Credentialing Alliance

ORGANIZATIONAL FACILITY APPLICATION

Initial Credentialing—Failure to legibly complete all sections of this Application and submit current copies of all required documentation may result in processing delays

Submit this form and all required documents:

TCH_PROVIDEROPERATIONS@CENTENE.COM

HNOR_PROVIDEROPERATIONS@HEALTHNET.COM

INSTRUCTIONS:

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING PROVIDING ANY ATTACHMENTS, TO PREVENT DELAYS IN PROCESSING YOUR REQUEST.

PLEASE NOTE: FOR EVERY ORGANIZATION/FACILITY TYPE, A SEPARATE APPLICATION MUST BE COMPLETED.

*Action Required: If your practitioners are registered with CAQH, credentialing documents must be current and uploaded to CAQH. Please ensure that Centene Corp. is listed as an authorized plan.

Please include with your completed/signed application the following items for each location:

- ☐ Copy of current State License and/or business license for each location
- ☐ Copy of Medicare Certification letter (if applicable)
- ☐ Copy of Certifications and/or Accreditation Certificates (e.g. TJC,CHAP, etc)
- ☐ Copy of your CLIA Certificate (if applicable)
- ☐ Copy of your current *Professional Malpractice* Insurance Policies
- ☐ Accurate W9
- ☐ Organizational Attestation
- ☐ DEA (if applicable)
- ☐ DOO 3974 for the provider group name, TIN and group NPI (Medicaid enrollment only)
- ☐ Policy for Seclusion and Restraint, OAR 410-141-3590 (2) (cc)

Prior to completing this credentialing application, please read and observe the following:

INSTRUCTIONS
This form should be **typed (using a different font than the form) or legibly printed in black or blue ink**. If more space is needed than provided on the original, attach additional sheets and reference the question being answered.

- Modification to the wording or format of the Organizational Provider Credentialing Application will invalidate the application.
- Complete the application in its entirety. Please sign and date pages 7 and 9. Mail application to:

  Trillium Community Health Plans: TCH_ProviderOperations@centene.com

  Health Net of Oregon: HNOR_ProviderOperations@healthnet.com
- Identify the health care related organization(s) to which this application is being submitted in the space provided below.

IMPORTANT

Current copies of all applicable documentation requested in Section VIII, *Attachments*, must accompany this Application. Failure to complete all sections of this Application or submit all required documentation will constitute an incomplete application and will be returned to the provider without processing.

I am applying to (please list: Hospital Staff, HMO, IPA)_____

_____

_____for

_____ (i.e., staff membership, network participation, if applicable).

PLEASE USE A SEPARATE APPLICATION FOR MULTIPLE LOCATIONS

I. PROVIDER IDENTIFICATION

A. Corporate Identification Information

Furnish the provider's legal business name (as reported to the IRS) "doing business as" name (name provider generally known by to the public), and the various operating dates and places of formal business registration and/or incorporation. All payments will be issued in the provider's legal business name in compliance with IRS regulations.

1. Legal Business Name as Reported to the IRS (claims will be paid to this name)

2. "Doing Business As" (DBA) Name (if applicable)	County where DBA Name Registered (if applicable)
3. Address:	**4**. Tax Identification Number:

B. Current Practice Location(s)

Practice Location Name:

Practice Location Address Line 1:

Practice Location Address Line 2:

City:	State:	Zip:	County:

Phone: ( )	Fax: ( )	E-mail:

Primary Contact Name:	Contact Title:

Phone: ( )	Fax: ( )	E-mail:

Administrator (Full Name):

C. Mailing/Correspondence Address

This must be an address where provider can be contacted directly.

Check here ❑ if all correspondence can be directed to the practice location in Section B.

