Part A: Disclosure of Ownership and Control
(Required by 42 C.F.R. §455.104)

Name of Provider: _____

1. List the name, address, social security number, and date of birth for each person with an ownership or control interest of 5% or more in the above named entity.

Name	Address	SSN	Date of Birth	Percent of Interest

2. Indicate whether any of the persons identified above are related to another listed above as a spouse, parent, child or sibling.

Name	Name	Relationship

3. Does any person listed in response to #1 above also have an ownership or control interest in another entity which is required to report ownership or control interest? If yes, identify the person and the name of the other entity.

Name	Name of Other Entity

4. The name, address, date of birth, and Social Security Number of any managing employee. "Managing employee" includes 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.

Name	Address	SSN	Date of Birth

By signing this form, I certify that the information provided is true and correct. I will notify LogistiCare Solutions, LLC if any information provided in this form changes. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security.

Name:_____ **Title:** _____
(print or type) (print or type)

Signature: _____ **Date:** _____

Text of 42 C.F.R. §455.104

§ 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

(a) *Who must provide disclosures.* The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) *What disclosures must be provided.* The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) *When the disclosures must be provided.*

(1) *Disclosures from providers or disclosing entities.* Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

(2) *Disclosures from fiscal agents.* Disclosures from fiscal agents are due at any of the following times:

(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

(ii) Upon the fiscal agent executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the fiscal agent.

(3) *Disclosures from managed care entities.* Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:

(i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.

(ii) Upon the managed care entity executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the managed care entity.

(4) *Disclosures from PCCMs.* PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section.

(d) *To whom must the disclosures be provided.* All disclosures must be provided to the Medicaid agency.

(e) *Consequences for failure to provide required disclosures.* Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

[76 FR 5967, Feb. 2, 2011]

Part B: Disclosure of Convictions
(Required by 42 C.F.R. § 455.106)

Name of Provider: _____

List the name and address of each person with an ownership or control interest of 5% or more in the above named entity, or is an agent or managing employee of the above named entity,

and

has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

(NOTE: "Agent or 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.)

Name	Relationship to Provider	Date of Conviction

By signing this form, I certify that the information provided is true and correct. I will notify LogistiCare Solutions, LLC if any information provided in this form changes. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security.

Name: _____ **Title:** _____
(print or type) (print or type)

Signature: _____ **Date:** _____

Text of 42 C.F.R. §455.106

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) *Information that must be disclosed.* Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) *Notification to Inspector General.* (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) *Denial or termination of provider participation.* (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

Part C: Disclosure of Business Transactions
(Required by 42 C.F.R. § 455.105)

TO BE COMPLETED UPON REQUEST

Name of Provider: _____

INSTRUCTIONS: Answer questions 1 and 2 and submit the requested information, if applicable, to LogistiCare no more than 35 calendar days from the date on the cover letter enclosed with this form.

In compliance with 42 CFR §455.105, LogistiCare will provide the information obtained from this form to Health Plans and/or State Medicaid agencies in compliance with its contractual obligations. LogistiCare also is obligated to report the names of all providers who failed to complete this Disclosure Form to the applicable State Medicaid Agency or Health Plan. LogistiCare 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.

1. Have you, as the provider, had any business transactions with any subcontractor totaling more than $25,000 during the previous twelve (12) month period (12 month period ending as of the date on this request)? ____Yes ____No

   If *No*, you may skip to question #2. If *Yes*, list the direct or indirect ownership of any subcontractor with whom you as the provider has had business transactions totaling more than $25,000 during the previous twelve (12) month period (12 month period ending as of the date on this request). Attach as separate sheet if necessary.

Name and business address of Subcontractor	**Provide One of the Following for the Subcontractor: SSN/EIN/TIN**	**Name and Address of the Owner of the Subcontractor (First/Middle/Last)**	**Transaction Amount**

2. Have you, as the provider, had any significant business transactions with any wholly owned supplier or subcontractor totaling more than $25,000 during the previous five (5) year period (5 year period ending as the date on this request)? _____Yes _____No

   If *No*, you may skip this section. If *Yes*, please provide the information below for 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 five (5) year period (5 year period ending as of the date of this request). Attach separate sheet if necessary.

"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.

"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).

"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.

Name and Business Address of Wholly Owned Supplier or Subcontractor	**Provide One of the Following for the Wholly Owned Supplier or Subcontractor: SSN/EIN/TIN**	**Name and Address of the Owner of the Wholly Owned Supplier or Subcontractor (First/Middle/Last)**	**Transaction Amount**

By signing this form, I certify that the information provided is true and correct. I will notify LogistiCare Solutions, LLC if any information provided in this form changes. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security.

Name: _____ **Title:** _____
(print or type) (print or type)

Signature: _____ **Date:** _____

Text of 42 C.F.R. §455.105

§ 455.105 Disclosure by providers: Information related to business transactions.

(a) *Provider agreements.* A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) *Information that must be submitted.* A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) *Denial of Federal financial participation (FFP).* (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).

(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

NOTE: See 42 C.F.R. §101 for definitions of subcontractor, supplier and significant business transaction.