

PROVIDER DISCLOSURES

Questions regarding this form may be directed to the BABHA Corporate Compliance Officer at 989-895-2760

(a) Information that must be disclosed. Provider must disclose the following information as defined in this Agreement and paragraph (b) of this Exhibit B. See BABH policy C13-S02-T11 Prohibited Affiliations, Exclusion and Debarment for more information:

Section 1: Managing Employee(s)

In accord with 42 CFR 455.104 and 42 CFR 455.106 all Providers must disclose information regarding any managing employee(s).

“Managing employee” is defined in 42 CFR 455.101 as “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.” Board members should be listed as managing employees, to the extent they meet the definition of a managing employee.

Table 1 Managing Employees

- Disclose the name of all managing employees, including title (e.g., Chief Financial Officer), address, date of birth (DOB) and the last four digits of their Social Security Number (SSN). If a match is found on exclusion/debarment databases the remaining digits of the SSN will be requested for verification.
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

Provider has no managing employees

Name of Managing Employee(s)	Title	Address	DOB	Last 4 Digits of Social Security #

Table 2 Managing Employee(s)' Health Care Related Criminal Convictions

- Disclose the names of any managing employees from Table 1 who have 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 these programs, even if not currently excluded by any federal or state program.
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

None of the managing employees have been convicted of a criminal offense related to that individual's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of these programs, even if not currently excluded by any federal or state program.

Name of Managing Employee(s)	Date of Conviction	Nature of Conviction

Section 2: Ownership and Control Interests

Table 3 Applicable Exceptions to Disclosure of Ownership and Control Interests

- Non-profit organizations do not have owners and are not required to complete Section 2 of Exhibit B.
- Sole proprietorships, individual practitioners and groups of individual practitioners practicing at the same location do not have owners or control interests and are not required to complete Section 2 of Exhibit B.
- For-profit corporations and partnerships must disclose ownership and control interests.
- Check the appropriate box if an exception is applicable.

Non-profit organization

Sole proprietor/ individual practitioner/ group of individual practitioners practicing at the same location.

Table 4 Individuals with an Ownership or Control Interest

“Ownership or control interest” is defined in 42 CFR 455.101 as an individual or corporation that:

- Has an ownership interest totaling 5 percent or more in a Provider entity;
- Has an indirect ownership interest equal to 5 percent or more in a Provider entity;
- Has a combination of direct and indirect ownership interests equal to 5 percent or more in a Provider entity;
- Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a Provider entity if that interest equals at least 5 percent of the value of the property or assets of the Provider;
- Is an officer or [executive] director of a provider entity that is organized as a corporation [managing employees do not need to be listed as persons with an ownership or control interest]; or
- Is a partner in a Provider entity that is organized as a partnership.

- Disclose the name of all individuals with an ownership or control interest in the Provider entity, including title (e.g., Chief Financial Officer), address, date of birth (DOB), and the last four digits of their Social Security Number (SSN) and percent of ownership. If a match is found on exclusion/debarment databases the remaining digits of the SSN will be requested for verification.

- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

There are no individuals with an ownership or control interest in the Provider entity

Name of Individual Owners	Title	% Ownership or Control Interest	Address	DOB	Last 4 Digits of Social Security #

Table 5 Corporations with an Ownership or Control Interest

- Disclose the name of any corporations with an ownership or control interest in the Provider Entity, including Tax Identification Number (TIN), the percent of ownership, the primary business address, all other business locations, and all P.O. Box address(es).
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

There are no corporations with an ownership or control interest in the Provider Entity

Name of Corporation	Tax Identification Number (TIN)	% Ownership or Control Interest	Primary Business Address	Other Business Locations	P.O. Box Address(es)

Table 6 Ownership or Control Interest in Other Disclosing Entities

'Other Disclosing Entity' is defined at 42 CFR 455.101 as 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, XVIII, 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 (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.

- Disclose if any of the owners listed in the previous tables in Exhibit B have an ownership or control interest in another organization(s) that would qualify as an 'Other Disclosing Entity'. List the name of the owner and the Other Disclosing Entity.
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

None of the owners have an ownership or control interest in another organization(s) that qualifies as an 'Other Disclosing Entity'

Name of Owner	% Ownership or Control Interest in the Other Disclosing Entity	Name of Other Disclosing Entity	Tax ID # (TIN) of Other Entity	Primary Business Address of Other Entity	Other Business Locations of Other Entity	P.O. Box Address(es) of Other Entity

Table 7 Ownership or Control Interest in Subcontractors

- Disclose if any of the owners listed in the previous tables in Exhibit B have an ownership or control interest in a subcontractor of the Provider entity. Include the Tax Identification Number (TIN), the percent of ownership in the Provider entity, the primary business address, every business location, and P.O. Box address(es).
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

None of the owners have an ownership or control interest in a subcontractor of the provider entity

Name of Owner	% Ownership or Control Interest in Subcontractor	Name of Subcontractor	Tax ID # (TIN) of Subcontractor	Primary Business Address of Subcontractor	Other Business Locations of Subcontractor	P.O. Box Address(es) of Subcontractor

Name of Owner	% Ownership or Control Interest in Subcontractor	Name of Subcontractor	Tax ID # (TIN) of Subcontractor	Primary Business Address of Subcontractor	Other Business Locations of Subcontractor	P.O. Box Address(es) of Subcontractor

Table 8 Owner Health Care Related Criminal Convictions

- Disclose whether any of the owners listed in the previous tables in Exhibit B have been convicted of a criminal offense related to that individual's or corporation's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of these programs, even if not currently excluded by any federal or state program.
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

None of the owners have been convicted of a criminal offense related to that individual's or corporation's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of these programs, even if not currently excluded by any federal or state program.

Name of Owner(s)	Date of Conviction	Nature of Conviction

Table 9 Relationships Between Owners

- Disclose whether any of the owners listed in the previous tables in Exhibit B are related to each other as a spouse, parent, child, or sibling. List their names and the relationship.
- Check the box provided if none. Attach additional pages as needed to ensure disclosure of all.

None of the owners are related to each other as spouse, parent, child or sibling

Owner Name(s)	Relationship(s)

Owner Name(s)	Relationship(s)

(b) Time and manner of disclosure.

(1) Updated information must be furnished to BABHA at the time of enrollment, re-enrollment, within 35 days after a change in Provider ownership or control takes place, within 20 working days after Provider becomes aware of a health care related criminal conviction, or within thirty-five (35) days of a written request by BABHA.

(2) In addition, ownership information must be submitted within 35 days of the date of a request by BABHA or its Medicaid payers(s), regarding any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12 month period ending on the date of the request and any significant business transactions between the provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request. Provider agrees that payment for services provided may be impacted in accord with 42 CFR 455.105 for failure to comply with such a request.

(c) Provider agreements and fiscal agent contracts. BABHA shall not approve a Provider contract and must terminate an existing contract, if Provider fails to disclose ownership or control information as required by this Exhibit B and this Agreement.

Signature of Provider

Date

Witness

Date

PLEASE RETURN THIS FORM TO THE CMHSP WITH YOUR SIGNED CONTRACT.