Mailing Address Line 1:

Mailing Address Line 2:

City:	State:	Zip:	County:

D. Type of Provider

Provider Type (*check all boxes that apply)*:

- ☐ Clinical Laboratories
- ☐ Comprehensive Outpatient Rehab Facility
- ☐ Durable Medical Equipment
- ☐ End-Stage Renal Disease Services
- ☐ Federally Qualified Health Centers
- ☐ Free Standing Laboratory
- ☐ Free Standing Surgical Center
- ☐ Hospice Agency
- ☐ Hospital
- ☐ Home Health Agency
- ☐ Outpatient Diabetes Self-Management Training
- ☐ Outpatient Physical Therapy
- ☐ Portable X-Ray Suppliers
- ☐ Rural Health Clinics
- ☐ Federally Qualified Health Center
- ☐ Skilled Nursing Facility
- ☐ Speech Pathology
- ☐ Urgent Care
- ☐ Other (explain): _____

_____

Behavioral Health Facility

Mental Health:

- ☐ Inpatient
- ☐ Residential
- ☐ Ambulatory Setting

Substance Abuse:

- ☐ Inpatient
- ☐ Residential
- ☐ Ambulatory Setting

E. Scope of Services

List all services provided at this facility:

- ☐ Acute Care
- ☐ Emergency Department (Level I, II, III, IV, V)
- ☐ PT, OT, Speech Therapy
- ☐ Imaging Department
- ☐ Laboratory/Pathology Department
- ☐ Skilled Nursing
- ☐ Outpatient Surgery
- ☐ Hospice
- ☐ Infusion Therapy
- ☐ Home Health
- ☐ Other _____

_____

_____

II. CERTIFICATION AND ACCREDITATION

A. Certification

1. Is this provider participating in the Medicare program? ❑ Yes ❑ No ❑ Pending

   If Yes, please provide the following:
2. Date of initial Medicare certification (MM/DD/YYYY): _____
3. Date of last full CMS survey* (MM/DD/YYYY): _____ _____

*if the provider is accredited by a national accreditation organization that has been granted deeming authority by CMS, the site survey performed by the accredited organization meets this requirement.

4. Were any deficiencies identified during the last full CMS/accreditation survey? ❑ Yes ❑ No

   If Yes, have all deficiencies been corrected?

   ❑ Yes (please provide evidence)

   ❑ No (please provide a complete copy of the most recent survey and any or all corrective action plans)

B. Accreditation

1. Is this provider accredited by a national accreditation organization? ❑ Yes ❑ No ❑ Pending

If Yes, please complete the following:

2. Check One:	❑ TJC ❑ URAC ❑ DNV/NIAHO	❑ AAAHC ❑ AAAASF ❑ CARF ❑ HFAP	❑ CHAP ❑ CLIA ❑ ACHC ❑ COA ❑ _____

Date of initial accreditation (MM/DD/YYYY): _____

3. Date of last survey (MM/DD/YYYY): _____

4. Name of Accreditation Organization: _____

5. Has the accreditation organization been granted deeming authority by CMS for this provider type?

❑ Yes ❑ No

6. Has this provider ever been denied accreditation by any accrediting body? ❑ Yes ❑ No

7. **If Yes,** please provide details below.

Details:

III. HEALTHCARE LICENSURE, REGISTRATION, CERTIFICATES, AND ID NUMBERS

	License #	Issue Date	Expiration Date	Licensing Agency
State of Oregon				
State of Washington				
Other:				

Medicare Number	Medicaid Number	NPI:
DEA Number (if applicable)		Expiration Date:

If the organizational provider does not have a Medicare Number, please submit an explanation:

IV. LIABILITY INSURANCE

This section is to be completed with information about the provider's professional liability and/or medical malpractice insurance including, but not limited to General Liability, Excess Liability, Umbrella and/or Reinsurance policies. If there is more than one carrier, copy and complete this section for each.

A copy of all face sheets showing current coverage amounts and expiration dates must be attached.

A. Current Coverage

Current Carrier Name:		Policy #:
Carrier Address:		Coverage Type: ❑ Occurrence Based ❑ Claims Based
City:	State:	Zip:
Effective Date:		Expiration Date:
Aggregate: $		Per Incident: $

V. CREDENTIALING PROGRAM

Contact Name:	Contact Title:	
Phone: ( )	Fax: ( )	Email:

Is there a formal credentialing program in place for health care professionals employed or contracted at the facility?
❑ Yes ❑ No

☐ **Credentialing procedures are performed internally**

☐ **Credentialing procedures are outsourced to: _____**

Include a description of how the facility conducts the credentialing process and clinical staff privileging program for each practitioner employed or contracted at your facility.

