CONFLICT OF INTEREST ATTESTATION

Individual Providers
Disclosure of Ownership, Controlling Interest and Management Statement
Attestation of Criminal Convictions, Sanctions, Exclusions, Debarment or Termination

PIHPs must comply with federal regulations to collect disclosure of ownership, controlling interest and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid and/or the Children's Health Insurance Program (CHIP) by Region 10 PIHP or by a delegate of Region 10 PIHP, pursuant to a Medicaid contract with the MDHHS and the federal regulations set forth in 42 CFR §455. Required information includes 1) the identity of all owners and others with a controlling interest of 5% or greater; 2) certain business transactions as described in 42 CFR§455.105; 3) the identity of managers and others in a position of influence or authority; and 4) criminal conviction, sanction, exclusion, debarment or termination information for the provider, owners and managers. The information required includes, but is not limited to name, address, date of birth, social security number (SSN) and tax identification (TIN).

Completion and submission of a *Disclosure Statement* is a condition of participation as a credentialed or enrolled provider in Region 10 PIHP managed care network for services to members under Medicaid and CHIP benefit plans. Failure to submit the requested information may result in a refusal to enter into a provider contract, termination of existing contract, refusal of participation in the network or denial of a claim.

This Statement should be submitted at the time of credentialing, enrollment, or updated annually prior to the contract renewal period, and at any time there is a revision to the information, or upon a request for updated information. A Statement must be provided to Region 10 PIHP within 30 days of a request for this information by the U.S. Department of Health and Human Service (HHS) or the State Agency.

Detailed instructions and a glossary for capitalized terms can be found at the end of this form. If attachments are included, please indicate which section those attachments refer.

Individual Provider Information

Please fill out the entire section. Every field must be complete. If fields are left blank, the form will not be processed and will be returned for corrections/completeness. If the form is unreadable due to illegible handwriting, the form will not be processed.

<table>
<tr><td colspan="2">Please choose appropriate category:
☐Individual Member of a Medical Group
☐Individual Contracted Practitioner
☐Sole Proprietor
☐HCBS Provider
☐Other _____

If Affiliated with a Group, do you have a Private Practice as well?
☐Yes ☐ No ☐N/A</td><td colspan="2">Name of Person Completing Form</td></tr>
<tr><td colspan="2">Legal Name of Individual (Individual Provider)</td><td colspan="2">Name of Group (if applicable)</td></tr>
<tr><td colspan="4">Physical Address
Street City State Zip</td></tr>
<tr><td colspan="4">Additional Addresses (list all Practice locations – attach a separate sheet if necessary)</td></tr>
<tr><td>SSN #:</td><td>*Medicaid ID #</td><td>National Provider ID (NPI) #</td><td></td></tr>
<tr><td colspan="2">*If billing under an Entity: Federal Tax Identification #:</td><td colspan="2">*If billing under an Entity: Billing Entity's NPI#</td></tr>
<tr><td colspan="4">*If billing under an Entity: Billing Entity's Medicaid ID #</td></tr>
</table>

***These fields cannot be left blank; "N/A" non-applicable and "applied for" are acceptable responses**
****Individual providers please use social security number; field cannot be left blank; "N/A" non-applicable and "applied for" are acceptable responses**

CONFLICT OF INTEREST ATTESTATION

Section I: Individual Provider Ownership Information

Are there any individuals or organizations with a Direct or Indirect Ownership or Controlling Interest of 5% or more in the Individual Provider? ☐ Yes ☐No

If yes, list the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Controlling Interest in the Individual Provider of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box Address of each organization, corporation, or entity having an Ownership or Controlling Interest of 5% or greater (42 CFR §455.104). [*Attach additional sheets as necessary]*

Name of Owner	**DOB (mm/dd/yyyy)**	**Complete Address (Street/City/State/Zip)**	****SSN (individual) and/or TIN (entity)** *List both as applicable*	**% Interest**

****SSN and TIN required under §455.104; see Sect 4313 of Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No. 22**

Section II: Ownership in Other Providers & Entities

Does the Owner identified in **Section I** have an Ownership or Controlling Interest in any other *provider or entity*? ☐Yes ☐ No

If yes, list the name and the SSN or TIN of **the other provider or entity** in which the Owner identified in **Section I** also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3)). [*Attach additional sheets as necessary]*

Name of Owner from Section I	**Name of Other Provider or Entity**	**Other Provider or Entity's SSN (individual) or TIN (entity)**

Section III: Subcontractor Ownership

Do you have a Direct or Indirect Interest of 5% or more in any Subcontractor? ☐ Yes ☐ No

If yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor? ☐Yes ☐No

If yes, list information for each person entity with an Ownership or Controlling Interest in and Subcontractor in which you *also* have Direct or Indirect Ownership Interest of 5% or more (42 CFR §455.104). [*Attach additional sheets as necessary]*

Legal Name of Subcontractor			
Name of Subcontractor's Other Owner			
Other Owner's Complete Address (Street/City/State/Zip)			
Other Owner's TIN:	**Other Owner SSN:**	**Other Owner's DOB**	**%Interest in Subcontractor**

Section IV: Familial Relationships of All Owners

Are any of the individuals identified in Sections I, II, or III related to each other? ☐ Yes ☐No

If yes, list the individuals identified and the relationship to each other (e.g., spouse, domestic partner, sibling, parent, child) (42 CFR §455.104(b)(2)). [*Attach additional sheets as necessary]*

Name of Owner 1	**Name of Owner 2**	**Relationship**

Section V. Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations*

1. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been indicted or convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title X Program? ☐ Yes ☐ No

   If yes, list those persons and the required information below (42 CFR §455.106) [*Attach documentation and additional sheets as necessary]*

Name		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	**State of Conviction**
Complete Address (Street/City/State/Zip)		
Matter of the Offense		
State and Date of Conviction (mm/dd/yyyy)	**Date of Reinstatement (mm/dd/yyyy)**	

2. Have you, or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employed of your Individual Provider practice every been sanctioned, excluded or debarred from Medicaid, Medicare, CHIP or a Title XX program? ☐ Yes ☐No

   If yes, list those persons and the required information below (42 CFR §455.436) [*Attach documentation and additional sheets as necessary]*

Name		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	
Complete Address (Street/City/State/Zip)		
Reason for Sanction, Exclusion or Debarment		
Date(s) of Sanctions, Exclusions or Debarment (mm/dd/yyyy)	**Date of Reinstatement (mm/dd/yyyy)**	**List all States where currently excluded**

3. Have you, or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? ☐ Yes ☐ No

   If yes, list those persons and the required information below. (42 CFR §455.416) [*Attach documentation and additional sheets as necessary]*

Name		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	
Complete Address (Street/City/State/Zip)		
Reason for Termination:		
Date of Termination (mm/dd/yyyy)	**State that originated Termination**	**Date of Reinstatement (mm/dd/yyyy)**

***At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments, and terminations (See Fed. Register, Vol. 44 No. 138)**

Section VI: Business Transaction Information

Business Transactions – Subcontractors: Have you, the Individual Provider, had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? ☐ Yes ☐ No

If yes, list the information for Subcontractors with the whom the Individual Provider has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of the request. (42 CFR §455.105(b)(1)). [*Attach additional sheets as necessary]*

Name of Subcontractor		**Subcontractor's SSN (individual) or TIN (entity):**	
Subcontractor's Street Address	**City**	**State**	**Zip**
Name of Subcontractor's Owner:		**Subcontractor's Owner's SSN/TIN**	
Subcontractor's Owner's Street Address	**City**	**State**	**Zip**

Significant Business Transactions _ Wholly Owned Suppliers: Have you, the Individual Provider, had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? ☐Yes ☐No

If yes, list the information for any Wholly Owned Supplier with whom the Individual Provider has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5 year period (42 CFR §455.105(b)(2)). *See Glossary for definition. [Attach additional sheets as necessary]*

Name of Supplier			**Supplier's SSN (individual) or TIN (entity)**
Suppliers Street Address	**City**	**State**	**Zip**

Significant Business Transaction – Subcontractors: Have you, the Individual Provider, had any Significant Business Transactions with a Subcontractor exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? ☐Yes ☐No

If yes, list the information for Subcontractor with whom the Individual Provider has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5 year period (42 CFR §455.105(b)(2)). [*Attach additional sheets as necessary]*

Name of Subcontractor		**Subcontractor's SSN (individual) or TIN (entity)**	
Subcontractor's Street Address	**City**	**State**	**Zip**
Name of Subcontractor's Owner		**Subcontractor's Owner's SSN/TIN**	
Subcontractor's Owner's Street Address	**City**	**State**	**Zip**

This information must be provided and/or updated within 30 days of a request. *Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received.* (42 CFR §455.105)

CONFLICT OF INTEREST ATTESTATION

Section VII: Management & Control

Managing Employees: Individual Provider have any Managing Employees? ☐ Yes ☐ No

If yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of Provider Entity (e.g. general manager, business manager, administrator or director, executive officer, chief operating officer, chief financial officer, medical director, clinical program director, corporate compliance officer etc.), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CRR §455.104). [*Attach additional sheets as necessary]*

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN	Title

Agents: Do you, as an Individual Provider, have any Agents? ☐ Yes ☐ No

If yes, list all Agents that have been delegated the authority to obligate or act on behalf of you, the Individual Provider, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104). [*Attach additional sheets as necessary]*

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN

Board of Directors: Do you, as an Individual Provider, have a Board of Directors? ☐ Yes ☐ No

If yes, list each member of the Board of Directors or Governing Board for corporations, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104). [*Attach additional sheets as necessary]*

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN

Through signature below, I hereby certify that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial or participation and denial of claims.

