Medicaid Disclosure Form

Purpose

In compliance with 42 CFR 457.935, 42 CFR 1001.1001, 42 USCS § 1395cc(j)(5), 42 CFR §455.104, §455.105, and §455.106, providers are required to disclose including, but not limited to, information regarding (1) the identity of all persons with an ownership or control interest in the provider, or in any subcontractor in which the disclosing entity has a direct or indirect ownership of 5 percent or more including the identity of managing employees, agents, and other disclosing entities; (2) certain business transactions between the provider and subcontractors/wholly owned suppliers; and (3) the identity of any person with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider or disclosing entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs. Magellan* is contractually obligated to collect this information. Magellan will provide the information obtained from this Form to the Health Plan and/or State Medicaid agency in compliance with its contractual obligations. Magellan is also obligated to report the names of all providers who failed to complete the Medicaid Disclosure Form to the applicable state Medicaid Agency or Health Plan. **Magellan may refuse to enter into a contract and may suspend or terminate an existing provider agreement if the provider fails to disclose the information required below.**

INSTRUCTIONS FOR COMPLETING THE MEDICAID DISCLOSURE FORM ("Form")

1. Read all definitions and instructions outlined throughout the Form and then reference the definitions and instructions while completing the Form. **This Form encompasses all Magellan Contracted locations.**
2. Complete and submit the Form to Magellan no longer than 35 calendar days from the date on the cover letter enclosed with the Form.
3. Answer all questions as of the current date.
4. If there is no information to include, indicate **"None"** or **"Not applicable" (N/A)** in the space provided. **Do not leave blank spaces unless advised to do otherwise in the instructions**. Incomplete Forms will be reported back to the applicable state agency or Health Plan.
5. Re-submit a new Form when any information in your disclosure changes.
6. **If more space is needed, please attach additional sheets.**
7. Complete this Form whether or not you have any information to report.
8. In any space requesting 'Name,' if it is the name of an individual, include First, Middle and Last.
9. **Business & Service Address:** The address for corporate/legal entities must include, as applicable, the primary business address, every business location, and P.O. Box address. **Individuals** must provide their home address.
10. Provide the Employer Identification Number (EIN) or Tax Identification Number (TIN) for legal entities. Provide the Social Security Number (SSN) for individuals.

Provider Statement:

By signing the ***Medicaid Disclosure Form***, I certify that the information provided on this Form is complete and accurate. I will notify Magellan immediately if any information changes. I will comply with all aspects of this Form. By completing and signing this ***Medicaid Disclosure Form***, I give consent for the information contained herein to be disclosed to a Health Plan based on Magellan's contractual obligations, the Department of Health and Human Services, or any other appropriate regulatory agency/body. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation or termination of an existing contract.

Name:_____ **Title:**_____

(Print or Type: First/Middle/Last) **(Print or Type)**

Signature:_____ **Date (MM/DD/YYYY):**_____

(Provider/Disclosing Entity or Authorized Agent of the Provider/Disclosing Entity)

* Magellan Healthcare, Inc. f/k/a Magellan Behavioral Health, Inc.; Magellan Behavioral Health Systems, LLC; MBH of North Carolina, LLC; Magellan Health Services of Arizona, Inc.; Magellan Health Services of California, Inc.-Employer Services; Human Affairs International of California; Magellan Behavioral Care of Iowa, Inc; Magellan Behavioral Health of Florida, Inc; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of New Jersey, LLC; Magellan Behavioral Health of Pennsylvania, Inc; Magellan Behavioral Health of Connecticut, LLC; Magellan Behavioral Health of Nebraska, Inc.; Magellan Behavioral Health Providers of Texas, Inc.; National Imaging Associates, Inc.; Florida MHS, Inc. d/b/a Magellan Complete Care; Magellan Complete Care of Indiana, Inc.; Magellan Complete Care of Iowa, Inc.; Magellan Complete Care of Louisiana, Inc.; Magellan Complete Care of Pennsylvania, Inc.; Magellan Complete Care of Virginia, LLC; Magellan Rx Management, LLC; Magellan Rx Management IPA, Inc.; Magellan Administrative Services, LLC; Magellan Pharmacy Solutions, Inc.; Magellan Medicaid Administration, Inc.; Magellan Rx Pharmacy, LLC; CDMI, LLC and their respective affiliates and subsidiaries are affiliates of Magellan Health, Inc. (collectively "Magellan").