VI. RESTRAINT AND SECLUSION

Attach a copy of your policy & procedure related to the use of seclusion and restraint as required under the Code of Federal Regulations (CFR), 438.100

*policy must include:

- Measures to ensure patients are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

VII. PATIENT VISITATION - HOSPITALS ONLY

Attach a copy of your policy & procedure* regarding the visitation rights of patients as required under the Code of Federal Regulations (CFR), 482.013

*policy must include:

- Identifying any clinically necessary or reasonable restriction or limitation the hospital may need to place on such rights and
- The reasons for the clinical restriction or limitation

VIII. EXCLUSION CERTIFICATION

I hereby certify the on-line exclusion lists for the Health and Human Services, Office of Inspector General (OIG) and Systems for Awards Management (SAM) are checked for all new hires and annually for existing employees to ensure that no excluded employees work on any jobs related to any Federal health care programs. I also hereby certify that I will remove any employee found on one of the above-referenced lists from any work related to a Federal health care program.

_____ _____

Authorized Signature for Facility Date

_____ _____

Print Name Title

IX. ATTACHMENTS

This section is a list of documents that, if applicable, should be submitted with this completed enrollment application

Place a check next to each document (as applicable or required) from the list below that is being included with this completed application:

- ❑ Copy(s) of all Federal, State, and/or local professional licenses, certifications and/or registrations specifically required to operate as a health care facility.
- ❑ Copy(s) of all Federal, State, and/or local business licenses, certifications and/or registrations specifically required to operate as a health care facility.
- ❑ Copy(s) of all Accreditation Certificates and copy of most recent survey results.
- ❑ Copy(s) of Federal Register Final Notice documenting deeming authority to any applicable accrediting organization which exempts provider from the CMS survey process.
- ❑ Copy(s) of most recent CMS survey, including corrective action plan if deficiencies were cited and evidence from CMS that all deficiencies are remedied, if no CMS exemption provision applies.
- ❑ IRS documents confirming the tax identification number and legal business name (e.g., CP 575).
- ❑ Description of credentialing and clinical staff privileging program for health care professionals.
- ❑ Copy of your policy and procedure for Restraint and Seclusion and Patient Visitation
- ❑ Copy of your policy and procedure for Patient Visitation Rights at hospitals (applicable to hospitals)

X. SITE REVIEW (as required)

I hereby grant permission for the Health Care Organization or its designated agent to conduct on-site and/or medical record reviews as necessary. I further agree that this provider will participate in, and support the Healthcare Organization(s) Credentialing, Quality Improvement and Utilization Review Programs.

XI. ATTESTATION QUESTIONS

Please answer the following questions **"YES**" or "**NO**". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. Please sign and date each additional sheet. ***Modification to the wording or format will invalidate the application.***

1.	Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service?	❑ Yes ❑ No
2.	Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	❑ Yes ❑ No
3.	Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR Section 1001.101 or 1001.201?	❑ Yes ❑ No
4.	Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	❑ Yes ❑ No

XI. ATTESTATION QUESTIONS	
5. Has this provider, under any current or former name or business identity, ever had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.	❑ Yes ❑ No
6. Has this provider, under any current or former name or business identity, ever had accreditation revoked or suspended?	❑ Yes ❑ No
7. Has this provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program?	❑ Yes ❑ No
8. Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?	❑ Yes ❑ No
9. Does this provider utilize seclusion and restraints? If yes, do you have policies and procedures that apply to use of seclusion and restraints? If yes, please submit a copy of the Policies & Procedures with this application. If yes, do you have a committee that oversees proper use of seclusion and restraints?	❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No

_____ _____

Printed Name of Authorized Representative | Signature of Authorized Representative

_____ _____

Authorized Representative's Title | Date Signed

AUTHORIZATION AND RELEASE OF INFORMATION FORM

By submitting this application, it is agreed and understood that:

1. As a representative of the health care provider(s)/supplier(s) listed on this application, I understand that, as a contracted facility, the burden of producing adequate information for proper evaluation of licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions indicated in this application is upon the contracted provider or its representative.

