Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Ownership and Conviction Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full and accurate disclosure of ownership and financial interests is required. Failure to submit full and accurate requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, attach the information at the end of the provider application before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program

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

Indirect ownership: an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. (Example: If A owns 10% of the stock in a corporation which owns 80% of the stock of the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported).

Ownership or control interest: a person or corporation that: (1) has an ownership interest totaling 5 percent or more in a disclosing entity; (2) has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (3) has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity; (4) 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; (5) is an officer or director of a disclosing entity that is organized as a corporation; or (6) is a partner in a disclosing entity that is organized as a partnership.

Ownership Interest: equity in the capital, stock, or profits of the disclosing entity. To determine the 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. (Example: If A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets equates to 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 equates to 4% and need not be reported).

Managing employee: a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or 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: 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.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

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[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Print the name, physical address and PO Box address and each location, complete Social Security Number and percentage of interest of each person, Corporation, Limited Liability Company, Partnership, Limited Liability Partnership, or other organization with a direct or indirect ownership or control interest of 5% or more in the named entity or in any subcontractor in which the named entity has direct or indirect ownership of 5% or more. [This applies to all Medicaid providers.]

Individuals – for each individual listed, provide date of birth and COMPLETE Social Security Number

Full Name	Date of Birth	Complete Primary Address and PO Box Address	% of Interest	Complete Social Security Number

Corporations/Limited Liability Companies/Partnerships/Other Legal Entities or

Organizations – for each legal entity or organization listed, provide the Tax ID Number and submit a copy of the legal entity or organization's IRS form SS4 and the approval letter with this application. Companies must include each business address location with complete addresses.

Name	Complete Primary Address and PO Box Address with Each Business Location	% of Interest	Tax ID Number

Are any of the above mentioned persons related to each other as a spouse, parent, child, or sibling?
Yes_____ No_____ If yes, print name and provide relationship.

Name	Relationship

Do any of the persons, legal entities or organizations with an ownership or control interest have any ownership or control interest of 5% or more in any other entity doing business with the Arkansas Medicaid Program?

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[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Yes_____ No_____ If yes, print name, address and Tax ID Number and amount of % of interest they own.

Name	Complete Primary Address and PO Box Address with Each Business Location	% of Interest	Tax ID Number

List the name, address, date of birth, and complete Social Security Number for any person who is a managing employee of the named entity. For larger corporations having more than 3 managing employees or board members, please use next page (4)*.

Name	Address	Date of Birth	Complete Social Security Number

List any person who has a direct or indirect ownership or control interest in the named entity, or is an agent, or managing employee of the named entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs in any state:

Name	Offense

List names of persons or entities with direct/indirect ownership or control interest in the named entity, or is an agent or managing employee of the named entity who, as listed in DHS Policy 1088 (Participant Exclusion Rule), has been found guilty, or pled guilty or nolo contendere, to any crime related to: (1) obtaining, attempting to obtain, or performing a public or private contract or subcontract, (2) embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty, (3) dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony, (4) federal antitrust statutes, (5) the submission of bids or proposals, (6) any physical or sexual abuse or neglect when the offense is a felony.

Name	Offense

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Name	Offense

***Use this sheet for multiple business managers/owners or board members.**

Name	Address	Date of Birth	Complete Social Security Number

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[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name:_____ Title:_____
(Print or Type) (Print or Type)

Signature:_____ Date:_____

Disclosure of Significant Business Transactions
DHS Division of Medical Services, Title XIX (Medicaid)
[As required by 42 C.F.R. §455, subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Significant Business Transactions Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full, complete and accurate disclosure of ownership and business transaction information is required. Upon request, the provider must furnish all records described in the provider contract within thirty-five (35) days of the date on a request by the Department, the Medicaid Fraud Control Unit, the Arkansas Office of the Medicaid Inspector General, or the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to those records, full and complete information about:

1) The ownership of 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

2) Any significant business transaction 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.

Full, complete and accurate disclosure of ownership and financial interests is required. Failure to submit requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, please attach the information at the end of the application for new enrollments, or attach to the form for updated information from existing providers, before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program.

