Washington State Health Care Authority

Medicaid Enrollment Application Packet for Participating Providers

This application packet is to be completed by providers who wish to enroll as a participating provider with the Health Care Authority in the medical assistance and medical care programs, and are unable to use the online enrollment application process.

This packet includes the following forms:

- Enrollment Application
- Core Provider Agreement
- Medicaid Provider Disclosure Statement
- Debarment Statement
- Link to IRS W-9 (https://www.irs.gov/pub/irs-pdf/fw9.pdf)

Any failure to submit all the requested information may cause the HCA to refuse to enter into an agreement with the enrolling provider. Please answer all questions as of the current date.

Mail completed forms and W-9 to: Provider Enrollment, PO Box 45562, Olympia WA 98504-5562, or Fax to 360-725-1259. Additional documents may be requested by the agency. Questions? Toll-Free 1-800-562-3022, extension 16137

ENROLLMENT APPLICATION

I. Enrolling Provider Information

Complete this section with information about the enrolling provider submitting a Core Provider Agreement.

Specify the provider's name, (legal name reported to the IRS), Federal Tax ID (SSN or FEIN), National Provider Identifier (NPI), address of the location where client services are performed, or in the case of multiple locations, where the head office of the business is located. Include the office telephone and facsimile (FAX) numbers, and the National Association of Boards of Pharmacy (NABP) number. Include contact information, type of practice, specialty, professional license number and associated taxonomies.

For enrolling solo practice health care professionals, include the Drug Enforcement Agency (DEA) number, date of birth and gender. Section III must be completed for the enrolling health care professional.

BUSINESS NAME (LEGAL NAME)		FEDERAL TAX ID: SSN / FEIN
DOING BUSINESS AS (DBA)		NATIONAL PROVIDER IDENTIFIER (NPI)
PHYSICAL BUSINESS ADDRESS	MAILING ADDRESS	PAY-TO ADDRESS
BUSINESS PHONE NUMBER	BUSINESS FAX NUMBER	NCPDP (NABP) NUMBER [*if applicable]*
CONTACT FIRST & LAST NAME	CONTACT PHONE NUMBER	CONTACT EMAIL
BUSINESS LICENSE NUMBER	MEDICARE NUMBER	FACILITY LICENSE
TYPE OF PRACTICE	SPECIALTY	PROFESSIONAL LICENSE [*if applicable]*
TAXONOMY	TAXONOMY	TAXONOMY
Drug Enforcement Agency (DEA) [*if applicable]*	DATE OF BIRTH [*if applicable]*	GENDER [*if applicable]*

Washington State Health Care Authority

Complete sections II and III for each performing provider practicing under the enrolling provider listed in section I. Attach additional pages as necessary.

II. Performing provider information:

Complete this section with information about the individual performing provider. Specify the provider's name, (legal name reported to the IRS), Social Security number, national provider identifier (NPI), date of birth and gender. Enter applicable professional license, the state the license was issued in, the Drug Enforcement Agency (DEA) number, and the type/specialty/subspecialty of the enrolling provider's practice.

FIRST NAME	LAST NAME	MIDDLE NAME
SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER
TYPE OF PRACTICE	SPECIALTY	Drug Enforcement Agency (DEA) Number
PROFESSIONAL LICENSE NUMBER	STATE OF PROFESSIONAL LICENSE	National Provider Identifier (NPI) Number

III. Provider Debarment, Suspension, and Exclusion Checklist

Complete this section by checking yes or no for each question. A response is required. If you answered "yes" to any of the questions in section III A, complete section III B.

