

PrimeWest Health is required by the Centers for Medicare & Medicaid Services (CMS) and the Minnesota Department of Human Services (DHS) to collect this information.

Each disclosing entity or subcontractor must complete this statement:

- As a condition of PrimeWest Health participation or subcontractor status
- When your disclosing entity first enrolls with PrimeWest Health
- Whenever any information on this statement changes
- When contracting with PrimeWest Health to provide items or services

Please see *Definitions* on the last page.

## Disclosing Entity Identifying Information and Structure

ENTITY'S LEGAL NAME ACCORDING TO IRS		ENTITY'S DOING BUSINESS AS NAME (DBA)	
PROVIDER TYPE		NPI OR UMPI	OFFICE PHONE NUMBER
FACILITY ADDRESS	CITY	STATE	ZIP CODE
FEDERAL EMPLOYER ID (FEIN)		MINNESOTA TAX ID NUMBER	
CHECK THE ENTITY TYPE THAT DESCRIBES THE ENROLLING PROVIDER:			
<input type="checkbox"/> Sole proprietorship	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation, LLC	<input type="checkbox"/> Nonprofit
<input type="checkbox"/> Hospital based clinic	<input type="checkbox"/> State	<input type="checkbox"/> Public	<input type="checkbox"/> Professional association
<input type="checkbox"/> Other (i.e., LP, LLP, LLLP) _____			

Each provider entity must complete the following sections for all people, businesses, or organizations that meet any of the following criteria:

- Have an ownership or control interest of 5 percent or more in this disclosing entity
- Have an ownership or control interest in a subcontractor in which this disclosing entity has a direct or indirect ownership interest of 5 percent or more
- Are a managing employee (see *Definitions* on the last page)

**For a person:** If you list a person, you must include that person's Social Security number (SSN) and residential (home) address.

**For a business:** If you list a business, you must include the business's Federal tax ID (FEIN) and primary business address for every business location (including street address) and every post office box address.

**If you have previously completed this Statement and no ownership or control interest in the entity has changed, you are not required to complete the rest of this form. Please attest that no information has changed by checking the box below and signing on page 5. You do not need to complete the rest of the Statement.**

- I have previously completed this form and attest that no ownership or control interest in the entity has changed since that time.

## Individual Person Ownership or Control Interest

List all individual owners, managing employees, and people with control interest. See *Instructions* on the last page for more information about completing this section.

Copy this page as needed to enter more individual owners.  Check if submitting multiple pages.

ARE YOU A(N) (check all that apply):					
<input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor) _____					
<input type="checkbox"/> Managing Employee (not CEO, CFO, COO, CTO)		<input type="checkbox"/> Owner - List percent of ownership interest if 5 percent or more _____ %			
<input type="checkbox"/> Indirect owner - List percent of ownership interest if 5 percent or more _____ % Entity name _____					
<input type="checkbox"/> Board member, officer, or business and finance controller - CEO, CFO, COO, CTO					
<input type="checkbox"/> Trustee		<input type="checkbox"/> Authorized agent		<input type="checkbox"/> Other _____	
FULL LEGAL NAME (LAST)		FIRST		MIDDLE	
SOCIAL SECURITY #			DATE OF BIRTH		
ADDRESS		CITY	STATE	ZIP CODE	COUNTY OR TRIBAL NATION
<input type="checkbox"/> Hire Date (mm/dd/yyyy) _____			RELATIONSHIP TO ANY OTHER LISTED PERSON		
<input type="checkbox"/> Termination Date (mm/dd/yyyy) _____			<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling		

ARE YOU A(N) (check all that apply):					
<input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor) _____					
<input type="checkbox"/> Managing Employee (not CEO, CFO, COO, CTO)		<input type="checkbox"/> Owner - List percent of ownership interest if 5 percent or more _____ %			
<input type="checkbox"/> Indirect owner - List percent of ownership interest if 5 percent or more _____ % Entity name _____					
<input type="checkbox"/> Board member, officer, or business and finance controller - CEO, CFO, COO, CTO					
<input type="checkbox"/> Trustee		<input type="checkbox"/> Authorized agent		<input type="checkbox"/> Other _____	
FULL LEGAL NAME (LAST)		FIRST		MIDDLE	
SOCIAL SECURITY #			DATE OF BIRTH (mm/dd/yyyy)		
ADDRESS		CITY	STATE	ZIP CODE	COUNTY OR TRIBAL NATION
<input type="checkbox"/> Hire Date (mm/dd/yyyy) _____			RELATIONSHIP TO ANY OTHER LISTED PERSON		
<input type="checkbox"/> Termination Date (mm/dd/yyyy) _____			<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling		

