Disclosure of Ownership, Control and Management Information and Exclusions Statement for Providers

I. Instructions

UCare requires that the Disclosure of Ownership, Control and Management Information and Exclusions Statement for Providers be completed prior to entering into a contract with UCare and, thereafter, upon request. A new form is also required when any information submitted on the original form has changed.

You should complete this form in conjunction with review of the requirements for: (1) disclosure of ownership, control and management and (2) exclusions of individuals and entities from government programs as set forth in UCare's administrative requirements. This statement must be completed whether or not you have any information to report. If more space is needed, please attach additional information.

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 III, IV and VIII.

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.

For assistance in completing this statement, please reference the Definitions provided below in Section II.

II. DEFINITIONS

For the purpose of this statement, 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; or D) is an officer or director of the Provider (if organized as a corporation) or is a partner in the Provider (if organized as a partnership).

4. **Provider** means an individual or entity that has entered into an agreement with UCare and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services.

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 UCare and to UCare's obligations under its contract with the Department of Human Services.

III. Identifying Information

LEGAL NAME ACCORDING TO THE IRS	DBA (Doing Business As)		
ADDRESS			NPI/UMPI
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER
FEDERAL EMPLOYER ID (FEIN)	MN TAX ID		

IV. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Co. ☐ Non-Profit

☐ Public ☐ State ☐ Other Partnership (i.e., LP, LLP, LLLP)

V. Ownership & Control Interests

A. Please provide the following information for each Managing Employee and Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you as a Provider have direct or indirect ownership of 5% of more. If no such ownership exists, please indicate this with an "N/A." (Additional spaces available on page 6).

NOTE: All fields below must be completed. The date of birth and social security number (SSN) are required if an *individual's* name is provided, and the federal employer identification (FEIN) number is required if an *entity's* name is provided. For entities, list all addresses, including primary business address, every business location and PO Box address.

No.	Full Legal Name	Address	Date of Birth	SSN or FEIN	% Ownership Interest
1					
2					
3					

B. If any Person with an Ownership or Control Interest listed in subsection V (A) is related to another Person with an Ownership or Control Interest listed in subsection V (A) as a spouse, parent, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name	SSN or FEIN	Name of Person Related To	Related Person's SSN or FEIN	Relationship
1					
2					
3					

C. For each Person with an Ownership or Control Interest listed in subsection V(A) who also has an ownership or control interest in an organization other than that indicated in subsection V(A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	SSN or FEIN	Name of Other Organization	% Ownership Interest
1					
2					
3					

VI. Significant Business Transactions

A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty-five thousand dollars ($25,000) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists, please indicate this with an "N/A."

No.	Name of Subcontractor	Address	SSN or FEIN	% Ownership Interest
1				
2				
3				

B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an "N/A."

No.	Name of Wholly-Owned Supplier	Address	SSN or FEIN	Nature of Business Transaction
1				
2				
3				

VII. 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?

☐ Yes ☐ No

B. Do you as a Provider have any agreements for the provision of items or services related to the health plan's obligations under its contract with the Department of Human Services or the Centers for Medicare and Medicaid Services 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 any other state or jurisdiction since the inception of these 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 or Tax ID 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).

No.	Full Legal Name	SSN or FEIN	Reason
1			
2			
3			

VIII. Certification and Submission

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

NAME (Print)	TITLE
SIGNATURE	DATE
EMAIL ADDRESS	

Please return the completed form to UCare via email or US Mail.

Email: PNM_Fax@ucare.org

Mail: UCare
Attn: Provider Relations & Contracting
PO Box 52
Minneapolis, MN 55440-0052

Please contact us via email at PNM_FAX@ucare.org with any questions.

Additional Space for Information:

V. Ownership & Control Interests

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

No.	Full Legal Name	Address	Date of Birth	SSN or FEIN	% Ownership Interest
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
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