A. Has the individual ever:

Had exclusion under Medicare, Medicaid, or any other federal health care program taken against them?	☐ YES	☐ NO
Had civil money penalties or assessment imposed under Section 1128A of the Social Security Act? More Info: http://www.socialsecurity.gov/OP_Home/ssact/title11/1128A.htm	☐ YES	☐ NO
Had a restriction or sanction imposed on their professional license, accreditation, or certification?	☐ YES	☐ NO
Had a program exclusion taken against them? More info: http://exclusions.oig.hhs.gov and https://www.sam.gov/	☐ YES	☐ NO
Been convicted of any health related crimes as defined by Washington State Department of Health? RCW 18.130.180: http://apps.leg.wa.gov/rcw/default.aspx?cite=18.130 and WAC 246-16: http://apps.leg.wa.gov/wac/default.aspx?cite=246-16	☐ YES	☐ NO
Been convicted of a criminal offense as described in Section 1128A (1), (2) or (3) of the Social Security Act? More Info: http://www.socialsecurity.gov/OP_Home/ssact/title11/1128A.htm	☐ YES	☐ NO
Been convicted of a crime involving the abuse, neglect, abandonment or exploitation of a vulnerable person? More info: WAC 388-71-0540; http://apps.leg.wa.gov/WAC/default.aspx?cite=388 and RCW 74.34, http://apps.leg.wa.gov/RCW/default.aspx?cite=74.34	☐ YES	☐ NO

B. If you answered "yes" to any of the questions listed under III A:

Report final adverse legal action history, including each final legal adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and the resolution, if any. Attach a copy of the relevant final legal adverse action documents.

Final adverse legal action	Date	Taken by	Resolution

For any person with an exclusion under Medicare, Medicaid, or any other federal health care program taken against them, items and services furnished, ordered or prescribed by a specified individual will not be reimbursed under Medicare, Medicaid, or any other federal health care program until the individual is reinstated by the Office of the Inspector General.

Washington State Health Care Authority

CORE PROVIDER AGREEMENT

The Health Care Authority (HCA) administers medical assistance and medical care programs for eligible clients. HCA provides medical assistance or medical care to certain eligible clients by enrolling eligible providers of medical services.

HCA reimburses enrolled eligible providers for covered medical services, equipment, and supplies they provide to eligible clients. To be eligible for enrollment, a provider must:

a. Agree to and sign this Core Provider Agreement ("Agreement");
b. Complete and sign a Medicaid Provider Disclosure Statement;
c. Complete an online enrollment application
d. Complete and sign a Debarment Statement;
e. Be an eligible provider and meet the conditions contained in WAC 182-502-0010;
f. Meet all the applicable state and/or federal licensure requirements to assure HCA of his/her qualifications to perform services under this Agreement. This includes maintaining professional licensure in good standing without any stipulation in the provider's license.

This Agreement will be effective and a provider will be considered a participating provider once the provider completes the above requirements and signs this Agreement, and HCA issues a provider number.

As a participating provider in the medical assistance and medical care programs, hereafter known as Provider, the Provider agrees to the following:

1. **Governing Law and Venue.** This Agreement shall be governed by the laws of the state of Washington. The jurisdiction for all lawsuits in which the Provider alleges a breach of this Agreement shall be exclusively in the Superior Court for the state of Washington. Venue for any such lawsuits shall be in the Superior Court for Thurston County, Washington.

   The medical assistance and medical care programs are authorized and governed by Title XIX of the Social Security Act, Title XXI of the Social Security Act, Chapter IV of Title 42 of the Code of Federal Regulations (CFR), Chapter 74.09 of the Revised Code of Washington (RCW), and Titles 182 and 388 of the Washington Administrative Code (WAC). The Provider is subject to and shall comply with all federal and state laws, rules, and regulations and all program policy provisions, including Pre-2012 Numbered Memoranda, Provider Notices, Medicaid Provider Guides, and other associated written HCA issuances in effect at the time the service is rendered, which are incorporated into this Agreement by this reference.

2. **License.** The Provider shall be licensed, certified, or registered as required by state and/or federal law. The Provider will notify HCA within seven (7) calendar days of learning of any adverse action initiated against the license, certification, or registration of the Provider or any of its officers, agents, or employees.

3. **Professional liability coverage**. By signing this agreement the provider organization or individual certifies that the organization or individual currently has and will maintain the professional liability insurance coverage so long as the organization or individual provider is providing services to Apple Health clients.