ARE YOU A(N) (check all that apply):					
<input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor) _____					
<input type="checkbox"/> Managing Employee (not CEO, CFO, COO, CTO)		<input type="checkbox"/> Owner - List percent of ownership interest if 5 percent or more _____ %			
<input type="checkbox"/> Indirect owner - List percent of ownership interest if 5 percent or more _____ % Entity name _____					
<input type="checkbox"/> Board member, officer, or business and finance controller - CEO, CFO, COO, CTO					
<input type="checkbox"/> Trustee		<input type="checkbox"/> Authorized agent		<input type="checkbox"/> Other _____	
FULL LEGAL NAME (LAST)		FIRST		MIDDLE	
SOCIAL SECURITY #			DATE OF BIRTH (mm/dd/yyyy)		
ADDRESS		CITY	STATE	ZIP CODE	COUNTY OR TRIBAL NATION
<input type="checkbox"/> Hire Date (mm/dd/yyyy) _____			RELATIONSHIP TO ANY OTHER LISTED PERSON		
<input type="checkbox"/> Termination Date (mm/dd/yyyy) _____			<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling		

## Business Ownership or Control Interest

Is your business owned by or does another entity have a control interest in your business?

Yes – list other entities     No – skip to the next page

**Copy this page and complete it for any additional people, businesses, or organizations**

Check if submitting multiple pages.

ARE YOU A(N) (check all that apply):			
<input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor) _____			
<input type="checkbox"/> Owner – List percent of ownership interest if 5 percent or more _____%			
<input type="checkbox"/> Indirect owner - List percent of ownership interest if 5 percent or more _____% Entity name _____			
<input type="checkbox"/> Trustee <input type="checkbox"/> Other _____			
FULL LEGAL NAME (taxpayer name of FEIN or on W-9 from IRS)			FEDERAL EMPLOYER ID (FEIN)
ADDRESS	CITY	STATE	ZIP CODE
COUNTY OR TRIBAL NATION	OWNERSHIP OR CONTROL INTEREST		
	<input type="checkbox"/> Begin date _____ (mm/dd/yyyy) <input type="checkbox"/> End date _____ (mm/dd/yyyy)		

ARE YOU A(N) (check all that apply):			
<input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor) _____			
<input type="checkbox"/> Owner – List percent of ownership interest if 5 percent or more _____%			
<input type="checkbox"/> Indirect owner - List percent of ownership interest if 5 percent or more _____% Entity name _____			
<input type="checkbox"/> Trustee <input type="checkbox"/> Other _____			
FULL LEGAL NAME (taxpayer name of FEIN or on W-9 from IRS)			FEDERAL EMPLOYER ID (FEIN)
ADDRESS	CITY	STATE	ZIP CODE
COUNTY OR TRIBAL NATION	OWNERSHIP OR CONTROL INTEREST		
	<input type="checkbox"/> Begin date _____ (mm/dd/yyyy) <input type="checkbox"/> End date _____ (mm/dd/yyyy)		

ARE YOU A(N) (check all that apply):			
<input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor) _____			
<input type="checkbox"/> Owner – List percent of ownership interest if 5 percent or more _____%			
<input type="checkbox"/> Indirect owner - List percent of ownership interest if 5 percent or more _____% Entity name _____			
<input type="checkbox"/> Trustee <input type="checkbox"/> Other _____			
FULL LEGAL NAME (taxpayer name of FEIN or on W-9 from IRS)			FEDERAL EMPLOYER ID (FEIN)
ADDRESS	CITY	STATE	ZIP CODE
COUNTY OR TRIBAL NATION	OWNERSHIP OR CONTROL INTEREST		
	<input type="checkbox"/> Begin date _____ (mm/dd/yyyy) <input type="checkbox"/> End date _____ (mm/dd/yyyy)		

Does any person, business, or organization you listed have an ownership or control interest in any other Medicaid disclosing entity or any entity that does not participate in Medicaid, but is required to disclose ownership and control interest because of participation in any Title V, XVIII, or XX programs?

Yes – complete the following for each person, business, or organization       No

FULL LEGAL NAME (Person: Last, first, middle; Business or Organization: taxpayer name of FEIN or on W-9 from IRS)		% OF OWNERSHIP INTEREST	
FULL LEGAL NAME OF OTHER PROVIDER (Taxpayer name of FEIN or on W-9 from IRS)			
COUNTY OR TRIBAL NATION		ADDRESS OF OTHER PROVIDER	
CITY	STATE	ZIP CODE	

Check the appropriate Yes or No box for each of the following questions.