2. I further understand and acknowledge that The Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, the provider(s)/supplier(s) agree to such investigation and to the HIPDB reporting and information as required by law as a part of the verification and credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which the provider(s)/supplier(s) have been associated and all professional liability insurers with which the provider (s)/supplier(s) have had or currently have professional liability insurance, who may have information bearing on the provider(s)/supplier(s) licensure, accreditation, Medicare certification, malpractice or sanctions to consult with The Healthcare Organization(s) or designated agent.

4. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating the provider(s)/supplier(s) application, and waive all legal claims against any representative of The Healthcare Organization(s) or its respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

5. I understand and agree that the authorizations and releases given by me herein shall be valid for three years according to The Healthcare Organization(s) cycle of recredentialing provided the provider(s)/ supplier(s) is actively pursuing or holds an active contract with The Healthcare Organization(s).

6. The provider(s)/supplier(s) agree to exhaust all available procedures and remedies as outlined in the rules, regulations, and policies, and/or contractual agreements of The Healthcare Organization(s) or its respective agent(s) before initiating judicial action.

7. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

8. I further acknowledge that failure to communicate any relevant information or to release any and all required documentation and authorizations in support of this application may be considered a request to withdraw from the credentialing process and participation with The Healthcare Organization.

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as The Healthcare Organization(s) Participating Provider or cause for summary dismissal from The Healthcare Organization(s) or be subject to applicable state or federal penalties for perjury.

Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with The Healthcare Organization(s) and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this provider by The Healthcare Organization(s) .

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

*This provider complies with all federal, state, and local handicapped access requirements as well as the standards required by the Federal Americans with Disabilities Act (ADA).

Signature: _____ Date: _____

Title: _____

Printed Name_____

As the authorized representative for the following provider(s)/supplier(s), I grant permission for the release of information related to licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions for the following provider(s)/supplier(s):

(Facility Name)	**City, State**
(Facility Name)	**City, State,**

Credentialing Alliance

ORGANIZATIONAL FACILITY APPLICATION

Organizational/Facility Assessment of Cognitive and Physical Disabilities Accommodations

Please identify what accommodations you provide at **each of your organizational facility locations** for members with cognitive or physical disabilities. If accommodations are the same at all locations, on Practice Location Address, please state ALL. Please, complete a separate Assessment for each location if accommodations vary.

Organizational Facility Location Address:

Accommodation	YES	NO	Comments
Provider/Staff trained to assist individuals with a cognitive disability, i.e., autism or intellectual disabilities			
Provider/Staff trained to assist individuals with a physical disability, i.e., mobility limitations or wheelchair bound			
Flexible appointment times available—sick appointments, same day appts—please specify			
Extended appointment times—before 8 am, after 5pm, Sat and/or Sunday—please specify			
Assistance available to members to fill out forms			
In-home and/or community services			
Large print materials			
Materials in electronic format			
Augmentative/Alternative communication devices			
TDD capabilities			
American Sign Language translator			
Signage with Braille and raised tactile text characters at office, elevator, stairwells and restroom doors mounted 60in from floor			
Visible & Audible alarms – emergency systems			
Dimmable Lights			
Ramps have non-slip surface material			
Railings between 30 & 38in high. On both sides.			
Paths are at least 36in wide and free of protruding objects			
Cane detectible objects on ground as a warning barrier			
Widened doorways (at least 32in clearance)			
Offset (swing-clear) hinges			
Power assisted or automatic door openers			
Door handles no higher than 48in			
Lever or loop handles vs knobs			
5ft circle or T-shaped space for turning a wheelchair completely			

Accommodation	YES	NO	Comments
A clear floor space, 30" x 48" minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer			
Adjustable height exam table or chair (lowers to 17-19in from floor)			
Positioning and support aids, such as wedges, rolled up blankets, straps and rails			
Ceiling or floor based patient lift			
Gurneys and/or stretchers			
Wheelchair accessible scales			
Adjustable height radiologic equipment			
Handicap parking			
Handicap accessible restroom			
Access ramps			
Accessible by bus			
Accessible by Valley Metro Rail			
Accessible by Taxi or similar options i.e., Uber/Lyft			
Provider/Staff has completed cultural competence training			
Do you provide Field Clinic services? (A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis)			
Do you provide Virtual Clinic services? (Integrated services provided in community settings through the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings)			

Attestation Statement

INSTRUCTIONS: Please complete either **Section A *or* Section B** for consideration to participate in the provider network. For any "Yes" response to one or more of the questions in Section B, complete the attached Attestation Question Explanation Form.