4. **Billing and Payment.** The Provider agrees:
   a. To submit claims for services rendered to eligible clients, as identified by HCA, in accordance with rules and Medicaid Provider Guides in effect at the time the service is rendered.
   b. To accept as sole and complete remuneration the amount paid in accordance with the reimbursement rate for services covered under the program, except where payment by the client is authorized by applicable rule. In no event shall HCA be responsible, either directly or indirectly, to any subcontractor or any other party that may provide services.

c. To be held to all the terms of this Agreement even though a third party may be involved in billing claims to HCA. It is a breach of this Agreement to discount client accounts (factor) to a third party biller or to pay a third party biller a percentage of the amount collected.

5. **Disclosure.** At the time the provider enters into this Agreement, or renews this Agreement, or at any time upon request by HCA or the federal Department of Health and Human Services, the Provider agrees to submit full and complete disclosure of the following:

   a. Ownership and control information as required by 42 CFR § 455.104;
   b. Information related to business transactions as required by 42 CFR § 455.105;
   c. Information on persons convicted of crimes as required by 42 CFR § 455.106; and
   d. Any denial, termination, or lack of professional liability coverage, or any change in professional liability coverage, including restrictions, modifications, or discontinuing coverage.

   At any time during the course of this Agreement, the Provider agrees to notify HCA of any material and/or substantial changes in information contained on the Medicaid Provider Disclosure Statement given to the HCA by the Provider. This notification must be made in writing within thirty (30) calendar days of the event triggering the reporting obligation. Material and/or substantial changes include, but are not limited to changes in:

   a. Ownership;
   b. Licensure;
   c. Federal tax identification number;
   d. Additions, deletions, or replacements in group membership; and
   e. Any change in address or telephone number.

6. **False Claims Act Education**. If the Provider receives annual Medicaid payments of $5 million or more, the Provider must comply with the requirements of 42 USC § 1396a(a)(68).

7. **National Provider Identifier (NPI)**. The Provider must provide its NPI to HCA (if eligible for an NPI) and include its NPI on all claims submitted.

8. **Inspection; Maintenance of Records.** For six (6)-years from the date of services, or longer if required specifically by law, the Provider shall:

   a. Keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services or items furnished and claims submitted to HCA.
   b. Make available upon request appropriate documentation, including client records, supporting material, and any information regarding payments claimed by the Provider, for review by the professional staff within HCA or the U.S. Department of Health and Human Services. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to HCA may result in recovery of payments for medical services not adequately documented, and may result in the termination or suspension of the Provider from participation in the medical assistance and medical care programs.

9. **Audit or Investigation.** Audits or investigations may be conducted to determine compliance with the rules and regulations of the program. If an audit or investigation is initiated, the Provider shall retain all original records and **supportive** materials until the audit is completed and all issues are resolved, even if the period of retention extends beyond the required 6-year period.

10. **Disputes.** Any party may initiate a dispute concerning this Agreement under the dispute resolution processes in Titles 182 and 388 WAC applicable to the specific subject matter of the dispute.

    Neither party may dispute a termination of this Agreement for convenience or for loss of funding under Section 10 Termination.

11. **Termination.** HCA shall deny or terminate this Agreement for cause according to applicable WAC. Either HCA or the Provider may terminate this agreement for convenience at any time upon 30 calendar days' written notification to the other. In the event that funding from state, federal, or other sources is withdrawn, reduced, or limited in any way, HCA may terminate this Agreement. If this Agreement is

terminated for any reason, HCA shall pay only for services authorized and provided through the date of termination.

