

**DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST INSTRUCTIONS**

<b>Field #</b>	<b>Description</b>
1	List current Kentucky Medicaid provider number that this ADO pertains to.
2	List current Medicare number(s).
3	If there has been a change of ownership or a Federal Tax Identification number, list previous Medicaid provider numbers and effective dates for each.
4	Describe relationship or similarities between the provider disclosing information on this form and items “A” through “C”.
5	Do you plan to have a change in ownership, management company or control within the next year? If so, when?
6	Do you anticipate filing bankruptcy? If so, when?
7	Enter the Federal Tax Identification Number ( <b>if there is an affiliation with a chain</b> ) along with name, address, city, state and zip code.
8	List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. <i>Complete question #19 with the officers’ and board members’ information. If no one owns 5% or more of provider, check box and complete question #19 with the officers’ and board members’ information.</i> If you are enrolled as an individual and do not own a FEIN, please enter <b>your</b> name and information.
<p><b><u>Indirect Ownership Interest</u></b> - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.</p> <p><b><u>Ownership interest</u></b> - means the possession of equity in the capital, the stock, or the profits of the disclosing entity.</p> <p><b><u>Person with an ownership or control interest</u></b> - means a person or corporation that:</p> <ul style="list-style-type: none"> <li>• Has an ownership interest totaling 5% or more in a disclosing entity;</li> <li>• Has an indirect ownership interest equal to 5% or more in a disclosing entity;</li> <li>• Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity;</li> <li>• Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity;</li> <li>• Is an officer or director of a disclosing entity that is organized as a corporation; or,</li> <li>• Is a partner in a disclosing entity that is organized as a partnership</li> </ul>	
9	List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.
<p><b><u>Subcontractor</u></b>- means an individual, agency, or organization to which a disclosing entity has contracted or delegated some 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</p>	
10	If applicant is related to persons listed in questions #8 and #19, list the relationship
11	List name of managing company, if not applicable enter N/A.
12	List names of the disclosing entities in which persons have ownership of other Medicare/Medicaid facilities
<p><b><u>Other Disclosing Entity</u></b>- means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:</p> <ul style="list-style-type: none"> <li>• Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII).</li> <li>• Any Medicare intermediary or carrier.</li> <li>• Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.</li> </ul>	
13	If entity engages with subcontractors (such as physical therapist, pharmacies, etc.) which exceeds the lesser of \$25,000 or 5% of applicant’s operating expense, list subcontractor’s name and address.
<p><b><u>Significant Business Transaction</u></b>- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of \$25,000 or 5% of applicant’s operating expense.</p>	

ADO (Annual Disclosure of Ownership)  
(Rev 07/10)

<b>14</b>	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period.
<b>15</b>	List name, SSN, address of any immediate family member who is authorized to prescribe drugs, medicine, devices or equipment.
<b>16</b>	List anyone disclosed in question #8 who has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act (SSA) or any criminal offense in this state or any other state. Please also indicate any KY Medicaid provider number(s) associated with individual or organization.
<b>17</b>	List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the SSA or any criminal offense in this state or any other state. Indicate any KY Medicaid provider number(s) associated with individual or organization.
<p><b>Agent-</b> means any person who has been delegated the authority to obligate or act on behalf of a provider.  <b>Managing Employee-</b> means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.</p>	
<b>18</b>	List the name, title, FEIN/SSN and business address of all managing employees as defined in 42 CFR 455.101.
<b>19</b>	If you completed question #8 and you are not enrolled as an individual provider, please list officers' and board members' information. If no one owns 5% or more and/or the provider is non-profit, the officers' and board members' information must be disclosed.
<b>20</b>	Indicate Tax Structure of Provider: Please check only one (1).
<b>21</b>	Please indicate which number you will be using for reporting monies to you from Medicaid for 1099 purposes. <i>Example: If you are an individual completing this question, please input your Social Security Number unless you are a sole proprietor. An individual provider can bill under his/her individual provider number even if they are working in a group setting. The individual must complete a <a href="#">Map-347</a> in order to be linked to the group setting under which they are reporting.</i>
<b>22</b>	Enter the address where you want your Medicaid 1099 mailed.
<b>23</b>	Enter the Drug Enforcement Agency number (DEA#).
<b>24</b>	Please attach your current attestation letter if you are a licensed Psychiatric Residential Treatment Facility (PRTF).
<b>25</b>	Please attach a listing of all KenPAC sites and current quotas.
<b>26</b>	Please attach a complete list of all professionals currently working in your group.
<b>27</b>	IRS verification letter or Social Security Card must be attached verifying FEIN/SSN in question #21.
<b>28</b>	Enter your initials if you maintain electronic medical records and are HIPAA compliant. Check the box if you do not keep electronic medical records.
<b>29</b>	Enter E-mail address of provider. (Optional)
<b>30</b>	<p><b>Signature:</b> Enter original signature from the director, administrator, individual provider, owner, or authorized personnel. If you are an individual provider, <i>your</i> signature is required.  <b>Date:</b> Enter the date this disclosure is signed.  <b>Title:</b> Must be title of person signing this form. EXAMPLE: administrator, doctor, etc.  <b>Witnessed By Signature:</b> Witness signature</p>
<b>31</b>	For Internal Purposes Only: DMS Authorized Signature

**DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST**

**ITEMS 3-19 BELOW ARE REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.101, 455.104, and 455.105 AND KRS CHAPTER 205, AS AMENDED). YOU WILL RECEIVE THIS FORM ANNUALLY TO UPDATE AND RETURN TO DMS.**

**Note:** See the instructions and page 4 of this form for definitions according to 42 CFR 455.101, 455.104, 455.105, and KRS Chapter 205, as amended, of underlined terms in Section B.

**Provider Name/Entity Name:**

**NPI:**

<b>1. List current Kentucky Medicaid provider number that this ADO pertains to:</b>	<b>2. List Current Medicare Provider Numbers:</b>
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**3. If there has been a change in ownership, change of tax ID number (FEIN), or change in Kentucky Provider Number for a previously enrolled Kentucky Medicaid provider, enter the previous provider number(s) and their effective date(s):**  *Check here for N/A*

<b>Previous Medicaid Prov. #:</b>	<b>Start Date:</b>	<b>End Date:</b>
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**4. If you completed #3, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) corporate boards of disclosing provider and previous Medicaid owner; i.e. board members and ownership or control interest (c) disenrollment circumstances. (Attach extra page if necessary.)**  *Check here for N/A*

a.

b.

c.

**5. If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change.**  *Check here for N/A*

Date:	Change:
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**6. If you anticipate filing for bankruptcy within the year, enter anticipated date of filing.**

*Check here for N/A*

**7. If this facility is a subsidiary of a parent corporation, enter corporate FEIN #:**

*Check here for N/A*

Name:

Box or Address:

City:	State:	Zip :
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**8. List name, date of birth, SSN#/FEIN# and address of each person or entity that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider. (Attach extra page if necessary.) *Complete question #19 with the officers' and board members' information. If you are enrolled as an individual, list your information. (N/A Not Acceptable.)*  *Check here if no one owns 5% or more and list officers' and board members' information in question #19.***

Name:	SSN:
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FEIN:	DOB:
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Box or Address:

City:	State:	Zip:
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**9. List name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. (Attach extra page if necessary.)**

*Check here for N/A*

Name(a):	SSN:
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Box or Address:	FEIN:
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City:	State:	Zip:
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Name(b):	SSN:
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Box or Address:	FEIN:
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City:	State:	Zip:
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<b>10. If any individuals listed in questions #8 and #19 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.)</b> <input type="checkbox"/> <i>Check here for N/A</i>		
Name(a):	SSN:	
Relationship:	FEIN:	
Name(b):	SSN:	
Relationship:	FEIN:	
<b>11. If this facility employs a management company, please provide following information:</b> <input type="checkbox"/> <i>Check here for N/A</i>		
Name:		
Box or Address:		
City:	State:	Zip:
<b>12. List the names of any other disclosing entity in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities.</b> <input type="checkbox"/> <i>Check here for N/A</i>		
Name:	Provider Number:	
Box or Address:		
City:	State:	Zip:
<b>13. List the names and addresses of all other Kentucky Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of \$25,000 or 5% of your total operating expense. (Attach extra page if necessary.)</b> <input type="checkbox"/> <i>Check here for N/A</i>		
Name:		
Box or Address:		
City:	State:	Zip:
<b>14. List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. (Attach extra page if necessary.)</b> <input type="checkbox"/> <i>Check here for N/A</i>		
Name:		
Box or Address:		
City:	State:	Zip:
<b>15. List the name, SSN, and address of any immediate family member who is authorized under Kentucky Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment in accordance with KRS 205.8477.</b> <input type="checkbox"/> <i>Check here for N/A</i>		
Name (a):	Credential (M.D., etc.):	
Box or Address:	DOB:	SSN:
City:	State:	Zip:
Name (b):	Credential (M.D., etc.):	
Box or Address:	DOB:	SSN:
City:	State:	Zip:
<b>16. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title 18 (Medicare), or Title 19 (Medicaid), or Title 20 (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state, since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a KY Medicaid provider number(s), please indicate below. (Attach extra page if necessary.)</b> <input type="checkbox"/> <i>Check here for N/A</i>		
NAME (a)/KY Medicaid Provider Number(s):		
NAME (b)/KY Medicaid Provider Numbers(s):		
<b>17. List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title 18, 19, or 20, or 21 of the Social Security Act or any criminal offense in this state or any other state. (Attach extra page if necessary.) If individual or organization is associated with a KY Medicaid provider number(s), indicate below. (Attach extra page if necessary.)</b> <input type="checkbox"/> <i>Check here for N/A</i>		
NAME (a)/KY Medicaid Provider Number(s):		
NAME (b)/KY Medicaid Provider Number(s):		