Definitions (42 CFR 455.101) and 42 CFR 1001.1001:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR 1001.1001).
2. **Disclosing entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.
3. **Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.
4. **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).
5. **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. It also means an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue (42 CFR 1001.1001). (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)
6. **Immediate family member** means a person's husband or wife; natural or adoptive parent; child or sibling; step-parent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild (42 CFR 1001.1001).
7. **Length of exclusion means –**
    a. Except as provided in § 1001.3002(c), exclusions under this section will be for the same period as that of the individual whose relationship with the entity is the basis for this exclusion, if the individual has been or is being excluded
    b. If the individual was not excluded, the length of the entity's exclusion will be determined by considering the factors that would have been considered if the individual had been excluded.
    c. An entity excluded under this section may apply for reinstatement at any time in accordance with the procedures set forth in §1001.3001(a) (2).
8. ***Managed care entity*** *(MCE)* means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs. These terms are defined in 42 CFR § 438.2.
9. **Managing employee** 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.
10. **Member of household** means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household (42 CFR 1001.1001).
11. **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 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.
12. **Ownership interest** means the possession of equity in the capital, the stock, or the profits of the disclosing entity. It also means an interest in:
    a. The capital, the stock or the profits of the entity, or
    b. Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.
13. **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 and 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.
14. **Significant business transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $ 25,000 and 5 percent of a provider's total operating expenses.
15. **Subcontractor** means:
    a. 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
    b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
16. **Supplier** means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

17. **Wholly owned supplier** means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.
18. **Termination** means - 1. For a--
    i. Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and
    ii. Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.
    2 i. In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.
    ii. The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.
    3. The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to-- (i) Fraud; (ii) Integrity; or (iii) Quality.

Additional Definitions

19. **Federal health care program** means-- (1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code [5 USCS §§ 8901 et seq.]); or (2) any State health care program, as defined in section 1128(h) [42 USCS § 1320a-7(h)].
    [**42 USCS § 1320a-7b(f)]**
20. **State health care program** means--
    a. a State plan approved under title XIX [42 USCS §§ 1396 et seq.],
    b. any program receiving funds under title V [42 USCS §§ 701 et seq.] or from an allotment to a State under such title,
    c. any program receiving funds under subtitle 1 of title XX [42 USCS §§ 1397 et seq.] or from an allotment to a State under such subtitle, or
    d. a State child health plan approved under title XXI [42 USCS §§ 1397aa et seq.].

    [42 USCS § 1320a-7(h)].
21. **Affiliate or affiliated person** means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another. It also includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:
    i. A compensation arrangement;
    ii. An ownership arrangement;
    iii. Managerial authority over any member of the affiliation;
    iv. The ability of one member of the affiliation to control any other;
    v. The ability of a third party to control any member of the affiliation; or
    vi. Any person who directly or indirectly manages, controls, or oversees the operation of a corporation or other business entity that is a Medicaid/SCHIP provider, regardless of whether such person is a partner, shareholder, owner, officer, director, agent, or employee of the entity.

    Affiliates also means associated business concerns or individuals if, directly or indirectly --
    1. Either one controls or can control the other; or
    2. A third party controls or can control both.

    48 CFR 2.101

How to Determine Ownership or Control Percentages (42 CFR 455.102).

a. **Indirect ownership interest.** The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which 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.
b. **Person with an ownership or control interest**. 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.

Medicaid Disclosure Form

Section 1 - Identifying Information

CONTRACT OWNER MUST REPORT FOR ALL MAGELLAN LOCATION ENTITIES UNDER THIS CONTRACT

MIS (Magellan Internal Number)	**Type of Magellan Provider/*Disclosing Entity.*** Check the applicable box. ☐ Individual ☐ Group Practice ☐ Facility ☐ Organization ☐ Pharmacy ☐ Subcontractor ☐ Vendor
Name of Provider/*Disclosing Entity*	

Check the entity type that best describes the structure of the provider/*disclosing entity*. Check **only one** box.			
☐ Unincorporated Associations	☐ Non-Profit - Religious Organizations	☐ Non-Profit - Other	☐ Proprietary – Other
☐ Sole Proprietorship	☐ For-Profit Corporation	☐ Private – For- Profit	☐ Private – Not-For-Profit
☐ Government-owned - Federal	☐ Government-owned - State	☐ Government-owned – City	☐ Government-owned – County
☐ Government-owned – City-County	☐ Government - Hospital District	☐ Partnership	☐ Investor-Owned
☐ Not Applicable	☐ Other (please specify): _____.		

