

# Disclosure of Ownership and Control Interest of an Entity

UnitedHealthcare Community Plan of Minnesota (“UnitedHealthcare”) is required to collect disclosure of ownership, controlling interest and management information from providers that participate in the Medicaid managed care network pursuant to a Medicaid contracts with the State Agency and the federal regulations set forth in 42 CFR Part §455.

Required information includes:

- 1) The identity of all owners and others with a controlling interest
- 2) Certain business transactions as described in 42 CFR §455.105
- 3) The identity of managing employees, agents and others in a position of influence or authority
- 4) Criminal conviction information for the provider, owners, officers, directors, agents and managing employees

The information required includes, but it is not limited to, name, address, date of birth, Social Security number (SSN) and tax identification number (TIN).

Providers participating in the UnitedHealthcare Medicaid managed care network must complete and submit the disclosure statement below in accordance with the terms of their Participation Agreement and as a condition of participation in Medicaid. Failure to submit the requested information may result in claims denials, exclusion from the UnitedHealthcare network or termination of an existing provider agreement.

This statement should be submitted with the initial contract and updated:

- Every five (5) years
- Upon renewal of the Participation Agreement
- At any time there is a revision to the information
- Within 35 days of a request for updated information

## Disclosing entity identifying information and structure

Entity’s legal name according to IRS	Entity’s doing business as name (DBA)		
Provider type	NPI or UMPI	Office phone number	
Facility address	City	State	ZIP code
Federal employer ID (FEIN)	Minnesota tax ID number		
<p>Check the entity type that describes the enrolling provider:</p> <p> <input type="checkbox"/> Sole proprietorship 2                  <input type="checkbox"/> Partnership 6                  <input type="checkbox"/> Corporation, LLC 7                  <input type="checkbox"/> Nonprofit 1  <input type="checkbox"/> Hospital-based clinic 3                  <input type="checkbox"/> State 4                  <input type="checkbox"/> Public 5                  <input type="checkbox"/> Professional association 9  <input type="checkbox"/> Other X (i.e., LP, LLP, LLLP)                  Specify Type: _____         </p>			

Each provider entity must complete the following sections for all people, businesses or organizations that meet any of the following criteria:

- Have an ownership or control interest of 5% or more in this disclosing entity
- Have an ownership or control interest in a subcontractor in which this disclosing entity has a direct or indirect ownership interest of 5% or more
- Are a managing employee (see definitions on page 5)

**For a person:** If you list a person, you must include that person’s SSN and residential (home) address.

**For a business:** If you list a business, you must include the business’ federal tax ID (FEIN) and primary business address for every business location (including street address) and every post office box address.

## Individual person(s) ownership or control interest

List all individual owners, managing employees and persons with control interest. See instructions on page 6 for more information about completing this section.

Are you a(n) (check all that apply): <input type="checkbox"/> Owner – List percent of ownership interest if 5% or more: _____ <input type="checkbox"/> Board member, officer or business and finance controller – CEO, CFO, COO, CTO <input type="checkbox"/> Managing employee (not CEO, CFO, COO, CTO) <input type="checkbox"/> Authorized agent <input type="checkbox"/> Other: _____					<input type="checkbox"/> Indirect owner – List percent of ownership interest if 5% or more: _____ Entity name: _____ <input type="checkbox"/> Trustee <input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor): _____				
Full legal name (Last)		First		Middle		Social Security number (SSN)		Date of birth	
Address			City		State	ZIP code		County/Indian reservation	
<input type="checkbox"/> Hire date _____ (mm/dd/yyyy) <input type="checkbox"/> Termination date _____ (mm/dd/yyyy)			Relationship to any other listed person <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling			Background study number/request ID			

Are you a(n) (check all that apply): <input type="checkbox"/> Owner – List percent of ownership interest if 5% or more: _____ <input type="checkbox"/> Board member, officer or business and finance controller – CEO, CFO, COO, CTO <input type="checkbox"/> Managing employee (not CEO, CFO, COO, CTO) <input type="checkbox"/> Authorized agent <input type="checkbox"/> Other: _____					<input type="checkbox"/> Indirect owner – List percent of ownership interest if 5% or more: _____ Entity name: _____ <input type="checkbox"/> Trustee <input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor): _____				
Full legal name (Last)		First		Middle		Social Security number (SSN)		Date of birth	
Address			City		State	ZIP code		County/Indian reservation	
<input type="checkbox"/> Hire date _____ (mm/dd/yyyy) <input type="checkbox"/> Termination date _____ (mm/dd/yyyy)			Relationship to any other listed person <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling			Background study number/request ID			

