sunshine health

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT INSTRUCTIONS -FACILITIES

Practice Information Section

Type of Entity Check Box – Check the box that most closely describes the type of entity you are contracting as. See the Definitions Page to assist in determine if the practice/entity is an Individual, Group Practice or Disclosing Entity.

Name of Individual, Group Practice or Disclosing Entity – Provide the name of the entity you are contracting as. If you are an individual practitioner who is participating through a Group Practice, enter your individual name here.

DBA name (if applicable) – If you are completing the form as a Disclosing Entity or Group Practice, enter any DBA name that your entity may utilize here. If you are an individual practitioner who is participating through a Group Practice, enter the Group Practice name here.

Address – Provide the main physical address of practice/Entity you are contracting as.

Federal Tax ID Number – Enter the Federal Tax ID Number for your Disclosing Entity or Group Practice. If you are an individual who is also participating through a Group Practice, enter your individual Federal Tax ID number here.

Section I – Provide the all information requested for any individual or entity with an ownership or controlling interest of 5% or greater in the Practice/Entity, *this includes date of birth and social security number. Provide all information requested for any general manager, business manager, administrator, director, or other individual who exercises operational or managerial control of the disclosing entity, this includes date of birth and social security number.*

Please note changes to Florida Statute, (F.S.) 408.809 Chapter 435, took effect July 1, 2018. The change amends the statute to require background screening for any person who is considered a controlling interest, owner, managing employee, or principal disclosing entity. Provide the information requested in order to confirm completion of background screening or to initiate a new screening.

Section II – Indicate whether or not any individuals listed in Section I are related to each other by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, list any owners that are related to each other and the type of relationship in the rows provided, attach a separate sheet if necessary to provide all information.

Section III – Indicate whether or not the Disclosing Entity has a 5% or more direct or indirect ownership in a subcontractor by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each subcontracted entity of which the Disclosing Entity has a 5% or more direct or indirect ownership.

Section IV – Indicate whether or not there are any individuals who have an ownership or control interest in the Disclosing Entity, or is an agent or managing employee of the Disclosing Entity who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Social Security Title XX services program since the inception of those programs by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each individual.

Section V – Indicate by checking either the Yes or No box whether or not the practice/entity has had any financial transaction with a subcontractor totaling more than $25,000 in the 12 months prior to the completion date of this form or any significant business transaction (see definitions) between the practice/entity and a wholly owned supplier or between the practice/entity and any subcontractor in the 5 years prior to the completion date of this form. If yes, provider the Name, address

Section VI – If the practice/entity is completing this form as a Disclosing Entity, as indicated in the Practice/Entity Information section, check yes and list each member of the Board of Directors or Governing Board including the name, date of birth, address, social security number (SSN) and percent of interest (if known at the time of completion). If your practice/entity is not a Disclosing Entity,

Signature/Title/Date – Provide the printed name, signature and title of the individual completing the form either for themselves if an individual practitioner on behalf of a disclosing entity. In the date field, enter the date the form was completed.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT INSTRUCTIONS -FACILITIES

Definitions

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

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

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

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.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person 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 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 transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

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).

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.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT INSTRUCTIONS - FACILITIES

Determination of Ownership or Control Percentages

Indirect ownership interest. 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.

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 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.

Provider Type Scenarios

Sole Practitioner – Sole Practitioners would identify themselves as Individuals, indicate "None" in Section I, indicate "Yes" or "No" in the remaining check boxes as appropriate then sign and date the form.

Group of Practitioners – the Group Practice being contracted with the Health Plan would fill out one Disclosure and Control Interest form for the Group Practice. The individual practitioners participating in the Group Practice, either as employees or co-owners, would each fill out a Disclosure and Control interest form for themselves as an Individual and list the Group Practice name in the "DBA Name" section, use the Group Practice address and use their own individual Federal Tax ID number.

Hospital or Hospital System – The Hospital would fill out one Disclosure and Control Interest form as a Disclosing Entity. We do not need a separate Disclosure and Control interest form for each practitioner who contracts and bills through the Hospital entity.