Parent/Joint Venture Information Is your organization a subsidiary company or joint venture? ☐ Yes ☐ No **If No**, you may skip this section. **If Yes**, provide the following information about your parent company/joint business.		
Legal Business Name		
Employer Taxpayer ID Number (TIN/EIN)	National Provider Identifier (NPI)	
Business Street Address Line 1		
Business Street Address Line 2		
City	State	ZIP Code
Phone Number ( ) -	Fax Number ( ) -	

Medicaid Disclosure Form

Section 2A - Ownership and Control Interest Disclosure

Including you, the provider, is there any *person* (individual or entity) *with an ownership or control interest* in the provider/*disclosing entity* providing this disclosure? ☐ Yes ☐ No

If No, you may skip this section. **If Yes**, provide the following information below about any *person (individual or entity) with an ownership or control interest* in the provider/disclosing entity.
If more space is needed, please attach additional sheets. (42 CFR 455.104)

* See the definition of *Person with an ownership or control interest*.

**** Business & Service Address:** The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address. **Individuals** must provide their home address.

Full Name (First/Middle/Last)	Title/Position	Address (Street, City, State, ZIP Code)	Date of Birth [if listing an individual] (MM/DD/YYYY)	National Provider Identifier (NPI)	SSN (if listing an individual, you must provide the SSN) EIN/TIN (if listing an entity)	% of Ownership or Controlling Interest
					☐SSN _____ ☐EIN _____ ☐TIN _____	
					☐SSN _____ ☐EIN _____ ☐TIN _____	
					☐SSN _____ ☐EIN _____ ☐TIN _____	

Section 2B - Ownership and Control Interest Disclosure Part I

Are there any *subcontractors* in which the *disclosing entity*/provider has a direct or indirect ownership interest of 5 percent or more? ☐ Yes ☐ No
*See the definition of *subcontractor.*

If No, you may skip this section. **If Yes**, provide the information below about the *subcontractor* in which the *disclosing entity*/provider has a 5 percent or more direct or indirect ownership or control interest. [42 CFR 455.104]
* **Business & Service Address:** The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address. Individuals must provide their home address.
**See the definition of *Person with an ownership or control interest*.
***See the definition of *Subcontractor*.

Full Name of the *Subcontractor* (First/Middle/Last)	Title/Position (If Applicable)	Address of the *Subcontractor* (Street, City, State, ZIP Code)	Date of Birth [if listing an individual] (MM/DD/YYYY)	National Provider Identifier (NPI)	SSN (if listing an individual, you must provide the SSN) EIN/TIN (if listing an entity)
					☐SSN_____ ☐EIN _____ ☐TIN _____
					☐SSN _____ ☐EIN _____ ☐TIN _____
					☐SSN _____ ☐EIN _____ ☐TIN _____

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Section 2B - Ownership and Control Interest Disclosure Part II

Are there any *subcontractors* in which the *disclosing entity*/provider has a direct or indirect ownership interest of 5 percent or more? ☐ Yes ☐ No
*See the definition of *subcontractor.*

If No, you may skip this section. **If Yes**, provide the information below about any *person (individual or entity) with an ownership or control interest,* in any *subcontractor* in which the *disclosing entity*/provider has a 5 percent or more direct or indirect ownership or control interest. [42 CFR 455.104]
* **Business & Service Address:** The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address. Individuals must provide their home address.
**See the definition of *Person with an ownership or control interest*.
***See the definition of *Subcontractor*.