This attestation pertains to all employed and contracted provider(s) authorized to provide or supervise care provided by _____(the "Agency").

I, _____ , the undersigned representative of Agency, on its behalf, understand and agree that as part of the credentialing process for participation in the Health Plan provider network,

Section A

…attest that the Agency has conducted the following on each caregiver prior to allowing each to provide care to a Health Plan member:

☐
- Criminal Background Check *and*;
- State Child Abuse Registry *and*;
- Other State Mandated Clearance Checks

Section B

…assure through a background check and other reasonable means the following with respect to each caregiver providing care and each attendant supervising care on behalf of the Agency:

☐ YES	☐ NO	1.	Have applicable license(s) held by caregiver(s) and/or attendant(s) been revoked, refused, restricted or voluntarily surrendered?
☐ YES	☐ NO	2.	Have caregiver(s) and/or attendant(s) been convicted of, or pled guilty to, a felony?
☐ YES	☐ NO	3.	Has any caregiver or attendant been terminated, suspended, barred, sanctioned or voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program?
☐ YES	☐ NO	4.	Is/Are caregiver(s) and/or attendant(s) unable to perform the essential functions of his or her job with reasonable accommodation?

Signature: _____

Print: _____

Title: _____

Date: _____

Tax ID: _____

Attestation Question Explanation Form

Use this form to report any "Yes" response to one or more of the questions on the Attestation Statement. Record the question number in the first column, then your explanation in the second column. If you need additional space to explain a "Yes" response, photocopy this page as needed.

QUESTION #	EXPLANATION:

HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Print Save Reset

Oregon Medicaid

(Oregon Health Plan)

Provider Disclosure Statement of Ownership and Control, Business Transactions and Criminal Convictions

All pages of this form must be returned even if pages are blank. This form supersedes any previous form received for this enrolled / enrolling provider.

Please check the box that explains the reason for disclosure:

- ☐ New Enrollment
- ☐ Re-enrollment
- ☐ Revalidation
- ☐ Change in ownership
- ☐ Change in managing employee
- ☐ Removal of owner or managing employee ***see page 12***
- ☐ Removal of director or officer *if organized as a corporation* ***see page 12***

Organization Information (disclosing entity)

Organization legal name:	
Doing Business As (DBA) name *(if applicable)*:	Federal Employer Identification Number (EIN) (## - ########):
National Provider Identifier (NPI):	Existing Medicaid Provider ID (MCD) *(if known)*:
Business address (not mailing) Street: City: State: Zip:	

Business type *(check one)*

- ☐ Corporation
- ☐ Government-owned
- ☐ Limited Liability Corporation (LLC)
- ☐ Limited Liability Partnership (LLP)
- ☐ Limited Partnership
- ☐ Not-for-profit
- ☐ Partnership
- ☐ Professional Corporation
- ☐ Tribally owned
- ☐ Other: *(enter below)* _____

Is the disclosing entity organized as a corporation? ☐ Yes ☐ No
If yes, complete Section II, Question 2 and 3 are also required.

Purpose

Federal law requires a State Medicaid Agency (SMA) to complete Federal database checks on newly enrolling, enrolled, and revalidating providers. This includes any person (individual or organization) with an ownership or control interest or who is a managing employee of the provider (disclosing entity). See 42 CFR § 455.436

Disclosure of Social Security Number (SSN) is ***required*** pursuant to 41 USC 405(c)(2)(C)(i) to establish identification, 42 CFR 455.104 and 455.436 for exclusion verification and 26 CFR 301.6109-1 for the purpose of reporting tax information. OHA may report information to the Internal Revenue Service (IRS) and the Oregon Department of Revenue under the name, Social Security Number (SSN) or Federal Employer Identification Number (FEIN) provided on this application. See 42 U.S.C. § 1320a-3, 42 U.S.C. § 405 (c)(1) and OHA's Privacy Policy and Disclosure Notice to learn more about this requirement.