12. **Advance Directives.** Hospitals, nursing facilities, providers of home health care and personal care services, hospices and HMOs must comply with the advance directive requirements as required by 42 CFR 489, Subpart I and 42 CFR 417.436.
13. **Provider Not Employee Or Agent.** The Provider or its directors, officers, partners, employees and agents are not employees or agents of HCA.
14. **Assignment.** The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement, to a third party without the written consent of HCA.
15. **Confidentiality.** The Provider may use personal information and other information gained by reason of this Agreement only for the purpose of this Agreement. The Provider shall not disclose, transfer, or sell any such information to any party, except as provided by law.
16. **Indemnification and Hold Harmless.** The Provider shall be responsible for and shall indemnify and hold HCA harmless from all liability resulting from the acts or omissions of the Provider or any subcontractor.
17. **Severability.** The provisions of the Agreement are severable. If any provision of the Agreement is held invalid by any court, that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.
18. **Certification.** This is to certify that the information provided in support of this Agreement is true and accurate and I completely understand that any falsification or concealment of a material fact may be prosecuted under federal and state laws. Willful misstatement of any material fact in the enrollment application may result in criminal prosecution. I acknowledge that this is being signed under the penalties of perjury and understand that HCA is relying on the accuracy of the information I have presented. I agree to abide by the terms of this Agreement including all applicable federal and state statutes, rules, and policies.
19. **Electronic Signatures.** Provider and HCA agree that each may treat executed faxes, scanned images, or photocopies as original documents.
20. **Signature Block.** If Provider is a legal entity other than a person, identify the organization in the first line of the signature block. The person signing this Core Provider Agreement on behalf of the Provider warrants that he/she has legal authority to bind Provider.

PROVIDER LEGAL ENTITY NAME		
SIGNATURE OF PROVIDER OR OWNER/MANAGER	TITLE	DATE
FULL NAME (PRINTED)	NPI	PROVIDER SPECIALTY

For additional information on Provider Enrollment go to:
http://hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider
Questions? Toll-Free 1-800-562-3022, ext. 16137

To fax:
- Go to the New Provider Enrollment website at:
  http://hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-billing-provider
- Click on “document submission cover sheet” link in step 4
- Follow directions on cover sheet

To mail, send to:
Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

Washington State Health Care Authority

DEBARMENT STATEMENT
SECTION ONE

FREQUENTLY ASKED QUESTIONS ABOUT DEBARMENT

What is "Debarment, Suspension, Ineligibility, and Voluntary Exclusion"?

These terms refer to the status of a person or entity that cannot contract with or receive grants from a federal agency.

In order to be debarred, suspended, ineligible, or voluntarily excluded, you must:

- Have had a contract or grant with a federal agency, and
- Have gone through some process where the federal agency notified or attempted to notify you that you could not contract with the federal agency.

Generally, this process occurs where you, the contractor, are not qualified or are not adequately performing under a contract, or have violated a regulation or law pertaining to the contract.

Why am I required to sign this certification?

You are requesting a contract or grant with the Washington State Health Care Authority (HCA). Federal law (Executive Order 12549) requires HCA to ensure that persons or companies that contract with HCA are not prohibited from having federal contracts.

What is Executive Order 12549?

"Executive Order 12549" refers to Federal Executive Order Number 12549. The executive order was signed by the President of the United States and directed federal agencies to ensure that federal agencies, and any state or other agency receiving federal funds, were not contracting or awarding grants to persons, organizations, or companies who have been excluded from participating in federal contracts or grants.

What does the word "proposal" mean when referred to in this certification?

Proposal means a solicited or unsolicited bid, application, request, invitation to consider or similar communication from you to HCA.

What or who is "lower tier participant"?

Lower tier participant means either (i) a person or organization that submits a proposal, enters into contracts with, or receives a grant from HCA, OR (ii) any subcontractor of a contract with HCA. If you hire subcontractors, you should require them to sign a certification and keep it with your subcontract.

What is a "covered transaction" when referred to in this certification?

Covered transaction means a contract, oral or written agreement, grant, or any other arrangement where you contract with or received money from HCA. Covered transaction does not include mandatory entitlements and individual benefits.

DEBARMENT STATEMENT
SECTION TWO

PROVIDER NAME	DOING BUSINESS AS (DBA)
ADDRESS	
NATIONAL PROVIDER IDENTIFIER (NPI)	

Instructions For Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion- -Lower Tier Covered Transactions

READ CAREFULLY BEFORE SIGNING THE CERTIFICATION. Federal regulations require contractors and bidders to sign and abide by the terms of this certification, without modification, in order to participate in certain transactions directly or indirectly involving federal funds.