Full Name of the *Subcontractor* (First/Middle/Last) From Section 2B Part I	Full Name of Person(s) with an ownership or control interest in the *subcontractor* (First/Middle/Last)	Title/Position of Person(s) with an ownership or control interest in the *subcontractor*	Address of Person(s) with an ownership or control interest in the *subcontractor* (Street, City, State, ZIP Code)	Date of Birth of Person(s) with an ownership or control interest in the *subcontractor* (MM/DD/YYYY)	National Provider Identifier (NPI) of Person(s) with an ownership or control interest in the *subcontractor*	SSN (if listing an individual) EIN/TIN (if listing an entity) of Person(s) with an ownership or control interest in the *subcontractor*	% of Ownership or Controlling Interest
						☐SSN_____ ☐EIN _____ ☐TIN _____	
						☐SSN _____ ☐EIN _____ ☐TIN _____	
						☐SSN _____ ☐EIN _____ ☐TIN _____	

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Section 2C - Ownership and Control Interest Disclosure - Relatives

Are any of the individuals listed above **in Section 2A related to each other** and/or related to any of the individuals in **Section 2B** (Parts I & II) related to each other? ☐Yes ☐No (Self / Not Applicable)

If No, you may skip this section. **If Yes**, provide the information described below.

i. List the name of the *person with an ownership or control interest* in the provider/*disclosing entity* who is related to another *person with an ownership or control interest* in the provider/*disclosing entity* as a spouse, sibling, parent, child, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage, including step and adoptive relationship, and indicate the type of relationship below. **(Individuals from Section 2A who are related to each other)**.

ii. List the name of the *subcontractor* in which the provider/*disclosing entity* has a 5 percent or more direct or indirect ownership interest and the name of the *person with an ownership or control interest* in any *subcontractor* in which the provider/*disclosing entity* has a 5 percent or more direct or indirect ownership interest, who is related to another *person with an ownership or control interest* in the provider/*disclosing entity* as a spouse, sibling, parent, child, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage, including step and adoptive relationships, and indicate the type of relationship below. **(Individuals from Section 2A who are related to individuals from Sections 2B)**.

iii. List the name of the *subcontractor* in which the provider/*disclosing entity* has a 5 percent or more direct or indirect ownership interest, and the names of the *persons with an ownership or control interest* in any *subcontractor* in which the provider/*disclosing entity* has a 5 percent or more direct or indirect ownership or control interest, who are related to one another as a spouse, sibling, parent, child, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage, including step and adoptive relationships, and indicate the type of relationship below. **(Individuals from Sections 2B who are related to each other)**.

From Section 2A or 2B Full Name (First/Middle/Last)	Type of Relationship	From Section 2A or 2B Full Name (First/Middle/Last)
	☐Spouse ☐Child ☐Uncle ☐Parent ☐Adoptive Child ☐Aunt ☐Adoptive Parent ☐Step Child ☐Niece ☐Step-Parent ☐ Other ☐Grandparent ☐Nephew ☐Sibling ☐Grandchild ☐Cousin ☐Relationship by Marriage	
	☐Spouse ☐Child ☐Uncle ☐Parent ☐Adoptive Child ☐Aunt ☐Adoptive Parent ☐Step Child ☐Niece ☐Step-Parent ☐ Other ☐Grandparent ☐Nephew ☐Sibling ☐Grandchild ☐Cousin ☐Relationship by Marriage	
	☐Spouse ☐Child ☐Uncle ☐Parent ☐Adoptive Child ☐Aunt ☐Adoptive Parent ☐Step Child ☐Niece ☐Step-Parent ☐ Other ☐Grandparent ☐Nephew ☐Sibling ☐Grandchild ☐Cousin ☐Relationship by Marriage	

Section 2D – Disclosure Regarding *Managing Employees* and *Agents*

Do you, as the provider/*disclosing entity*, have any agent or managing employee? ☐ Yes ☐ No

If No, you may skip this section. **If Yes**, provide the name, address, date of birth, and Social Security Number of any *agent* and *managing employee* of the disclosing entity/provider.
*See the definition of *agent* and *managing employee*.
**The address for entities must include, as applicable, primary business address, every business location, and P.O. Box address. Individuals must provide their home address.
***If more space is needed, please attach additional sheets.**

Full Name (First/Middle/Last)	Agent or Managing Employee	Address (Street, City, State, ZIP Code)	Date of Birth (MM/DD/YYYY)	Social Security Number
	☐Agent ☐Managing Employee			
	☐Agent ☐Managing Employee			
	☐Agent ☐Managing Employee			
	☐Agent ☐Managing Employee			
	☐Agent ☐Managing Employee			
	☐Agent ☐Managing Employee			
	☐Agent ☐Managing Employee			
	☐Agent ☐Managing Employee			

Magellan HEALTH

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Section 2E – *Other Disclosing Entity* Disclosure