Agent / Authorized Signer Information *see Glossary for definition.*

Agent name:	Agent email:
Agent phone number (### - ### - ####):	Agent fax number (### - ### - ####):

If the contact person for this request is different than the Agent listed above, list contact person below.

Contact name:	Contact email:
Contact phone number (### - ### - ####):	Contact fax number (### - ### - ####):

Section I: Identification of All Owners

Section I, Question 1:
List all individual(s) and/or organization(s) with a **Direct or Indirect Ownership** of 5% or more. *Refer to glossary to determine who should be listed as an Owner and/or to calculate Ownership Interest.*
Individuals: List the name, primary business address, date of birth (DOB) and Social Security Number (SSN) for each person having a 5% or greater Ownership Interest in the Entity.

Entities: List the name, Tax Identification Number (TIN), primary business address, every business location and PO Box address of each organization, corporation, or entity having 5% or greater Ownership Interest. *Use Section IV to list the other business locations.*
Note: If there are 1 – 7 owners, fill out the chart below. If there are 8 or more owners, attach a list with the required fields labeled, "Section 1, Question 1".
Check this box if you attached a list. ☐

Check box ☐ If there are no owners or if there are owners, but all have less than 5% ownership.

Name of Owner	Complete Address	DOB (Individual) SSN (Individual) TIN (entity)	% Interest
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	

Section II: Identification of All Individuals & Entities with a Controlling Interest

Section II, Question 1: Managing Employee(s) *Refer to glossary for definition.*
List each individual who is a managing employee of the disclosed entity. Information to be disclosed must include name, date of birth (DOB), primary business address and Social Security Number (SSN). If no managing employee(s) is listed, form will be returned as incomplete.

Note: If there are 1 – 8 managing employees, fill out the chart below. If there are 9 or more managing employees, attach a list with the required fields labeled, "Section 2, Question 1".

Check this box if you attached a list. ☐

Name of Managing Employee	Complete Address	SSN *(Individual)*	DOB *(Individual)*
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		

Section II, Question 2: Officers *Refer to glossary for definition.*
This question is required if indicated on page 1 that the disclosing entity is organized as a corporation.

List each individual who is an officer of the disclosing entity. Information to be disclosed must include name, date of birth (DOB), primary business address and Social Security Number (SSN)

Note: If there are 1 – 8 officers, fill out the chart below. If there are 9 or more officers, attach a list with the required fields labeled, "Section 2, Question 2".

Check this box if you attached a list. ☐

Name of Officer	Complete Address	SSN *(Individual)*	DOB *(Individual)*
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		

Section II, Question 3: Directors *Refer to glossary for definition.*
This question is required if indicated on page 1 that the disclosing entity is organized as a corporation.

List each individual who is a director of the disclosing entity. Information to be disclosed must include name, date of birth (DOB), address and Social Security Number (SSN)

Note: If there are 1 – 8 directors, fill out the chart below. If there are 9 or more directors, attach a list with the required fields labeled, "Section 2, Question 3".

Check this box if you attached a list. ☐

Name of Director	Complete Address	SSN *(Individual)*	DOB *(Individual)*
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		
	Street: City: State: Zip:		

Section II, Question 4: Controlling Interest
Complete this question if there are any other individuals or organizations with a **Controlling Interest** in the disclosing entity. *Refer to glossary for definition.*

List the name, address, date of birth (DOB) and Social Security Number (SSN) for each person who has a Controlling Interest in the disclosing entity. List the name, Tax Identification Number (TIN), primary business address, every business location and PO Box Address of each organization, corporation, entity having a Controlling Interest.

Note: If there are 1 – 7 individuals/organizations with Controlling Interest, fill out the chart below. If there are 8 or more individuals/organizations with Controlling Interest, attach a list with the required fields labeled, "Section 2, Question 4".