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal and voluntarily excluded as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, I shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CRF part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion- -Lower Tier Covered Transaction,” without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transition may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the LIST of Parties Excluded from Federal Procurement and Nonprocurement Programs.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
10. The individual completing this form must have legal authority to sign on behalf of the business.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion- - Lower Tier Covered Transactions

1. The prospective lower tier participant certifies, by submission of its proposal and this certification, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared in eligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

NAME OF INDIVIDUAL COMPLETING THIS FORM	DATE

Signature_____

Washington State Health Care Authority

Medicaid Provider Disclosure Statement

Completion and submission of this form is a federal and state requirement and a condition of participation in Medicaid reimbursement (see instructions for specific citations). Full and accurate disclosure of ownership as well as financial, managerial, and controlling interests is required. Submission of this form to Health Care Authority is also required for changes in ownership, managing employees, or controlling interests. Any failure to submit the requested information may cause the Health Care Authority to refuse to enter into an agreement or contract with the individual or entity, or to terminate existing agreements. See the instructions for definitions of the terms used in this form.

Please answer all questions as of the current date. If additional space is needed use an attached sheet.

Sections

I. Enrolling Provider's Information (see instructions)	
PROVIDER NAME (LEGAL NAME)	FEDERAL TAX ID: SSN / FEIN
DOING BUSINESS AS (DBA)	NATIONAL PROVIDER IDENTIFIER (NPI)

II. Individuals with Ownership Interest (see instructions)		
List each individual who has direct or indirect ownership, separately or in combination, amounting to an ownership interest of 5% or more of the provider listed in Section I. Attach additional pages as necessary.		
FIRST NAME	LAST NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER	START DATE	OWNERSHIP PERCENTAGE
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		
CITY / TOWN	STATE	ZIP CODE + 4
If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):		
FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

II. Individuals with Ownership Interest (continued)

List each individual who has direct or indirect ownership, separately or in combination, amounting to an ownership interest of 5% or more of the provider listed in Section I. Attach additional pages as necessary.

FIRST NAME	LAST NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER	START DATE	OWNERSHIP PERCENTAGE
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		
CITY/TOWN	STATE	ZIP CODE + 4

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

FIRST NAME	LAST NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER	START DATE	OWNERSHIP PERCENTAGE
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		
CITY/TOWN	STATE	ZIP CODE + 4

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

FIRST NAME	LAST NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER	START DATE	OWNERSHIP PERCENTAGE
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		
CITY/TOWN	STATE	ZIP CODE + 4

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

III. Managing Employees and other Controlling Interests (see instructions)

List each managing employee and other controlling interests (e.g. members of a board of directors or officer) of the provider listed in Section I. Attach additional pages as necessary.

FIRST NAME	LAST NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER		START DATE
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		
CITY/TOWN	STATE	ZIP CODE + 4

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

FIRST NAME	LAST NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER		START DATE
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		
CITY/TOWN	STATE	ZIP CODE + 4

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

FIRST NAME	LAST NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER		START DATE
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		
CITY/TOWN	STATE	ZIP CODE + 4

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

IV. Organizations with Ownership or Management Interest (see instructions)

List each office, organization, corporation or entity that has a management interest or direct / indirect ownership separately or in combination, amounting to an ownership interest of 5% or more in the provider listed in Section I. Attach additional pages as necessary.

ORGANIZATION NAME (LEGAL NAME)	FEDERAL TAX ID --FEIN	(check one) ☐ OWNERSHIP INTEREST ☐ MANAGEMENT INTEREST
DOING BUSINESS AS (DBA)	START DATE	OWNERSHIP PERCENTAGE
PRIMARY BUSINESS STREET ADDRESS		
CITY/TOWN	STATE	ZIP CODE + 4

Mailing Address (PO Box) for the disclosed organization, if different from Primary Business Address

MAILING ADDRESS		
CITY/TOWN	STATE	ZIP CODE + 4

Business Locations for the disclosed organization, if different from the Primary Business Address

STREET NAME AND NUMBER, SUITE, ROOM, ETC		
CITY/TOWN	STATE	ZIP CODE + 4
STREET NAME AND NUMBER, SUITE, ROOM, ETC		
CITY/TOWN	STATE	ZIP CODE + 4

