interest—continued

Individual's Name	Date of Birth	Social Security No.	Association Type
Individual's Home Street Address	City	State	Zip Code + 4

Familial Relationship ☐ None ☐ Parent ☐ Spouse ☐ Child ☐ Sibling

Individual's Name	Date of Birth	Social Security No.	Association Type
Individual's Home Street Address	City	State	Zip Code + 4

Familial Relationship ☐ None ☐ Parent ☐ Spouse ☐ Child ☐ Sibling

Individual's Name	Date of Birth	Social Security No.	Association Type
Individual's Home Street Address	City	State	Zip Code + 4

Familial Relationship ☐ None ☐ Parent ☐ Spouse ☐ Child ☐ Sibling

Individual's Name	Date of Birth	Social Security No.	Association Type
Individual's Home Street Address	City	State	Zip Code + 4

Familial Relationship ☐ None ☐ Parent ☐ Spouse ☐ Child ☐ Sibling

Individual's Name	Date of Birth	Social Security No.	Association Type
Individual's Home Street Address	City	State	Zip Code + 4

Familial Relationship ☐ None ☐ Parent ☐ Spouse ☐ Child ☐ Sibling

Individual's Name	Date of Birth	Social Security No.	Association Type
Individual's Home Street Address	City	State	Zip Code + 4

Familial Relationship ☐ None ☐ Parent ☐ Spouse ☐ Child ☐ Sibling

Individual's Name	Date of Birth	Social Security No.	Association Type
Individual's Home Street Address	City	State	Zip Code + 4

Familial Relationship ☐ None ☐ Parent ☐ Spouse ☐ Child ☐ Sibling

Continued on page 4

Entity Name *FEIN*

Section 5: Managing Employees and Those with a Controlling Interest—continued

Individual's Name	Date of Birth	Social Security No.	Association Type

Individual's Home Street Address	City	State	Zip Code + 4

Familial Relationship ☐ None ☐ Parent ☐ Spouse ☐ Child ☐ Sibling

Individual's Name	Date of Birth	Social Security No.	Association Type

Individual's Home Street Address	City	State	Zip Code + 4

Familial Relationship ☐ None ☐ Parent ☐ Spouse ☐ Child ☐ Sibling

Section 6: Disclosures

Respond to the following questions on behalf of the Applicant, all individuals and entities identified in Section 1 and Section 5, and any entity in which the Applicant has a 5% or more ownership. ***This information is being collected per the New York State Department of Health Standard Clauses. These Clauses are part of your Contract with MVP Health Plan, Inc.***

Has the Applicant, any individuals or entities identified in Section 1 and Section 5, or entity in which the Applicant has a 5% or more ownership been terminated, denied enrollment, suspended, restricted by Agreement, or otherwise sanctioned by the Medicaid Program in New York State, or in any other State, Medicare, or governmental or private medical insurance program? ☐ **Yes** ☐ **No**

Has the Applicant, any individuals or entities identified in Section 1 and Section 5, or entity in which the Applicant has a 5% or more ownership ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies, or which is considered an offense involving theft or fraud, or an offense against public administration or against public health and morals of any State? ☐ **Yes** ☐ **No**

Has the Applicant, any individuals or entities identified in Section 1 and Section 5, or entity in which the Applicant has a 5% or more ownership ever had their business or professional license or certification, or the license of an entity in which they had an ownership interest over 5% revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State? ☐ **Yes** ☐ **No**

Is there currently pending any proceedings that could result in the above stated sanctions for the Applicant, any individuals or entities identified in Section 1 and Section 5, or entity in which the Applicant has a 5% or more ownership? ☐ **Yes** ☐ **No**

Has there been a change of ownership or control within the last 12 months of the Applicant, any individuals or entities identified in Section 1 and Section 5, or entity in which the Applicant has a 5% or more ownership? ☐ **Yes** ☐ **No**

If ***Yes***, what is the date of the change in ownership? ____________ NY Medicaid ID or NPI No.

Is there a change of owner anticipated within the next 12 months to the Applicant, any individuals or entities identified in Section 1 and Section 5, or entity in which the Applicant has a 5% or more ownership? ☐ **Yes** ☐ **No**

If ***Yes***, what is the date of the anticipated change in ownership? ____________

Is the Applicant operated by a management company, or leased in whole or part by another organization? ☐ **Yes** ☐ **No**

Has there been a change in the laboratory director or supervising pharmacist within the past year? ☐ **Yes** ☐ **No** ☐ **Not Applicable**

Continued on page 5

Entity Name *FEIN*

Section 7: Attestation and Signature

By signing this Disclosure form, the Applicant/Provider understands and agrees to the following with respect to Medicaid Managed Care and Child Health Plus participants:

- The Applicant/Provider agrees to comply with the rules, regulations, and official directives of the New York State Department of Health including, but not limited to, Part 504 of 18NYCRR, which can be found at **health.ny.gov/regulations**.
- Pursuant to 42 CFR, Part 455.105, the Applicant/Provider agrees to disclose the following regarding business transactions within 35 days upon request of the New York State Department of Health or the Secretary of Health and Human Services: (1) Information about the ownership of any subcontractor with whom the provider has 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 the provider and any wholly owned supplier, or between the provider and any subcontractor during the five-year period ending on the date of the request.
- The Applicant/Provider agrees to abide by all applicable Federal and State laws as well as the rules and regulations of other New York State agencies.
- Providers for whom the Mandatory Compliance Law applies, have certified via the Office of the Medicaid Inspector General's website at **omig.ny.gov** that the Provider and its affiliates have adopted, implemented, and maintain an effective compliance program that meets the requirements of New York Social Services Law § 363-D and 18NYCRR, Part 521.
- Unannounced site visits by Medicaid, the Centers for Medicare & Medicaid Services, or their agents/designated contractors may be a condition of initial and continued enrollment. In addition, the provider and/or owners may be required to consent to criminal background checks, including fingerprinting.
- The Applicant/Provider agrees to notify MVP Health Care immediately of any changes to information supplied on this Disclosure form.

By signing below, the Applicant/Provider further understands that knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the provider already participates, a termination of its participation agreement with MVP Health Care.

If the Applicant/Provider is a legal entity other than a person, the individual signing this Disclosure form on behalf of the Applicant/Provider warrants that he/she has legal authority to bind the Applicant/Provider. If there is a change of ownership, the new owner or their representative may sign this document.

Name of Applicant/Provider or Authorized Representative (print) *Title*

Signature of Applicant/Provider or Authorized Representative *Date*

Name of Individual Who Prepared this Disclosure Form (print) *Contact Phone No.*

Submit by Email