



Disclosure of Ownership, Control and Management Information, and Exclusions Statement (“Disclosure Form”)

I. Instructions

This form must be completed and submitted to Medica Health Plans (“Medica”) before entering into a contract with Medica and annually. A new Disclosure Form is required and must be submitted to Medica when any information in your original form has changed. This Disclosure Form is to be completed to ensure compliance with government program requirements pertaining to: (1) disclosure of ownership, control and management; and (2) exclusions of individuals and entities from government programs as set forth in your contract with Medica and Medica’s administrative requirements.

The disclosure, reporting and exclusion requirements apply to partnerships and both non-profit and for-profit corporations, including without limitation limited liability companies. Governmental entities, such as counties organized as corporations are required to complete all sections of this Disclosure Form. Counties that are not organized as corporations are only required to complete Sections II, III and VI of this Disclosure Form.

Definitions noted throughout this document and Section VII (Definitions) clarify which individuals and entities you must provide information about in the Disclosure Form. The definitions are based on law, regulation, and sub-regulatory guidance.

Important Note: For the purposes of this Disclosure Form, the term “Person with an Ownership or Control Interest” is not limited to persons or corporations with an ownership interest. For example, it also includes:

- (i) officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies; and
- (ii) partners of a partnership, including without limitation limited liability partnerships. See Section VII for a complete definition of “Person with an Ownership or Control Interest” as well as definitions of other key terms such as “Managing Employee,” “Provider,” and “Agent.”

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Please complete this Disclosure Form whether or not you have any information to report. If more space is needed, please attach additional information on a separate page.

For assistance in completing this Disclosure Form, please reference the Definitions provided under Section VII. Please use clear legible print.



II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS

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DBA (Doing Business As), if applicable

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NPI / UMPI

OFFICE PHONE NUMBER

--	--

STREE ADDRESS

--

CITY

STATE

ZIP CODE

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FEDERAL EMPLOYER ID (FEIN)

MN TAX ID

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[Contract ID]

III. Structure

Check the entity type that describes your structure:

- | | |
|---|--|
| <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Limited Liability Co. | <input type="checkbox"/> Other Partnership (i.e., LP, LLP, LLLP) |
| <input type="checkbox"/> For Profit Corporation | <input type="checkbox"/> Non-Profit Corporation |
| <input type="checkbox"/> Public Corporation | <input type="checkbox"/> State |
| <input type="checkbox"/> Incorporated County | <input type="checkbox"/> Other |
| ----- | |
| <input type="checkbox"/> Unincorporated County | |
- (You may advance to Section VI for Certification)

[Contract ID]



IV. Ownership, Control and Management Information

A. Please complete the below grid with information about each **Person with an Ownership or Control Interest** in the legal entity identified in Section II or in any Subcontractor (of the legal entity identified in Section II) in which the legal entity has direct or indirect ownership of 5% or more.

Person with an Ownership or Control Interest means a person or corporation that:

- 1) has an ownership interest, directly or indirectly, totaling 5% or more in the legal entity identified in Section II;
- 2) has a combination of direct and indirect ownership interests equal to 5% or more in the legal entity identified in Section II;
- 3) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least 5% of the value of the property or assets of the Provider;
- 4) is an officer or director of a Provider organized as a corporation (this includes officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies); or
- 5) is a partner in a Provider organized as a partnership, including without limitation limited liability partnerships.

All fields in the grid must be completed. The date of birth and social security number (SSN) are required if a person's name is provided, and the federal employer identification (FEIN) number is required if an entity's name is provided.

“Please omit the % sign in the field for Percentage of Ownership Interest (POI)”

First Name	MI	Last Name	Individual's home address or Entities' business location(s) & P.O. box(es)	Date of Birth	SSN (person) or FEIN (entity)	POI

[Contract ID]



B. Please complete the below grid with information for each **Managing Employee**.

Managing Employee means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Provider, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Provider, or part thereof.

All fields in the grid must be completed. The date of birth and social security number (SSN) are required for each name provided.