1. Are you or any of the individuals or entities listed in either **sections 2A or 2B** (Parts I & II)**,** also current/previous *persons with an ownership or control interest* in any other Medicaid disclosing entities/facilities/providers? ☐ Yes ☐ No ☐ Not Applicable (N/A)

2. Do you or any of the persons (individuals or entities) listed in **sections 2A or 2B** (Parts I & II)**,** also have any ownership or control interest in any *other disclosing entity* that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in programs established under Titles V, XVIII, XXI, or XX of the Act? ☐ Yes ☐ No ☐ N/A

If No or N/A, you may skip this section. **If Yes**, provide the information below.
* See the definition of *Person with an ownership or control interest*. ** See the definition of *other disclosing entity.*

Name (First/Middle/Last) of the Individual or Entity from Sections 2A or 2B or Self	**Name of the *Other Disclosing Entity* (First/Middle/Last)**	***Other Disclosing Entity's Address* (Street, City, State, ZIP Code)**	***Other Disclosing Entity's* SSN/EIN/TIN**	**Identify the Type of Program**	**Corresponding Program ID**
			☐SSN ______________ ☐EIN ______________ ☐TIN ______________	☐ Title XIX - Medicaid ☐Title XVIII – Medicare ☐Title XX – Block Grants to States for Social Services & Elder Justice ☐Title V – Maternal & Child Health Services Block Grant ☐Title XXI – State Children's Health Insurance Program	
			☐SSN ______________ ☐EIN ______________ ☐TIN ______________	☐ Title XIX - Medicaid ☐Title XVIII – Medicare ☐Title XX – Block Grants to States for Social Services & Elder Justice ☐Title V – Maternal & Child Health Services Block Grant ☐Title XXI – State Children's Health Insurance Program	
			☐SSN ______________ ☐EIN ______________ ☐TIN ______________	☐ Title XIX - Medicaid ☐Title XVIII – Medicare ☐Title XX – Block Grants to States for Social Services & Elder Justice ☐Title V – Maternal & Child Health Services Block Grant ☐Title XXI – State Children's Health Insurance Program	

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Section 3A - Sanctions/Exclusions Disclosure

Including you the provider/*disclosing entity*, are there any persons (individual or entity) with an ownership or control interest in the provider/disclosing entity, or is an agent, or managing employee, officer, consultant, director, co-partner, board member of the provider/disclosing entity who is excluded, suspended, terminated, sanctioned, or debarred, or any adverse legal action taken by the United States Department of Health and Human Services or by any state from participation in any program established under Title XVIII (Medicare), XIX (Medicaid programs), XX (Social Services Block Grants), XXI (State Children's Health Insurance Program), Title V (Maternal & Child Health Services Block Grant), or any other government-funded program since the inception of these programs? ☐ Yes ☐ No

If No, you may skip this section. **If Yes**, provide the information below.
* See the definition of *Person with an ownership or control interest*.

Full Name (First/Middle/Last)	Title/Position	Offense Description	Date the Federal or State Program/Agency Took Action (MM/DD/YYYY)

Section 3B - Criminal Offense Disclosure

Has the provider/disclosing entity, or any person (individual or entity) with an ownership or control interest in the provider/disclosing entity, or is an agent or managing employee, officer, consultant, director, co-partner, board member, or shareholder of the provider/disclosing entity ever been convicted of a criminal offense related to that person's involvement in any program established under Titles XIX (Medicaid), XVIII (Medicare), Title XX programs (Social Services Block Grants), Title V (Maternal & Child Health Services Block Grant), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs? ☐Yes ☐No

If No, you may skip this section. **If Yes**, please provide the information below. (42 CFR 455.106)
* See the definition of *Person with an ownership or control interest*.

Full Name (First/Middle/Last)	Title/Position	Criminal Offense Description	Date of Conviction (MM/DD/YYYY)	Date the Federal or State Program/Agency Took Action (MM/DD/YYYY)

Section 3C - Other Offense Disclosure

Including you the provider/disclosing entity, are there any persons (individual or entity) with an ownership or control interest in the provider/disclosing entity, or is an officer, consultant, director, co-partner, board member, shareholder, agent or managing employee of the provider/disclosing entity, who is presently indicted for, or otherwise criminally (felony and/or misdemeanor) or civilly charged by a governmental entity or who has been found guilty, or pled guilty or nolo contendere, or assessed fines or penalties for any of the offenses listed below, under any federal law or in any state, in connection with the delivery of a health care item or service, or with respect to any act or omission in a health care program operated by or financed in whole or in part by any Federal, State, or local government agency? ☐ Yes ☐ No