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

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or 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: 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 Significant Business Transactions
DHS Division of Medical Services, Title XIX (Medicaid)
[As required by 42 C.F.R. §455, subpart B: Disclosure of Information by Providers and Fiscal Agents]

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

DISCLOSURE OF SIGNIFICANT BUSINESS TRANSACTIONS

Submit full, accurate and complete disclosure concerning the following information:

1) Ownership of any subcontractor with whom the named entity has had business transactions totaling more than $25,000 during the last 12 months (12-month period ending as of the date on this application).

_____
_____
_____

2) Any significant business transaction between the named entity and any wholly owned supplier in the last 5 years (5-year period ending as of the date of this application).

_____
_____
_____

3) Any significant business transaction between the named entity and any subcontractor in the last 5 years (5-year period ending as of the date of this application).

_____
_____
_____

Beginning on the effective date of enrollment in the Arkansas Medicaid Program, full, accurate and complete disclosure shall be submitted concerning any significant business transaction that occurs between the named entity and any subcontractor or wholly owned supplier. This information shall be submitted within 35 days of the date the transaction takes place.

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name:_____ Title:_____
(Print or Type) (Print or Type)

Signature:_____ Date:_____

CONTRACT
TO PARTICIPATE IN THE ARKANSAS NURSING HOME PROGRAM
ADMINISTERED BY THE DIVISION OF ECONOMIC AND MEDICAL SERVICES
OFFICE OF LONG TERM CARE
UNDER TITLE XIX (MEDICAID)

This __Facility__ agreement made and entered into this the _____ day of _____, _____
(to be completed by DMS) (to be completed by DMS)

by and between _____ hereinafter called Provider, and
(to be completed by DMS)

the Department of Economic and Medical Services, Office of Long Term Care hereinafter called State.

WITNESSTH:

I. Provider agrees that its responsibilities hereunder shall be as follows:

A. To keep all records, as set forth in applicable Federal and/or State regulations, and Long Term Care Provider Manuals, and any duly promulgated changes in or additions thereto, and to fully disclose the extent of all services provided to individuals receiving assistance under the State Plan.

B. To make available for inspection all records herein specified to satisfy audit requirements under the program; to furnish all such records for audit conduction periodically by State or its designated agents and/or representatives of the Department of Human Services, and the Department of Health and Human Services of the United States of America or its designees or representatives. For all Medicaid recipients these records shall include, but not necessarily be limited to those records as defined in Section A above.

C. Provider shall at all times provide State access to the facility, residents, and resident records. Provider expressly agrees not to hinder, impede, or otherwise restrict State from carrying out its official duties, and expressly agrees to reasonably assist State in carrying out its official duties. In this context, "official duties" include inspections, surveys and investigations and reviews as prescribed by State and Federal laws, rules and regulations, and shall allow "observation and recordings made and conducted relative to long term care facilities, long term care residents, and records of or possessed by facility and/or residents. 'Observation' includes the right and ability to move in or around the interior and/or exterior, including resident rooms of a long term care facility, unaccompanied (except upon request if the inspector[s]) at any time. 'Recordings' include photostatic copies, notes, writings, drawings, and photographs (whether still or motion, in accordance with Section 2 of Ark. Act 33 of 1989), and sound recordings."

D. To accept only residents who have met the requirements of the duly promulgated Pre-Admission Screening Program and for whom the facility can provide all required and necessary services. Provider specifically herein agrees to insure availability of all medications prescribed by the resident's physician.

E. To provide all services without discrimination on the grounds of race, color, national origin, or physical or mental disability within the provisions of Title VI of the Federal Civil Rights Act, and Section 504 of the Rehabilitation Act of 1973. Provider agrees herewith that it has been furnished with a copy of the LTC Provider Manual, and shall be bound by all provisions thereof, including any and all changes and/or additions thereto.

F. To comply with all rules, regulations, changes in and additions thereto issued by the United States Department of Health and Human Services pertaining to nursing homes, and to comply with all rules, regulations, duly promulgated changes in and additions thereto issued by the State.

G. To meet all requirements of applicable Life Safety Code and all State Fire and Safety Codes.

H. Provider will not transfer or discharge any recipient without a minimum of 30 days advance notice to the individual or a responsible person. Provider may transfer or discharge a Medicaid recipient under the following circumstances:

1. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
3. The safety of the individuals in the facility is endangered;
4. The health of individuals in the facility would otherwise be endangered;
5. The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Title XIX or Title XVIII on the resident's behalf an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with federal and state laws and regulations; or
6. The facility ceases to operate.

