Disclosure of Ownership and Management Information, Business Transactions & Exclusions Statement for Providers

I. Instructions

This statement should be completed and submitted to the health plan listed on Section VII. This statement must be submitted within 35 days, and a new statement must be submitted when any information in your original statement has changed.

You should complete this form in conjunction with review of the requirements for: (1) disclosure of ownership; (2) exclusions of individuals and entities from government programs as set forth in our health plan's administrative requirements; and 3) Significant Business Transactions.

This statement must be completed whether or not you have any information to report. If more space is needed, please attach additional information.

For assistance in completing this statement, please reference the attached instructions document and Definitions section provided under Section VIII.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS	DBA (Doing Business As)		
ADDRESS			NPI/UMPI
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER ( )
FEDERAL EMPLOYER ID (FEIN)	TAX ID		

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Co. ☐ Non-Profit

☐ Public ☐ State ☐ Other Partnership (i.e., LP, LLP, LLLP)

IV. Ownership & Control Interests

Important Note: For purposes of this Disclosure Form, the term "Person with an Ownership or Control Interest" is not limited to persons or corporations with an ownership interest. For example, it also includes:

- **Officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies; and**
- **Partners of a partnership, including without limitation limited liability partnerships.**

A. Please provide the following information for each Managing Employee and Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you as a Provider have direct or indirect ownership of 5% of more. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	Date of Birth	SSN or FEIN	% Ownership Interest
1					
2					
3					

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in subsection IV (A) as a spouse, parent, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name	SSN or FEIN	Name of Person Related To	Related Person's SSN or FEIN	Relationship
1					
2					
3					

C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in an organization other than that indicated in subsection IV(A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	SSN or FEIN	Name of Other Organization	% Ownership Interest
1					
2					
3					

V. Significant Business Transactions

A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty-five thousand dollars ($25,000) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists, please indicate this with an "N/A."

No.	Name of Subcontractor	Address	SSN or FEIN	% Ownership Interest
1				
2				
3				

B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an "N/A."

No.	Name of Wholly-Owned Supplier	Address	SSN or FEIN	Nature of Business Transaction
1				
2				
3				

VI. Excluded Individuals or Entities

A. Are there any employees, Persons with an Ownership or Control Interest in you as a Provider, or any of your Managing Employees or Agents who are or have ever:

- Been excluded from participation in Medicare or any of the State health care programs?

☐ Yes ☐ No

- 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 inception of these programs?

☐ Yes ☐ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☐ No

B. Do you as a Provider have any agreements for the provision of items or services related to the health plan's obligations under its contract with the Department of Human Services or the Centers for Medicare and Medicaid Services with an individual or entity who: (i)) has been excluded from participation in Medicare or any of the State health care programs; (ii) has 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

inception of these programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and social security number or Tax ID of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government health care programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN	Reason
1			
2			
3			

VII Certification and Submission

I am authorized to bind the entity and I certify that the above information is true and correct. I will notify each of the health plans listed below of any changes to this information.

NAME (Print)	TITLE
SIGNATURE	DATE
EMAIL ADDRESS	

Return a completed, signed statement to the following:

- ChiroCare WI/Chiropractic Care of MN, Inc.
  Fax to (414) 476-4517
  Mail to: ChiroCare WI/Chiropractic Care of MN, Inc.
  250 Bishops Way
  Suite 101
  Brookfield, WI 53005
  Questions: (414) 476-4733 ext. 404

VIII. DEFINITIONS

For the purpose of this statement, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider.

2. **Managing Employee** means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Provider, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Provider, or part thereof.

3. **Person with an Ownership or Control Interest** means a person or corporation that: A) has an ownership interest, directly or indirectly, totaling 5% or more in the Provider; B) has a combination of direct and indirect ownership

interests equal to 5% or more in the Provider; C) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least 5% of the value of the property or assets of the Provider; or D) is an officer or director of the Provider (if organized as a corporation) or is a partner in the Provider (if organized as a partnership).

4. **Provider** means an individual or entity that has entered into an agreement with any of the health plans listed on page 4 of this statement and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services.

5. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted (or a person with an employment, consulting or other arrangement with the Provider) for the provision of items and services that are significant and material to the Provider's contract with any of the health plans listed on page 4 of this statement and to that health plan's obligations under its contract with the Department of Human Services.

6. **Significant Business Transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the less of $25,000 and 5% of the Provider's total operating expenses.

7. **Wholly Owned Supplier** means a supplier (i.e., an individual, agency, or organization from which a Medicaid provider purchases good and services used in carrying out its responsibilities under Medicaid) whose total ownership interest is held by a Medicaid provider or by a person, persons, or other entity with an ownership or control interest in a Medicaid provider.