ORGANIZATION NAME (LEGAL NAME)	FEDERAL TAX ID --FEIN	(check one) ☐ OWNERSHIP INTEREST ☐ MANAGEMENT INTEREST
DOING BUSINESS AS (DBA)	START DATE	OWNERSHIP PERCENTAGE
PRIMARY BUSINESS STREET ADDRESS		
CITY/TOWN	STATE	ZIP CODE + 4

Mailing Address (PO Box) for the disclosed organization, if different from Primary Business Address

MAILING ADDRESS		
CITY/TOWN	STATE	ZIP CODE + 4

Business Locations for the disclosed organization, if different from the Primary Business Address

STREET NAME AND NUMBER, SUITE, ROOM, ETC		
CITY/TOWN	STATE	ZIP CODE + 4
STREET NAME AND NUMBER, SUITE, ROOM, ETC		
CITY/TOWN	STATE	ZIP CODE + 4

V. Subcontractor Information (see instructions)

List each person with an ownership or controlling interest in any subcontractor in which the provider listed in Section I has direct or indirect ownership of 5% or more. Attach additional pages as necessary.

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

Does any owner of the provider listed in Section I also have an ownership or controlling interest of 5% or more in any other entity? Attach additional pages as necessary.

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

VI. Criminal Offenses (see instructions)

List each individual who has ownership, controlling interest, is an agent, managing employee, officer, or member of the board of directors of the provider listed in Section I and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XVIII, XIX, or XX, since the inception of those programs. Attach additional pages as necessary.

NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		
NAME AND TITLE	SSN/TIN	PERCENTAGE
ADDRESS		

VII. Suspension or Debarment (see instructions)

Federal statutes and regulations clearly prohibit states from paying for items or services furnished, ordered or prescribed by excluded parties. States are required to search the exclusions databases by the name of a provider entity seeking to participate in the program and also by the name of any owner, managing employee, or controlling interests including officers and members of a board of directors.

Have you, any of your employees, or any individual who has an ownership or controlling interest of the provider listed in Section I ever been placed on the federal Office of the Inspector General, Health and Human Services (OIG/HHS) exclusions list or on the System for Award Management (SAM), or otherwise been suspended or debarred from participation in Medicare, Medicaid, or Title XVIII, XIX, or XX services programs. If yes, list each person below. Attach additional pages as necessary. The lists of excluded individuals can be found at: http://exclusions.oig.hhs.gov/search.aspx **and** https://www.sam.gov.

NAME AND TITLE	SSN/TIN	DATE OF BIRTH
ADDRESS		
NAME AND TITLE	SSN/TIN	DATE OF BIRTH
ADDRESS		

VIII. Status Changes (see instructions)	
Is a change of ownership anticipated within the next year?	☐ Yes ☐ No
Is this facility operated by a management company or leased in whole or party by another organization?	☐ Yes ☐ No
If yes, list date of change in operations	
Has there been a past bankruptcy or do you anticipate filing for bankruptcy within the next year?	☐ Yes ☐ No
If yes, when?	

IX. Signature (see instructions)	
Anyone who knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the appropriate state agency. By signature I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.	
NAME OF INDIVIDUAL COMPLETING THIS FORM	
TITLE OF INDIVIDUAL COMPLETING THIS FORM	
SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM	DATE

Instructions for the Medicaid Provider Disclosure Statement

These instructions are for use with the Medicaid Provider Disclosure Statement. Definitions of the terms used in this form are included at the end of this document. Please answer all questions as of the current date.

Completion and submission of this form is a federal and state requirement, and a condition of participation in Medicaid reimbursement. Full and accurate disclosure of ownership as well as financial, managerial, and controlling interests is required. Completion of this form is also required to notify the Health Care Authority of changes to ownership, managing employees, and controlling interests. Failure to submit the requested information may cause the Health Care Authority to refuse to enter into an agreement or contract with the individual and/or entity or to terminate existing agreements.

Instructions by Section:

I. Enrolling Provider's Information

Complete this section with information about the provider entity. Specify the provider's name, (legal name reported to the IRS), the Federal Tax ID associated with the provider (FEIN or SSN), the National Provider Identifier (NPI), and the Doing Business As (DBA) name, if applicable.