If No, you may skip this section. **If Yes**, please provide the information below. * See the definition of *Person with an ownership or control interest*.
***** If more space is needed, please attach additional sheets.**

Full Name (First/Middle/Last)	Title/Position	Offense	Offense Detail (Please keep to 2,000 characters or less)	Date of Conviction (MM/DD/YYYY)	Date the Federal or State Program/ Agency Took Action (MM/DD/YYYY)
		☐ Neglect or Patient Abuse ☐ Fraud ☐ Health Care Fraud ☐ Theft ☐ Embezzlement ☐ Breach of fiduciary responsibility ☐ Other financial misconduct ☐ Unlawful manufacture of a controlled substance ☐ Unlawful distribution of a controlled substance ☐ Unlawful prescription of a controlled substance ☐ Unlawful dispensing of a controlled substance ☐ Interference with an investigation or audit ☐ Obstruction of an investigation or audit ☐ Falsification or destruction of records ☐ Physical/sexual abuse ☐ Program-related crimes ☐ Offenses under 42 USCS § 1320a-7 ☐ Offenses under 42 USCS § 1320a-7a ☐ Offenses under 42 USCS § 1320a-7b ☐ Offenses under 42 USCS § 1320c-5 ☐ Offenses in 42 CFR 1001.1001 ☐ Other			

Section 3D – Payment Suspension Disclosure

1. Are you, the provider/*disclosing entity*, your *affiliates*, or any of the individuals or entities listed in your response to **Sections 2A, 2B** (Parts I & II)**, 2D, 2E, 3A, 3B, and 3C,** subject to any of the following actions listed below, by any regulatory agency/body, under any *federal or state health care program* established under Title XIX (Medicaid), XVIII (Medicare), or Title XX program (Social Services Block Grants), Title V (Maternal & Child Health Services Block Grant), or XXI (State Children's Health Insurance Program) of the Social Security Act?

   a) Ever been subject to a payment suspension because of a credible allegation of fraud by a regulatory body/agency? ☐ Yes ☐ No

   b) Currently under a prepayment review status? ☐ Yes ☐ No

   c) Currently subject to a payment suspension? ☐ Yes ☐ No

   d) Had its billing privileges denied or revoked? ☐ Yes ☐ No

   e) Has been involuntarily administratively dissolved by a secretary of state, or similar action has been taken by a comparable agency in any state? ☐ Yes ☐ No

2. Disclose whether or not each scenario described below is applicable to you, the provider/*disclosing entity*, your *affiliates*, or any of the individuals or entities listed in your response to **Sections 2A, 2B**(Parts I & II)**, 2D, 2E, 3A, 3B, and 3C,** under any *federal or state health care program* established under Title XIX (Medicaid), XVIII (Medicare), or Title XX program (Social Services Block Grants), Title V (Maternal & Child Health Services Block Grant), or XXI (State Children's Health Insurance Program) of the Social Security Act?**:**

   a) Any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services, or supplier that has been or is currently subject to a payment suspension? ☐Yes ☐ No

   b) Any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services, or supplier that had its billing privileges denied or revoked? ☐ Yes ☐ No

   c) Any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services, or supplier that has uncollected debt? ☐ Yes ☐ No

   d) Any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services, or supplier that has been excluded from participating in any of the health care programs referenced above? ☐ Yes ☐ No

If you answered "NO" to every question in this section, you may skip the section below. If you answered "**YES" to any question in this section**, **check ☐ the box that applies to the questions and then provide the information below**. If more space is needed, please continue on next page or attach additional sheets.