<b>18. List the name, title, FEIN/SSN, and business address of all managing employees below as defined in 42 CFR 455.101.</b> (Attach extra sheet if necessary listing same details below.) <input type="checkbox"/> <i>Check here for N/A</i>			
Name (a):		Title:	
Box or Address:		DOB:	SSN:
City:		State:	Zip:
Name (b):		Title:	
Box or Address:		DOB:	SSN:
City:		State:	Zip:
<b>19. If you responded to question #8 and are <u>not</u> enrolled as an individual, please list officers' and board members' information.</b> (Attach extra sheet if necessary listing same details below.)			
Name (a):		Title:	
Box or Address:		DOB:	SSN:
City:		State:	Zip:
Name (b):		Title:	
Box or Address:		DOB:	SSN:
City:		State:	Zip:
<b>20. Indicate Tax Structure of Provider: Please check only one (1).</b>			
<input type="checkbox"/>	(A)	Individual	
<input type="checkbox"/>	(B)	Sole Proprietor	
<input type="checkbox"/>	(C)	Partnership	
<input type="checkbox"/>	(D)	Estate/Trust	
<input type="checkbox"/>	(E)	Corporation	
<input type="checkbox"/>	(F)	Public Service Corporation	
<input type="checkbox"/>	(G)	Government/Non-Profit	
<input type="checkbox"/>	(H)	Limited Liability Company	
<b>21. DMS will report all monies paid to you to the IRS. Please indicate <u>which</u> number you use for tax reporting. If enrolled as an individual and you do not own a FEIN, please complete SSN only.</b>			
Report DMS payments to my <u>FEIN</u> : _____			
Report DMS payments to my <u>SSN</u> : _____			
<b>22. Where do you want your Medicaid 1099 (annual earnings form) mailed?</b>			
Name:			
Address:			
City:		State:	Zip:
Contact Name for 1099 purposes only:		Phone:	Fax:
<b>23. If you are an individual who can prescribe controlled substances, please indicate your DEA (Drug Enforcement Agency) number. DEA Number:</b>			
<b>24. If you are a licensed Psychiatric Residential Treatment Facility (PRTF), please attach current attestation letter.</b>			
<b>25. Please attach a listing of all KenPAC sites and current quotas.</b>			
<b>26. If you are a Kentucky Medicaid group (more than one professional of the same provider type), please attach a listing of all professionals currently working in your group. Include the name, begin and end date with group, and the individual KY Medicaid provider number.</b>			
<b>27. Please attach a copy of your IRS verification letter OR a copy of your Social Security Card verifying FEIN/SSN in question #21.</b>			
<b>28. If you keep medical records on an electronic database, you hereby certify by your initials in the space provided that electronic records are confidential and patient privacy is protected (KRS 205.510). Every health care provider, regardless of size, who creates or maintains individual protected health information in any form (written, oral, or electronic) for the purpose of treatment, payment, or operation - or who has someone else perform electronic billing on his behalf - is a covered entity and must comply with HIPAA's Privacy Rule. _____ [ ] I do not keep electronic medical records.</b>			
<b>29. Email Address (optional):</b>			

**30.** I certify that all the information I have provided on this Department of Medicaid Services Annual Disclosure of Ownership Form is accurate. Failure to provide accurate information could result in termination from the Medicaid program.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Title: \_\_\_\_\_

**31. For Internal Use Only:**

**Department for Medicaid Services Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**455.104 Definitions:**

1. Indirect Ownership Interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
2. Other Disclosing Entity Means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
  - (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
  - (b) Any Medicare intermediary or carrier; and
  - (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishings of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.
3. Person with an Ownership or Control Interest means a person or corporation that:
  - (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
  - (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
  - (c) Has a combination of direct or indirect ownership interests equal to 5 percent or more in a disclosing entity;
  - (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
  - (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
  - (f) Is a partner in a disclosing entity that is organized as a partnership
4. Subcontractor means:
  - (a) An individual, a agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
  - (b) 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.

**Please return form to:**  
**KY Medicaid**  
**P.O. Box 2110**  
**Frankfort, KY 40602-2110**