The notice of transfer or discharge must be made at least 30 days in advance of the resident's transfer or discharge except:

a. In a case described in item H(3) or H(4) above;
b. In a case described in item H(2) above where the resident's health improves sufficiently to allow for a more immediate transfer or discharge;
c. In a case described in item H(1) above where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or
d. In a case where the resident has not resided in the facility for 30 days.

I. Provider shall give 30 day notice to the State prior to any change of ownership including a change which contemplates or provides for the assumptions of existing liabilities by the new owner.

J. To bill State (Medicaid) only after the service has been provided.

K. To accept Medicaid reimbursement rates determined by the State as full payment for all Medicaid eligible care and services required by the classification of each resident and rendered by the provider, and make no additional charges to the resident, or to accept any additional payment from the resident, relatives, or responsible parties for that service which is covered under the Medicaid Program.

L. To promptly refund to the resident or responsible party any unused portion of recipient applied income collected in advance and not owed due to death, discharge or transfer. Recipient income is to be prorated on a per diem basis according to the number of days in the month.

M. To promptly refund to a resident or other responsible person any deposit or entrance fee collected while awaiting approval for Medicaid eligibility to the extent those days are covered by Medicaid payments.

N. To provide all services and specific items as defined in the Medical Assistance Reasonable Cost Related Reimbursement Manual for Long Term Care Facilities (MARCRRM-LTCF), or any additions thereto or subsequent manuals. Receipt of Medicaid per diem reimbursement rates is considered payment in full for services and items included in the MARCRRM.

O. To accept assignment and file a claim in a timely and proper manner with all third party sources, and if said claim is collected from a third party, to reimburse Medicaid up to the amount Medicaid paid for said services.

P. The $30 Personal Needs Allowance which is provided for by the Medicaid Program for personal expenditures of a resident cannot and shall not be used for any other purpose except as authorized in writing by the resident or responsible party.

Q. To comply with all State and/or Federal regulations pertaining to resident personal funds and to provide the State access to patient account records or any other financial records maintained by the provider for benefit of the patient. The new owner must specify in writing which owner will be responsible for recipient Medicaid claims and facility account receivable balances resulting from dates of service prior to the ownership change.

Further Provider agrees that it will not prevent or interfere with the individual or responsible person, or the Office of Long Term Care in the transfer or discharging of a patient when same is appropriate.

II. The State agrees that it shall have the following responsibilities hereunder:

A. To make timely payments to Provider for the appropriate Medicaid services provided the eligible Medicaid recipients in accordance with the terms of the LTC Provider Manual or other appropriate regulations and procedures previously mentioned herein.

B. To notify Provider of any changes of rules or regulations to be followed hereunder as promptly as is practicable at all times.

C. To safeguard the confidentiality of any Medicaid records maintained for the State, its agents, and/or fiscal intermediary as specified in Federal and State regulations.

III. Mutual Covenants, Duties, Responsibilities, and Undertakings

A. State and Provider mutually agree to comply with all Federal and State laws, rules and regulations.

B. State and Provider agree that the rights and privileges of the residents are of primary concern to the parties and the parties expressly agree and covenant to protect and preserve those rights and privileges and that failure to act in a manner consistent with those rights and privileges shall constitute an immediate breach of agreement and may result in immediate termination of this agreement without recourse.

C. State and Provider agree and covenant that this written instrument constitutes the entirety of the agreement between both parties and no statement or representations not reduced to writing or incorporated herein by express reference shall be binding upon the parties and such statements or representations not incorporated herein by express reference or not contained herein shall constitute no part of this agreement.

IV. This contract may be terminated in accordance with the following provisions:

A. This contract may be terminated by either party by giving 30 days written notice to the other party.

B. This contract may be terminated immediately by State for the following reasons:

1. Federal sanction of Provider.
2. Change of ownership.
3. Violation of any provision herein contained.
4. In accordance with termination procedures as set out in appropriate Federal and/or State regulations or rules by which Provider is bound hereunder.

Provider	**Division of Economic and Medical Services Office of Long Term Care**
By: _____ (Signature)	By: _____ (Signature)
Name: _____ (Type Name)	Name: Carol Shockley (Type Name)
Title: Administrator	Title: Director, LTC
Date: _____	Date: _____