Disclosure of Ownership & Management Information Statement

I. Instructions

This statement is a requirement from the Department of Human Services (DHS) and Medicare (CMS).

This statement should be completed and submitted to HealthPartners annually and upon contract renewal. A new statement must be submitted when any information in your statement has changed or upon contract renewal, whichever is first.

This statement must be completed whether or not you have any information to report. If more space is needed, please attach additional information on a separate sheet. Terms in bold are defined on the final page of this form.

II. Disclosing Entity Identifying Information/Structure

(Enter the W9 Legal address in the below section.)

Legal Name according to the IRS	
Doing Business As (DBA)	
Address	
City, State, Zip Code	
Phone Number	
Federal Tax ID	
NPI/UMPI Number	

III. Structure (Check the entity type that best describes the structure of your organization.)

☐ Sole Proprietorship	☐ Partnership	☐ Corporation, LLC	☐ Non-Profit
☐ Hospital-based Clinic	☐ State	☐ Public	☐ Professional Association
☐ Other (LP, LLP, LLLP) Specify Type _____			

IV. Ownership or Control Interests

A. Please provide the following information for each **Person with an Ownership or Control Interest** in the provider group, or in any **Subcontractor** in which you as a **Provider** have direct or indirect ownership of 5% or more. If no such ownership exists, please indicate this with a N/A.

PERSON 1

1. Full Legal Name	
2. Address	
3. City, State, Zip Code	
4. Social Security # or Federal Tax ID #	
5. Date of Birth	
6. % of Ownership Interest	

PERSON 2

1. Full Legal Name	
2. Address	
3. City, State, Zip Code	
4. Social Security # or Federal Tax ID #	
5. Date of Birth	
6. % of Ownership Interest	

NOTE: For additional Persons with an Ownership or Control Interest, please provide the same information on a separate sheet.

B. If any **Person with an Ownership or Control Interest** listed in section III.A above, is related to another **Person with an Ownership or Control Interest** listed in section III.A as a spouse, parent, child or sibling, please complete the following section. If no such relationship exists, please indicate with a N/A.

☐ NA

1. Full Legal Name
2. Social Security # or Federal Tax ID #
3. Name of Person Related To
4. Related Person's Social Security # or Federal Tax ID #
5. Relationship

C. If any **Person with an Ownership or Control Interest** listed in Section III.A above has an Ownership or Control Interest in an organization other than in the Disclosing Entity listed in Section II above, please complete the following section. If no such relationship exists, please indicate with a N/A.

☐ NA

1. Full Legal Name
2. Address
3. City, State, Zip Code
4. Social Security # or Federal Tax ID #
5. Name of Other Organization
6. % of Ownership Interest

V. Managing Employees

Please provide the following information for each **Managing Employee** in the provider group

PERSON 1	
1. Full Legal Name	
2. Address	
3. City, State, Zip Code	
4. Social Security #	
5. Date of Birth	
6. % of Ownership Interest	
PERSON 2	
1. Full Legal Name	
2. Address	
3. City, State, Zip Code	
4. Social Security #	
5. Date of Birth	
6. % of Ownership Interest	

NOTE: For additional Managing Employees, please provide the same information on a separate sheet.

VI. Excluded Individuals or Entities

A. Are there any persons listed in IV.A or V above who are or have ever been:

- Excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 and/or 1128A of the Social Security Act?

  ☐ Yes ☐ No

- Convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 and/or 1128A of the Social Security Act?

  ☐ Yes ☐ No

B. Do you as a **Provider** have any agreements for the provisions of items or services with any individual or entity who has been convicted of a criminal offense related to or excluded from Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 and/or 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the questions under Section VI, please list the name of the individual or entity, their social security number or tax id, and the reason for the conviction or exclusion.

Full Legal Name	Social Security # or Federal Tax ID #	Reason for conviction or exclusion

VII. Certification

I certify that the above information is true and correct and I am authorized to sign this statement on behalf of this individual or entity.

Name (please print)	
Title	
Signature	
E-Mail Address	
Date Signed	

Please mail or fax completed document to:

Provider Electronic Commerce & Operations
ATTN: Compliance Business Analyst
Mail Stop 21108C
8170 33rd Ave. S.
Bloomington, MN 55440
Fax: 952-853-8708

Disclosure of Ownership 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, director, etc) 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 theindividual or entity delivers services; and
   B) has entered into an agreement with HealthPartners to provide health care services to HealthPartners members, including members enrolled through HealthPartners'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 HealthPartners to members enrolled through HealthPartners's government program contracts with DHS or CMS, provided those services are significant and material to HealthPartners'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 HealthPartners and HealthPartners's obligations under its contracts with DHS or CMS.