Check this box if you attached a list. ☐

Name of Individual or Organization	Complete Address	DOB (Individual) SSN (Individual) TIN (entity)	Title *(as applicable)*
	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	
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	Street: City: State: Zip:	DOB: SSN/TIN:	
	Street: City: State: Zip:	DOB: SSN/TIN:	

Section III: Ownership & Controlling Interest in Other Disclosing Entities

Section III, Question 1:
Complete this question if the individuals or organizations *identified in* ***Section I*** as an owner have an Ownership or Controlling Interest in any **Other Disclosing Entity**? *Refer to glossary for definition.*

List the name and SSN or TIN of the Other Disclosing Entity in which the Owner identified in ***Section I*** also has an Ownership or Controlling Interest

Note: If there are 1 – 10 owners, fill out the chart below. If there are 11 or more owners, attach a list with the required fields labeled, "Section 3, Question 1".

Check this box if you attached a list. ☐

Name of Owner Listed in Section I	Name of Other Disclosing Entity	Other Disclosing Entity's SSN (individual) or TIN (entity)

Section IV: Ownership & Controlling Interest in Subcontractors

Section IV, Question 1:
If the disclosing entity has a Direct or Indirect Ownership Interest of 5% or more in any **Subcontractor,** list those below. *Refer to glossary for definition.*

If an individual or organization with an Ownership or Controlling Interest in any Subcontractor in which the disclosing entity ***also has*** Direct or Indirect Ownership Interest of 5% or more, list those below.

Note: If there are 1 – 2 subcontractors, fill out the chart below. If there are 3 or more subcontractors, attach a list with the required fields labeled, "Section 4, Question 1".
Check this box if you attached a list. ☐

Legal Name of Subcontractor:			Subcontract TIN/SSN:
Name of *Other Individual/Organization with Ownership or Controlling Interest*:			
Other *Individual/Organization's* Complete Address (Street/City/State/Zip) Street: City:		State:	Zip:
Other Organization's TIN:	*Other Individual's SSN*:	*Other Individual's DOB*:	% Interest in Subcontractor:

Legal Name of Subcontractor:			Subcontract TIN/SSN:
Name of *Other Individual/Organization with Ownership or Controlling Interest*:			
Other *Individual/Organization's* Complete Address (Street/City/State/Zip) Street: City:		State:	Zip:
Other Organization's TIN:	*Other Individual's SSN*:	*Other Individual's DOB*:	% Interest in Subcontractor:

Section V: Family Relationships

Section V, Question 1:
If any of the individuals identified in Sections I, II, III or IV, are related to each other (e.g., spouse, sibling, parent, child), list the individuals and relationship to each other.

Note: If there are 1 – 4 relationships, fill out the chart below. If there are 5 or more relationships, attach a list with the required fields labeled, "Section 5, Question 1".

Check this box if you attached a list. ☐

Name of Individual #1	Name of Individual #2	Relationship

Section VI: Criminal Convictions, Sanction, Exclusions, Debarment and Terminations

Section VI, Question 1:
If the disclosing entity, or any person who has an Ownership or Controlling Interest in the disclosing entity, or who is an Agent or Managing Employee of the disclosing entity **ever been convicted of a crime** related to that person's involvement in any program under Medicaid, Medicare, CCHIP or Title XX program since the inception of those programs, list those individuals and the required information below.

Note: If providing additional documentation, attach a list with the required fields labeled "Section VI, Question1".

Do you have additional documentation to attach? ☐ Yes ☐ No

Name:		
DOB:	SSN (individual) or TIN (entity):	State of Conviction:
Complete Address (Street/City/State/Zip) Street: City: State: Zip:		
Matter of the Offense:		
Date of Conviction:	Date of Reinstatement *(enter N/A if not reinstated)*:	

Section VI, Question 2:
If the disclosing entity, or any person who has an Ownership or Controlling Interest in the disclosing entity, or who is an Agent or Managing Employee of the disclosing entity has **ever been sanctioned, excluded, or debarred** from Medicaid, Medicare, CCHIP or Title XX program, list those individuals and the required information below.

Note: If providing additional documentation, attach a list with the required fields labeled "Section VI, Question2".

Do you have additional documentation to attach? ☐ Yes ☐ No

Name:	
DOB:	SSN (individual) or TIN (entity) :
Complete Address (Street/City/State/Zip) Street: City: State: Zip:	
Reason for Sanction, Exclusion or Debarment:	
Date(s) of Sanctions, Exclusions or Debarments:	Date of Reinstatement *(enter N/A if not reinstated)*:
List all States where currently excluded:	

Section VII: Removal of Owner(s) or Managing employee(s)

If additional space is needed to list the name(s) of previous owners or managing employees who need to be removed from the enrollment record, please enclose a separate page listing the name(s), DOB, SSN or TIN.