II. Individuals with Ownership Interest

Complete this section with information about individuals who have direct or indirect ownership interest of 5% or more of the provider listed in Section I. Report organizational owners in Section IV. See the definitions section at the end of this document for instructions on how to compute ownership percentage.

For each owner, specify the name, date of birth, Social Security number, percentage of ownership, street address, and the start date of ownership interest with the provider.

If the individual owner is related to another owner, a managing employee, or someone with controlling interest, list the related individual. Report the related individual only if the individual is a spouse, parent, child, or sibling.

III. Managing Employees and other Controlling Interests

Complete this section with information about managing employees and controlling interests of the provider listed in Section I. Include the 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. Also list controlling interests including each member of the board of directors, agents with the authority to act on behalf of the provider listed in Section I, and officers or directors of a provider entity that is organized as a corporation.

For each individual listed, specify the name, date of birth, Social Security number, street address, and the start date of controlling or managerial interest with the provider listed in Section I.

If the individual owner is related to another owner, managing employee, or someone with controlling interest of the provider listed in Section I, list the related individual (s). Report the related individual only if the individual is a spouse, parent, child, or sibling.

IV. Organizations with Ownership Interest or Management Interest

Complete this section with information about organizations that have direct or indirect ownership interest of 5% or more of the provider listed in Section I. Also include organizations that have management interest in the provider listed in Section I. See the definitions section at the end of this document for instructions on how to compute ownership percentage.

For each organization listed, specify the legal name (as reported to the IRS), Federal Tax ID (FEIN), check whether the organization has ownership or management interest in the provider listed in Section I, Doing Business As (DBA) name, if applicable, the first date the organization started with ownership interest (or management interest), the percentage of ownership (if applicable), and the primary business address.

List mailing address (such as a PO Box) and the address for each business location if different from the Primary Business Address.

V. Subcontractor Information

Complete this section with information about each person who has an ownership or controlling interest in any subcontractor in which the provider listed in Section I has direct or indirect ownership of 5% or more.

For each individual listed, specify the name, title, Social Security number, ownership percentage, and address for each individual with an ownership or controlling interest in a subcontractor.

List any individuals with ownership or controlling interest in the provider listed in Section I that also has an ownership or controlling interest of 5% or more in any other entity.

VI. Criminal Offenses

Complete this section with information about each individual who has ownership, controlling interest, is an agent, managing employee, officer, or member of the board of directors of the provider listed in Section I and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XVIII, XIX, or XX, since the inception of those programs.

For each individual listed, specify the name, Social Security number, ownership percentage (if applicable), and address.

VII. Suspension or Debarment

Complete this section with information about each individual who is an officer, owner, agent, or managing employee of the provider listed in Section I who has been suspended or debarred from participation in Medicare, Medicaid, or the Title XVIII, XIX or XX services programs. These individuals would have been placed on the federal Office of the Inspector General, Health and Human Services (OIG/HHS) exclusions list, or on the System for Award Management (SAM). The current lists to excluded individuals can be found at: http://exclusions.oig.hhs.gov/search.aspx and https://www.sam.gov.

For each individual listed, specify the name, Social Security number, ownership percentage (if applicable), and address.

VIII. Status Changes

Indicate any anticipated changes within the next year.

IX. Signature

Provide the name and title of the individual completing statement, along with the signature and the date the statement is signed.

Definitions

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

Exclusion
Items and services furnished, ordered or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid, and all other federal health care programs until the individual or entity is reinstated by the OIG.

Indirect ownership interest
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
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

OIG
Office of Inspector General of the Department of Health and Human Services.

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

Person with an ownership or control interest

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.

(f) Is a partner in a disclosing entity that is organized as a partnership.

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.

(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.

How to calculate ownership percentages:

(a) **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 that 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 that 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 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.

Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government. These regulations can be found at:
http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR

Washington Administrative Code (WAC) is the regulations of executive branch agencies issued by authority of statutes. Like legislation and the Constitution, regulations are a source of primary law in Washington State. The WAC codifies the regulations and arranges them by subject or agency. These regulations can be found at:
http://apps.leg.wa.gov/wac/default.aspx