Independent Clinical Lab – The entity would fill out one Disclosure and Control Interest form as a Disclosing Entity. If the Independent Clinical Lab employs a group of practitioners that will be enrolled with the Health Plan, each practitioner would fill out a Disclosure and Control Interest form for themselves as an Individual and list the Independent Clinic Lab name in the "DBA Name" section, use the Independent Clinic Lab address and use their own individual Federal Tax ID number.

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DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT - FACILITIES

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to Sunshine Health within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Entity:
DBA Name:
Address:
Federal Tax Identification Number:

Section I

List the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater. List the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. *Per 42 CFR 455.104, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) of any general manager, business manager, administrator, director, or other individual who exercises operational or managerial control of the disclosing entity. Please attach a separate sheet if necessary.*

Name of individual or entity	Title	Address	DOB	SSN (if listing an individual) TIN (if listing an entity)

Please refer to attached addendum and grid for updated background requirements

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐ Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

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DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT - FACILITIES

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX Program? ☐ Yes ☐ No (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. 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 of participation.

Signature _____ Title (or indicate if authorized Agent) _____

Name (please print) _____ Date _____

Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

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DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT - FACILITIES

AHCA LEVEL II BACKGROUND SCREENING REQUIREMENTS ADDENDUM

The following is a summary of Chapter 2018-24, Laws of Florida, (SB 622) that apply to employees and contractors of health care providers licensed through the Agency for Health Care Administration and other employees subject to Chapter 435. The changes to section 408.809 and Chapter 435, Florida Statutes, (F.S.) take effect July 1, 2018:

- The bill amends s. 408.809, F.S., to require background screening for any person who is a controlling interest, contractors with a licensee or provider who work for 20 hours or more per week and have access to client funds, personal property, or living areas. The contractor's employer or the licensee may retain evidence of contractor screening.
- The bill amends s. 395.1055, F.S., to require Level 2 background screening for personnel of distinct part nursing units of hospitals who provide personal care or services directly to clients or have access to client funds, personal property, or living areas.

***Please provide copies of the Level II Background results based on AHCA's Level II Background Screening Requirements Grid by Facility/Service Type in the next page. If background results are not available, please provide the Social Security number and Date of Birth so that the plan can initiate the screening process. ***

Name	Position Title	% of Owner-ship	Social Security Number	Date of Birth	Background Results Attached (Yes/No)

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DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT - FACILITIES

AHCA LEVEL II BACKGROUND SCREENING REQUIREMENTS GRID BY FACILITY/SERVICE TYPE

Facility/Service Type	Owner/Administrator Controlling Interest	Financial Officer	Employees and Contractors Providing Personal Care/Services	Employees that have access to client property, funds, or living areas	Contractors who work 20 hours a week or more who will have access to client funds, personal property, or living areas.
Abortion Clinics Ambulatory Surgery Centers Birth Centers Drug Free Workplace Multiphasic Health Testing Centers Organ Procurement Organizations, Tissue Banks, Eye Banks	Level 2	Level 2	N/A	N/A	N/A
Adult Day Care Centers	Level 2	Level 2	Level 2	Level 2	Level 2
Adult Family Care Homes		(Excluding Adult Family Care Homes)		(Volunteers working in a Hospice are considered employees and are required to undergo Level 2 screening)	
Assisted Living Facilities Health Care Service Pools Home Health Agencies Homemaker/Sitter/Companion Home Medical Equipment Providers Homes for Special Services Hospice Intermediate Care Facilities for the Developmentally Disabled Nurse Registries Nursing Homes Prescribed Pediatric Extended Care Transitional Living Facilities					
Community Mental Health	Level 2	Level 2	Level 2	Level 2	Level 2
Crisis Stabilization Units	(Excludes Community Mental Health)	(Excludes Community Mental Health)		(Includes volunteers unless they work less than 10 hours/month as long as the volunteer is within the line of sight of an employee that has successfully completed a Level	
Residential Treatment Centers for Children and Adolescents Residential Treatment Facilities Short Term Residential Treatment Facilities					
Health Care Clinics	Level 2 (Includes owners with 5% or more interest in the clinic)	Level 2	Level 2	Level 2	Level 2
Hospitals	Level 2	Level 2	Level 2 (Only applies to staff working within mental health or psychiatric centers)	N/A	N/A