Individual Provider must sign the form.

Signature _____ Title _____

Full Name [Please Print] _____ Date _____

Phone Number _____ Fax Number _____ Email Address _____

GLOSSARY

CHIP: The Federal insurance program for children, Child Health Insurance Program, in Michigan this is known as MIChild.

Provider Entity an individual or entity who operates as a Medicaid provider 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. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing entity.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

Ownership or Control Interest: an individual or corporation that –

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent 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;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership

Direct Ownership Interest: the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Indirect Ownership Interest: an ownership interest in an entity that has an ownership interest in the disclosing entity. This tern includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.

Controlling Interest: defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Determination of ownership or control percentages: (a) indirect ownership Interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. If A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to 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 which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied 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 equates to a 6 percent and must be reported. Conversely, 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 equates to a 4 percent and need not be reported.

Other Entity: any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, SV, III, or XX of the Act. This includes:
(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XV III);
(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Significant Business Transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand ($25,000) or five percent (5%) or a Provider Entity's total operating expenses.

Subcontractor: (a) an individual, agency, or organization to which a Provider 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 to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity.

Agent: any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

Managing Employee: A general manager, business manager, administrator, director or other individual who exercises operational or managerial control, or who directly or indirectly conducts the day-to-day operation of an institution. As an example, Region 10 defines its managing employees as: the CEO, COO, CIO, and CFO.

INSTRUCTIONS FOR DISCLOSURE OF OWNERSHIP/CONTROLLING INTEREST AND MANAGEMENT STATEMENT

If additional space is needed, please note on the form that the answer is being continued and attach a sheet referencing the section number that is being continued. (For example: Section I Ownership Information, continued). Please see Glossary for definitions of capitalized terms.

Section I: Provider Entity Ownership Information:
Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Controlling Interest in our entity. If the Owner is a corporation: the primary business address must be listed and every business location and P.O. Box address. Provider members of a group practice who have ownership or a controlling interest in Provider Entity must submit a separate Statement.

Providing the SSN and TIN (as applicable) is required under 42 CFR §455.104; The Balanced Budget Act of 1997 (BBA) (Public Law 105-33) section 4313, amended sections 1123 (a)(1) and 1124A of the Act to require disclosure of both the Employer Identification Number (EIN) and Social Security Number (SSN) of each provider or supplier, each person with ownership or control interest in the provider or supplier, as well as any managing employees. The Secretary of Health and Human Services (the Secretary) signed and send to the Congress a "Report to Congress on Steps Taken to Assure Confidentiality of Social Security Account Numbers as Required by the Balanced Budget Act" on January 26, 1999, with mandatory collection of SSNs and EINs effective on or about April 26, 1999.

Section II: Ownership in Other Providers & Entities:
Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section I that has an Ownership or Controlling Interest in your entity. This information is to identify shared and interconnected ownership and controlling interests.

Section III: Subcontractor Ownership:
If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

Section IV: Familial Relationships of All Owners:
Report whether any of the persons listed in Sections I, II, and III are related to each other and identify the parties and their relationship. For a definition of domestic partner, refer to your state's laws. Provider members of a group practice who are related to the Provider Entity's owners or those with a controlling interest must submit a separate Statement.

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations:
List your own criminal convictions, exclusions, sanctions, debarments and terminations, **and** for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information:

1. Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at https://oig.hhs.gov/exclusions/index.asp
2. Sanction information is available in the GSA's SAM (System for Award Management) database; www.sam.gov
3. State specific exclusion/sanction databases may be accessed through the State Agency's website, www.michigan.gov/medicaidproviders (Billing and Reimbursement/List of Sanctioned Providers)

Section VI: Business Transaction Information:
1. List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2. List any **Significant Business Transaction** between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any **Significant Business Transaction** between your entity and any Subcontractor during the past 5 years.

Remember that a **Significant Business Transaction** is defined as any transaction or series or related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year.

This information must be available within 30 days of a request by the U.S. Department of Health and Human Services (HHS), the State Medicaid Agency, and the Medicaid Managed Care Organization responding to an HHS or State request.

Section VII: Management & Control:
1. List the required information for all employees that hold a position of Managing Employee within your entity.
2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.
3. List the required information for all individuals on the governing board or board of directors if your entity is organized as a corporation. CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.