Question # (Identify the question by checking one box as applicable for each row)	Full Name (First/Middle/Last)	Type of Relationship/Connection to the provider/disclosing entity	Name of the Sanctioning Regulatory Body/Agency	Sanction Begin Date (MM/DD/YYYY)	Sanction End Date (MM/DD/YYYY)
☐ *1a* ☐ 2a ☐ *1b* ☐ 2b ☐ *1c* ☐ 2c ☐ 1d ☐ 2d ☐ *1e*		☐ *Person with an ownership or control interest* ☐ *Managing Employee* ☐ *Agent* ☐ *Affiliate* ☐ *Other Disclosing Entity* ☐ Self (Provider/*disclosing entity*) ☐ Other:_____	Agency Name:_____ ☐ Federal ☐ State (specify):_____		☐ Permanent ☐ No End Date ☐ End Date (Specify)_____

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Section 3D – Payment Suspension Disclosure - Continued

Question # (Identify the question by checking one box as applicable for each row)	Full Name (First/Middle/Last)	Type of Relationship/Connection to the provider/disclosing entity	Name of the Sanctioning Regulatory Body/Agency	Sanction Begin Date (MM/DD/YYYY)	Sanction End Date (MM/DD/YYYY)
☐ *1a* ☐ 2a ☐ *1b* ☐ 2b ☐ *1c* ☐ 2c ☐ 1d ☐ 2d ☐ *1e*		☐ *Person with an ownership or control interest* ☐ *Managing Employee* ☐ *Agent* ☐ *Affiliate* ☐ *Other Disclosing Entity* ☐ Self (Provider/*disclosing entity*) ☐ Other:_____________	Agency Name:__________ ☐ Federal ☐ State (specify):________		☐ Permanent ☐ No End Date ☐ End Date (Specify) _____
☐ *1a* ☐ 2a ☐ *1b* ☐ 2b ☐ *1c* ☐ 2c ☐ 1d ☐ 2d ☐ *1e*		☐ *Person with an ownership or control interest* ☐ *Managing Employee* ☐ *Agent* ☐ *Affiliate* ☐ *Other Disclosing Entity* ☐ Self (Provider/*disclosing entity*) ☐ Other:_____________	Agency Name:__________ ☐ Federal ☐ State (specify):________		☐ Permanent ☐ No End Date ☐ End Date (Specify) _____
☐ *1a* ☐ 2a ☐ *1b* ☐ 2b ☐ *1c* ☐ 2c ☐ 1d ☐ 2d ☐ *1e*		☐ *Person with an ownership or control interest* ☐ *Managing Employee* ☐ *Agent* ☐ *Affiliate* ☐ *Other Disclosing Entity* ☐ Self (Provider/*disclosing entity*) ☐ Other:_____________	Agency Name:__________ ☐ Federal ☐ State (specify):________		☐ Permanent ☐ No End Date ☐ End Date (Specify) _____

Section 4A – Disclosure Regarding Business Transactions

Have you, as the provider, had any business transactions with any *subcontractor* totaling more than $25,000 during the previous 12-month period (12-month period ending as of the date on this request)?
☐Yes ☐No

If No, you may skip this section. **If Yes**, provide the information below about the ownership of any *subcontractor* with whom you as the provider has had business transactions totaling more than $25,000 during the previous 12-month period (12-month period ending as of the date on this request). **If more space is needed, please attach additional sheets.** (42 CFR 455.105)
* See the definition of *subcontractor.*

Name of Subcontractor (First/Middle/Last)	Provide One of the Following for the Subcontractor: SSN/EIN/TIN	Subcontractor's Address (Street, City, State, ZIP Code)	Name of the Owner of the Subcontractor (First/Middle/Last)	Provide One of the Following for the Owner of the Subcontractor: SSN/EIN/TIN	Owner of the Subcontractor's Address (Street, City, State, ZIP Code)	Transaction Amount
	☐SSN ______________ ☐EIN ______________ ☐TIN ______________			☐SSN ______________ ☐EIN ______________ ☐TIN ______________		☐$25,000.01-$50,000.00 ☐$50,000.01-$75,000.00 ☐$75,000.01-$100,000 ☐ > $100,000
	☐SSN ______________ ☐EIN ______________ ☐TIN ______________			☐SSN ______________ ☐EIN ______________ ☐TIN ______________		☐$25,000.01-$50,000.00 ☐$50,000.01-$75,000.00 ☐$75,000.01-$100,000 ☐ > $100,000
	☐SSN ______________ ☐EIN ______________ ☐TIN ______________			☐SSN ______________ ☐EIN ______________ ☐TIN ______________		☐$25,000.01-$50,000.00 ☐$50,000.01-$75,000.00 ☐$75,000.01-$100,000 ☐ > $100,000
	☐SSN ______________ ☐EIN ______________ ☐TIN ______________			☐SSN ______________ ☐EIN ______________ ☐TIN ______________		☐$25,000.01-$50,000.00 ☐$50,000.01-$75,000.00 ☐$75,000.01-$100,000 ☐ > $100,000