A. Has any person having an ownership or control interest ever:

- 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 start of these programs?  Yes  No
- Had civil money penalties or assessments imposed under section 1128A of the Social Security Act?  Yes  No
- Been excluded from participation in Medicare or any of the state health care programs?  Yes  No

B. Has any managing employee or agent ever:

- 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 start of these programs?  Yes  No
- Had civil money penalties or assessments imposed under section 1128A of the Social Security Act?  Yes  No
- Been excluded from participation in Medicare or any of the State health care programs?  Yes  No

Complete the following for any Yes answer.

FULL LEGAL NAME (Last, first, middle)	SOCIAL SECURITY NUMBER
REASON FOR ANSWERING YES (for example: conviction, money penalties, exclusion from Medicare or state health care programs)	

**Personal Care Assistant (PCA)/Housing Stabilization Services (HSS) providers only:** Complete the following information for all residential properties you own, lease, or manage that could be or are used for providing home care services.

FULL LEGAL NAME OF RESIDENCE OR PROVIDER (Taxpayer name of FEIN or on W-9 from IRS)		DO YOU OWN, LEASE, OR MANAGE THE PROPERTY?	
		<input type="checkbox"/> Own	<input type="checkbox"/> Lease <input type="checkbox"/> Manage
ADDRESS OF PROPERTY			
CITY	STATE	ZIP CODE	COUNTY OR TRIBAL NATION

### Signature

By signing below, I, an authorized officer with authority to bind the entity, certify that:

- The information on this form is true and correct
- I will notify Minnesota Health Care Programs (MHCP) Provider Eligibility and Compliance of any changes to this information

Check if signing electronically:

- I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. sec. 325L.02[h], 325L.05 and 325L.08)

NAME (PRINT)	TITLE	PHONE NUMBER
SIGNATURE		DATE

## Definitions

### Agent

Agent means any person who has been delegated the authority to obligate or act on behalf of the provider.

### Managing employee

Managing employee (not CEO, CFO, COO, CTO) means a person who exercises operational or managerial control over, or who directly or indirectly conducts or manages the day-to-day operations of an institution, organization, agency or school, such as a general manager, business manager, administrator, director.

### Ownership or control interest

Ownership or control interest means any person, business or organization to which any one or more of the following apply:

- Direct ownership of 5 percent or more in the disclosing entity
- Indirect ownership interest equal to 5 percent or more in a disclosing entity (meaning ownership in another entity that has an ownership interest in the disclosing entity)
- Determine the amount of indirect ownership interest by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equals 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 that owns 5 percent of the stock of the disclosing entity, B's interest equals a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
- A combination of direct and indirect ownership interest equal to 5 percent or more in the disclosing entity

- 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. Determine the percentage of ownership, mortgage, deed of trust, note, or other obligation by multiplying the percentage of interest owned in the obligation 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 equals 6 percent and must be reported. 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 equals 4 percent and need not be reported.
- Is an officer or director of a disclosing entity that is organized as a corporation (for profit or non-profit)
- Is a partner in a disclosing entity that is organized as a partnership

### Subcontractor

Subcontractor 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.

### Title V

Maternal and Child Health Services Block Grant

### Title XVIII

Health Insurance for the Aged and Disabled (Medicare)

### Title XX

Block Grants to States for Social Services and Elder Justice

### Title XXI

State Children's Health Insurance Program

## Instructions for completing Individual Person Ownership or Control Interest

### IMPORTANT

If you are notable to complete this form online, print the form and complete it by hand. Mail to Attn: Emily Roering, PrimeWest Health, 3905 Dakota St, Alexandria, MN 56308.

### "Are you a(n)..."

If a person holds multiple positions within the entity, company, or organization, you must select all roles that apply.

### Full legal name (last, first, middle)

You must disclose full legal name, including a full middle name. If a person does not have a middle name, enter "N/A."

### Social Security number

The person's Social Security number is required.

### Date of birth

The person's date of birth is required.

### Home residence address, city, county or Tribal nation, state, zip code

Do not use the enrolling business address. Use the address of where the person lives.

### Hire date or termination date

- If a person is being added to an existing record, or if this is being reported as a new enrollment requirement, select "Hire date" and provide the date of hire.
- If a person has left the agency or company, select "Termination date" and provide the date of termination.

### Relationship to any other listed person

Disclose any of the following, if applicable: spouse, child, parent, sibling.

### Background study number or request ID

The following providers must complete this section:

- PCA agencies
- Transportation providers (excludes ambulance transportation)
- Anyone with 5 percent or more ownership interest or control when the entity has been assigned as high risk
- Home and community-based services (HCBS) providers providing the following services:
  - Homemaker basic cleaning
  - Caregiver living expenses
  - Housing access coordination (HAC)
  - Independent living skills (ILS) therapy services