First Name	MI	Last Name	Individual's home address	Date of Birth	SSN (person)

[Contract ID]

C. Please complete the below grid with information for each person with an **Ownership or Control Interest** identified in subsection IV (A) who is related to any other Person with an Ownership or Control Interest.

"Related to" means, a spouse, parent, child or sibling. If no such relationship exists, please indicate this with an "N/A."

First Name	MI	Last Name	Date of Birth	SSN (person)	Name of Person Related to	Related Person's SSN	Relationship

[Contract ID]



D. Please complete the below grid with information for each **Person with an Ownership or Control Interest** listed in subsection IV (A) that has an ownership or control interest in any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose ownership and control interest because of participation in any Title V (Maternal and Child Health), XVIII (Medicare), or XX (block grants for social services) programs.

“Please omit the % sign in the field for Percentage of Ownership Interest (POI)”

First Name	MI	Last Name	Address	Date of Birth	SSN (person) or FEIN (entity)	Name of Other Organization	POI

[Contract ID]

V. Excluded Individuals or Entities

A. Are there any employees, Persons with an Ownership or Control Interest in, you as a Provider, or any of your Managing Employees or Agents who are or have ever:

- Been excluded from participation in Medicare or any of the State health care programs?

Yes No

- Been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs?

Yes No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (that is, federal fraud and abuse law civil monetary penalty provisions)?

Yes No



B. Do you as a Provider have any agreements for the provision of items or services related to Medica’s obligations under its contracts with the Minnesota Department of Human Services (DHS) or the Centers for Medicare and Medicaid Services (CMS) with an individual or entity who: (i) has been excluded from participation in Medicare or any of the State health care programs; (ii) has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or other state or jurisdiction since the inception of those programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

Yes No

If you answered “Yes” to any of the above questions, list the name and social security number (SSN) or federal employer identification number (FEIN) of the individual or entity, and reason for answering “Yes” (i.e., conviction of a criminal offense related to involvement in, or exclusion from participation in, Medicare, Medicaid, or other federally funded government health care programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

First Name	MI	Last Name	SSN (person) or FEIN (entity)	Reason

[Contract ID]

VI. Certification

I am authorized to bind the entity named in this document and I certify that the above information is true and correct. I will notify Medica of any changes to this information.

NAME (Print)

TITLE

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EMAIL ADDRESS

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SIGNATURE

DATE

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[Contract ID]

Return a completed, signed Disclosure Form to Medica as follows:

Email a scanned copy of the signed form to: providercertifications@medica.com. (Preferred method)

Mail the form to: Medica Health Plans, Mail Route CP425, P.O. Box 9310, Minneapolis, MN 55440-9310.

If you have any questions, please call Medica Provider Services at 1-800-458-5512, or send an email to the above email address.



VII. DEFINITIONS

For the purpose of this disclosure, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider.
2. **Managing Employee** means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Provider, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Provider, or part thereof.
3. **Person with an Ownership or Control Interest** means a person or corporation that:
 - A) has an ownership interest, directly or indirectly, totaling 5% or more in the Provider;
 - B) has a combination of direct and indirect ownership interests equal to 5% or more in the Provider;
 - C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least 5% of the value of the property or assets of the Provider;
 - D) is an officer or director of a Provider organized as a corporation (this includes officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies); or
 - E) is a partner in a Provider organized as a partnership, including without limitation limited liability partnerships.
4. **Provider** means an individual or entity that: A) is engaged in the delivery of health care services and is legally authorized to do so by the state in which the individual or entity delivers services; and B) has entered into an agreement with Medica to provide health care services to Medica members, including members enrolled through Medica's contracts with DHS or CMS. For purposes of this disclosure, "Provider" also means a vendor providing non-health care services through an agreement with Medica to members enrolled through Medica's government program contracts with DHS or CMS, provided those services are significant and material to Medica's obligations under the respective government program contract.
5. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted (or a person with an employment, consulting or other arrangement with the Provider) for the provision of items and services that are significant and material to the Provider's contract with Medica and Medica's obligations under its contracts with DHS or CMS.

[Contract ID]