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Section 4B – Disclosure Regarding Significant Business Transactions

Have you, as the provider, had any significant business transactions with any *wholly owned supplier or subcontractor* during the previous 5-year period (5-year period ending as of the date on this request)?
☐Yes ☐No

If No, you may skip this section. **If Yes**, please provide the information below about any *significant business transactions* between you as the provider and any *wholly owned supplier*, or between you as the provider and any *subcontractor*, during the last 5-year period (5-year period ending as of the date of this request).
* See the definition of *significant business transaction*, *wholly-owned supplier,* and *subcontractor*. **If more space is needed, please attach additional sheets.**
(42 CFR 455.105)

Name of *Wholly Owned Supplier* or Name of *Subcontractor* (First/Middle/Last)	**Type of Entity**	**Provide One of the Following for the *Wholly Owned Supplier* or *Subcontractor*: SSN/EIN/TIN**	**Provide the Address for the *Wholly Owned Supplier* or *Subcontractor* (Street, City, State, ZIP Code)**	**Provide the Name of the Owner of the *Wholly Owned Supplier* or *Subcontractor* (First/Middle/Last)**	**Provide One of the Following for the Owner of the *Wholly Owned Supplier or Subcontractor* : SSN/EIN/TIN**	**Provide the Address for the Owner of the *Wholly Owned Supplier or Subcontractor* (Street, City, State, ZIP Code)**	**Transaction Amount**
	☐Wholly Owned Supplier ☐Subcontractor	☐SSN ___________ ☐EIN ___________ ☐TIN ___________			☐SSN___________ ☐EIN ___________ ☐TIN ___________		☐$25,000.01-$50,000.00 ☐$50,000.01-$75,000.00 ☐$75,000.01-$100,000 ☐ > $100,000
	☐Wholly Owned Supplier ☐Subcontractor	☐SSN ___________ ☐EIN ___________ ☐TIN ___________			☐SSN___________ ☐EIN ___________ ☐TIN ___________		☐$25,000.01-$50,000.00 ☐$50,000.01-$75,000.00 ☐$75,000.01-$100,000 ☐ > $100,000
	☐Wholly Owned Supplier ☐Subcontractor	☐SSN ___________ ☐EIN ___________ ☐TIN ___________			☐SSN___________ ☐EIN ___________ ☐TIN ___________		☐$25,000.01-$50,000.00 ☐$50,000.01-$75,000.00 ☐$75,000.01-$100,000 ☐ > $100,000

Medicaid Disclosure Form

Section 5 – Change of Ownership

A	Has there been a change in ownership or control within the last year? ☐Yes ☐ No **If Yes,** please provide the date. (MM/DD/YYYY) _____
B	Do you anticipate any change of ownership or control within the year? ☐Yes ☐ No **If Yes,** please provide the estimated date. (MM/DD/YYYY) _____
C	Do you anticipate filing for bankruptcy within the year? ☐Yes ☐No **If Yes,** please provide the estimated date. (MM/DD/YYYY) _____
D	Is this facility operated by a management company, or leased in whole or part by another organization? ☐ Yes ☐ No **If Yes,** please provide the date of operation. (MM/DD/YYYY) _____
E	Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? ☐Yes ☐ No
F	Is this facility chain-affiliated? (**If Yes,** list name, address of corporation, and EIN/TIN) ☐ Yes ☐ No Name _____ ☐EIN ☐TIN _____ (Please choose one) Address _____
G	If the answer to Question 5F is No, was the facility previously affiliated with a chain? (**If Yes,** list name, address of corporation, and EIN/TIN) ☐Yes ☐No Name _____ ☐EIN ☐TIN _____ (Please choose one) Address _____
H	Have you increased your bed capacity within the last 2 years by 10 percent or more, or by 10 beds, whichever is greater? ☐ Yes ☐ No ☐ Not Applicable **If Yes,** provide year of increased bed capacity. _____ How many beds do you currently have? _____ How many beds did you have previously?_____

Return this form <u>by mail</u> within 35 days of the date on the accompanying letter to:

Magellan Health, Inc.
Attn: Network Services
14100 Magellan Plaza
Maryland Heights, MO 63043