If removing owner(s), complete section I, question 1 to either update ownership percentage for existing owner(s) or to add new 5% or more owner(s).

Name of Owner	**SSN (*Individual*)** **TIN (*entity*)**	**DOB (*Individual*)**

Complete the corresponding section(s) above if adding individuals to replace those removed.

Name of Managing Employee	**SSN *(Individual)***	**DOB *(Individual)***

Name of Director or Officer	**SSN *(Individual)***	**DOB *(Individual)***

Section VIII: Business Transaction Information

Section VII is not required at the time of supplying this form but may be required upon request of CMS or the State Medicaid Agency (SMA). By signing this form, you are acknowledging that you will supply the following information within 35 days if requested by the Secretary of Health and Human Services or the SMA.

Section VII, Question 1: Business Transactions – Subcontractors

List the information for Subcontractors with whom the disclosing entity has had business transactions totaling more than $25,000 during the previous 12-month period ending on the date of the request.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractors Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN (individual) or TIN (entity), and Subcontractor Owner's Address

Section VIII, Question 2: Significant Business Transactions – Wholly Owned Suppliers

List the information of any Wholly Owned Supplier with whom the disclosing entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period.

- Name of Supplier, Supplier's SSN (individual) or TIN (entity), and Supplier's Address

Section VIII, Question 3: Significant Business Transactions – Subcontractors

List the information for Subcontractor with whom the disclosing entity has had any Significant Business Transactions exceeding the lesser or $25,000 or 5% of operating expensed during any one fiscal year in the past 5-year period.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractors Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN (individual) or TIN (entity), and Subcontractor Owner's Address

Disclosing entity's attestation, signature and date

I certify that the information on this form, and any attached statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that by knowingly providing false information on this form or in connection with any claim for payment from the State of Oregon, which may include federal funds, I may be liable for a false claim under the Oregon False Claims Act (ORS 1807.750 to 180.785) and the federal False Claims Act (31 USC 3279 to 3733). I agree to inform OHA or its designee, in writing, within 30 days of any changes or if additional information becomes available.

Print name of Provider Agent / Authorized Signer	Title
Signature of Provider Agent / Authorized Signer	Date

Glossary – many of these definitions have been sourced from **42 CFR § 455.101.**

Agent: means any person who has been delegated the authority to obligate or act on behalf of a provider. This individual also acts as an authorized signer for the entity.

Direct Ownership Interest: An individual or entity that possesses equity in the capital, the stock, or the profits of the disclosing entity. Ownership Interest also includes an interest in any mortgage, deed of trust, note, or other obligations.

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 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 4 percent and need not be reported (42 CFR §455.102).

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Indirect Ownership Interest: An individual or entity that has an ownership interest in an entity that has a direct or indirect ownership interest in the disclosing entity.

The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, 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 (42 CFR §455.102).

Managing Employee: 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.

Managed Care Entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Officers and directors: All officers and directors must be disclosed if the disclosing entity is organized as a corporation. *See question on page 1*. This includes board members, board of directors, volunteers, and if a non-profit corporation has "trustees" instead of officers or directors, these trustees must be disclosed. To clarify further on "director" this would not be the Finance Director unless the Finance Director is also on the Board of Directors. However, if the Finance Director meets the definition of a managing employee, then the Finance Director should be disclosed as a managing employee.

Other Disclosing 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, XV 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
(b) (title XV III);
(c) Any Medicare intermediary or carrier; and

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.

Person with an ownership or control interest means a person or corporation that;

(a) Has an ownership interest totaling 5 percent of 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 or indirect ownership interests equal to 5 percent of more in a disclosing entity;
(d) 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;
(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.

Significant Business Transaction: means any business transaction or series of related that, during any one fiscal year, exceeds the lesser of $25,000 or five percent (5%) of a providers total operating expenses.

Subcontractor:

(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, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Provider Enrollment at provider.enrollment@odhsoha.oregon.gov or 1-800-336-6016 (voice). We accept all relay calls.