Are you a(n) (check all that apply): <input type="checkbox"/> Owner – List percent of ownership interest if 5% or more: _____ <input type="checkbox"/> Board member, officer or business and finance controller – CEO, CFO, COO, CTO <input type="checkbox"/> Managing employee (not CEO, CFO, COO, CTO) <input type="checkbox"/> Authorized agent <input type="checkbox"/> Other: _____					<input type="checkbox"/> Indirect owner – List percent of ownership interest if 5% or more: _____ Entity name: _____ <input type="checkbox"/> Trustee <input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor): _____				
Full legal name (Last)		First		Middle		Social Security number (SSN)		Date of birth	
Address			City		State	Zip Code		County/Indian reservation	
<input type="checkbox"/> Hire date _____ (mm/dd/yyyy) <input type="checkbox"/> Termination date _____ (mm/dd/yyyy)			Relationship to any other listed person <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling			Background study number/request ID			

Copy this page as needed to enter any more individual people.

Check this box if you are submitting multiple pages with more people listed

## Business ownership or control interest

Is your business owned by or does another entity have a control interest in your business?

- Yes – list all other entities  No – skip to the next page

Are you a(n) (check all that apply): <input type="checkbox"/> Owner – List percent of ownership interest if 5% or more: _____ <input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor): _____					<input type="checkbox"/> Indirect owner – List percent of ownership interest if 5% or more: _____ Entity name: _____ <input type="checkbox"/> Trustee <input type="checkbox"/> Other: _____						
Full legal name (taxpayer name of FEIN or on W-9 from IRS)				Federal Employer ID (FEIN)							
Address			City			State		ZIP code		County/Indian reservation	
Ownership or control interest <input type="checkbox"/> Begin date _____ (mm/dd/yyyy) <input type="checkbox"/> End date _____ (mm/dd/yyyy)											

Are You a(n) (check all that apply): <input type="checkbox"/> Owner – List percent of ownership interest if 5% or more: _____ <input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor): _____					<input type="checkbox"/> Indirect owner – List percent of ownership interest if 5% or more: _____ Entity name: _____ <input type="checkbox"/> Trustee <input type="checkbox"/> Other: _____						
Full legal name (taxpayer name of FEIN or on W-9 from IRS)				Federal Employer ID (FEIN)							
Address			City			State		ZIP code		County/Indian reservation	
Ownership or control interest <input type="checkbox"/> Begin date _____ (mm/dd/yyyy) <input type="checkbox"/> End date _____ (mm/dd/yyyy)											

Are you a(n) (check all that apply): <input type="checkbox"/> Owner – List percent of ownership interest if 5% or more: _____ <input type="checkbox"/> Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor): _____					<input type="checkbox"/> Indirect owner – List percent of ownership interest if 5% or more: _____ Entity name: _____ <input type="checkbox"/> Trustee <input type="checkbox"/> Other: _____						
Full legal name (taxpayer name of FEIN or on W-9 from IRS)				Federal Employer ID (FEIN)							
Address			City			State		ZIP code		County/Indian reservation	
Ownership or control interest <input type="checkbox"/> Begin date _____ (mm/dd/yyyy) <input type="checkbox"/> End date _____ (mm/dd/yyyy)											

Copy this page and complete it for any additional people, business or organizations.

- Check this box if you are submitting any more pages with information about people, businesses or organizations who own or have a control interest in your business

Does any person, business or organization you listed have an ownership or control interest in any other Medicaid disclosing entity or any entity that does not participate in Medicaid, but is required to disclose ownership and control interest because of participation in any Title V, XVIII or XX programs?

Yes – Complete the following for each person, business or organization  No – Skip to the next section

Full legal name (Person: Last, first, middle; Business or organization: taxpayer name of FEIN or on W-9 from IRS)				% of ownership interest
Full legal name of other provider (taxpayer name of FEIN or on W-9 from IRS)				
Address of other provider	City	State	ZIP code	County/Indian reservation

Check the appropriate Yes or No box for each of the following questions.

A. Has any person having an ownership or control interest ever:

- Been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, Title XX or Title XXI in Minnesota or any other state or jurisdiction since the start of these programs?  
 Yes  No
- Had civil money penalties or assessments imposed under section 1128A of the Social Security Act?  
 Yes  No
- Been excluded from participation in Medicare or any of the state health care programs?  
 Yes  No

B. Has any managing employee or agent ever:

- Been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, Title XX or Title XXI in Minnesota or any other state or jurisdiction since the start of these programs?  
 Yes  No
- Had civil money penalties or assessments imposed under section 1128A of the Social Security Act?  
 Yes  No
- Been excluded from participation in Medicare or any of the state health care programs?  
 Yes  No

Complete the following for any Yes answer to the questions above.

