MetroPlusHealth

Clear Form

Disclosures of Ownership and Control

Name of Provider/Organization: _____ **TIN:** _____

Instructions: If you answer "Yes" to any of the questions below, please provide the requested information in the space provided.

Please Note: New York State requires ALL providers/organizations provide ownership or controlling interest information (Question 1) AND/OR managing employee information (Question 2). The form will be recorded as incomplete without this information and it will delay your credentialing with MetroPlus.

	Yes	No
1. Are there any persons (individual or entity) with an ownership or controlling interest (5% or more) in the disclosing entity?	☐	☐

Name	Date of Birth	SSN/TIN	Title/Position	Address	Ownership Percentage

2. Does the disclosing entity have any managing employees?	☐	☐

Name	Date of Birth	SSN/TIN	Title/Position	Address	NPI

3. Does the entity, its owners or managing employees have an ownership or controlling interest (5% or more) in MetroPlus or does it/they act as agent of the Plan?	☐	☐

Name	Date of Birth	SSN/TIN	Title/Position	Address	Ownership Percentage

4. Do any of the entity's owner's or managing employee's spouse, parent, child or sibling have an ownership or control interest (5% or more) in MetroPlus or does an owner's or managing employee's spouse, parent, child or sibling act as an agent of the Plan?	☐	☐

Name	Date of Birth	Nature of Relationship	Name of Related Individual

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	Yes	No
5. Does the disclosing entity, its owners, or managing employees have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor?	☐	☐

Name of Subcontractor	Date of Birth	SSN/TIN	Type of Entity	Address	Ownership Percentage

6. Does the disclosing entity's owners or managing employee's spouse, parent, child or sibling have an ownership or control interest (5% or more) in any Subcontractor or do any of the disclosing entity's owner's or managing employee's spouse, parent, child or sibling act as an agent of the Subcontractor? If yes, please disclose the nature of the relationship.	☐	☐

Name	Date of Birth	Nature of Relationship	Name of Related Individual

7. Has the disclosing entity, its owners, or managing employees, had any Significant Business Transactions totaling more than $25,000 in the previous twelve (12) month period (as of the date of this request) with a wholly or partially owned subcontractor and have they had any Significant Business Transactions with a wholly owned supplier or subcontractor during the previous five (5) year period from the date of this submission?	☐	☐

Name	Date of Birth	SSN/TIN	Type of Entity	Address	Transaction Amount

8. Does the disclosing entity or anyone disclosed above have an Ownership or Control interest in any other Medicaid Provider? Or, disclosing entity that *does not* participate in Medicaid but is required to disclose ownership and control information due to participation in any of the programs established under Title V (Maternal and Child Health Services Block Grant), XVII (Medicare), XX (Block Grants to States for Social Services), or Title XXI (State Children's Health Insurance Program) of the Social Security Act?	☐	☐

Name	Name of Other Disclosing Entity of Other Medicaid Provider	SSN/TIN of the other disclosing entity of Medicaid Provider

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	Yes	No
9. Has any person with ownership or controlling interest in the disclosing entity or an agent or managing employee of the disclosing entity 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?	☐	☐

Name	Date of Birth	SSN/TIN	Description of Offense

By my signature, I hereby attest that the information is complete and accurate, and I agree to provide information as required to support this application. I understand that I have a continuing obligation to amend and update my answers as necessary to ensure accuracy and completeness of the responses. I further understand that the submission of false and/or significantly misleading information or the withholding of relevant information is grounds for termination of the agreement.

Name:_____ Title:_____
(Person Completing Form)

Signature:_____ Name of Practice/Facility: _____

Date:_____