Full legal name (last, first, middle)	Social Security number
Reason for answering Yes (for example: conviction, money penalties, exclusion from Medicare or state health care programs)	

**PCA providers only:** Complete the following information for all residential properties you own, lease or manage that could be or are used for providing home care services.

Full legal name of residence or provider (taxpayer name of FEIN or on W-9 from IRS)			Do you own, lease or manage the property? <input type="checkbox"/> Own <input type="checkbox"/> Lease <input type="checkbox"/> Manage	
Address of property	City	State	ZIP code	County/Indian reservation

## Signature

By signing below, I, an authorized office (CEO, president) with authority to bind the entity, certify that:

- The information on this form is true and correct
- I will notify UnitedHealthcare Community Plan of Minnesota of any changes to this information

Name (print)	Title	Phone number
Signature		Date
Send all pages of this form to UnitedHealthcare Community Plan in one of several ways:	<b>Fax:</b> 866-562-7184	<b>Email:</b> <a href="mailto:uhc_disclosures@uhc.com">uhc_disclosures@uhc.com</a>
<b>Mail:</b> UnitedHealthcare Community Plan Attn: C&S Forms Compliance 2300 W. Plano Pkwy., #C1E105 Plano, TX 75075		

## Definitions

**Agent:** Any person who has been delegated the authority to obligate or act on behalf of the provider.

**Managing employee (not CEO, CFO, COO, CTO):** A person who exercises operational or managerial control over, or who directly or indirectly conducts or manages the day-to-day operations of an institution, organization, agency or school, such as a general manager, business manager, administrator, director.

**Ownership or control interest:** Any person, business or organization to which any one or more of the following apply:

- Direct ownership of 5% or more in the disclosing entity
- Indirect ownership interest equal to 5% or more in a disclosing entity (meaning ownership in another entity that has an ownership interest in the disclosing entity)
- Determine the amount of indirect ownership interest by multiplying the percentages of ownership in each entity. For example, if A owns 10% of the stock in a corporation that owns 80% of the stock of the disclosing entity, A's interest equals an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation that owns 5% of the stock of the disclosing entity, B's interest equals a 4% indirect ownership interest in the disclosing entity and need not be reported.
- A combination of direct and indirect ownership interest equal to 5% or more in the disclosing entity
- Owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity. Determine the percentage of ownership, mortgage, deed of trust, note or other obligation by multiplying the percentage of interest owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. For example: If A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets equals 6% and must be reported. If B owns 40% of a note secured by 10% of the provider's assets, B's interest in the provider's assets equals 4% and need not be reported.
- Is an officer or director of a disclosing entity that is organized as a corporation (for profit or non-profit)
- Is a partner in a disclosing entity that is organized as a partnership

**Subcontractor:** 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.

**Title V:** Maternal and Child Health Services Block Grant

**Title XVIII:** Health Insurance for the Aged and Disabled (Medicare)

**Title XX:** Block Grants to States for Social Services and Elder Justice

**Title XXI:** State Children's Health Insurance Program

## Instructions for completing individual person(s) ownership or control interest – Page 2

### “Are you a(n)…”

If a person holds multiple positions within the entity, company or organization, you must select all roles that apply.

### Full legal name (last, first, middle)

You must disclose full legal name, including a full middle name.

If a person does not have a middle name, enter “N/A.”

### Social Security number (SSN)

The person's Social Security number is required.

### Date of birth

The person's date of birth is required.

### Home residence address, city, county or

### Indian reservation, state, ZIP code

Do not use the enrolling business address. Use the address of where the person lives.

### Hire date

If a person is being added to an existing record, or if this is being reported as a new enrollment requirement, select “Hire date” and provide the date of hire.

### Termination date

If a person has left the agency or company, select “Termination date” and provide the date of termination.

### Relationship to any other listed person

Disclose any of the following, if applicable: spouse, child, parent, sibling.

### Background study number or request ID

The following providers must complete this section:

- PCA agencies
- Transportation providers (excludes ambulance transportation)
- Anyone with 5% or more ownership interest or control when the entity has been assigned as high risk
- Home- and Community-Based Services (HCBS) providers providing the following services:
  - Homemaker basic cleaning
  - Caregiver living expenses
  - Housing access coordination (HAC)
  - Independent living skills (ILS) therapy services