arkansas total care

# Enrollment Application

ATTACHMENTS NEEDED. Please include the following items for each location with your completed form:

- ☐ Completed W-9 (fill out a separate W-9 for each Tax ID used at your practice)
- ☐ Completed, signed, and dated Disclosure of Ownership Form
- ☐ Copy of current State License/Approval (as applicable)
- ☐ Copy of Medicare/Medicaid Participation Certification (as applicable)
- ☐ Copy of Declaration Sheet and/or Certificate of Insurance
  - ☐ **Home and Community Based Services (HCBS) Providers** who are not providing medical or behavioral health service: General Liability Insurance policies
  - ☐ **All other provider types: BOTH** current Professional Malpractice and Comprehensive General Liability Insurance policies
- ☐ Signed and dated Participating Provider Agreement
- ☐ Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/ JCAHO/ CARF/COA/or AOA) Accreditation letter with dates of accreditation (if applicable)
- ☐ If not accredited by a nationally recognized accrediting body, attach the Site Evaluation results from a governmental agency (if applicable)

**Instructions**: Please print legibly or type this application in its entirety using N/A where applicable. Please return via:

Email: ArkCredentialing@centene.com

Fax: 844-357-7890

Standard mail:

**Arkansas Total Care**

ATTN: Credentialing

P.O. Box 25538

Little Rock, AR 72212

## License or Certification Type – Choose all that apply and provide License # or Certification

| | |
|---|---|
| ☐ Behavioral Therapy: | ☐ Nursing Facility: |
| ☐ Adult Daily Living (Residential Care): | ☐ Nutritional Counseling: |
| ☐ Cognitive Therapy: | ☐ Personal Assistant Services: |
| ☐ Durable Medical Equipment: | ☐ Personal Assistant Services (CSLA): |
| ☐ Home Health Agency: | ☐ Respite: |
| ☐ Home Modification: | ☐ Other (please describe): |
| ☐ Other (please describe): | ☐ Other (please describe): |

## Legal Information

| | | |
|---|---|---|
| Legal Name: | Tax ID: | Medicaid Certified?<br>Yes ☐ No ☐ |
| DBA (if applicable): | Is Tax ID held for all locations?<br>Yes ☐ No ☐ | If answered NO above, provide Tax ID for each applicable location: |
| Profit/Non-Profit: | National Provider ID (NPI) if applicable: | 2nd National Provider ID (NPI) if applicable: |
| 3rd National Provider ID (NPI) if applicable: | PROMISe™ ID/Medicaid Number: | Medicare Number: |
| Website URL: | | |

## Billing Information

| | | |
|---|---|---|
| Pay To: | | |
| Pay to Address: | City/State/Zip: | Phone: |

## Mailing Information

| | | |
|---|---|---|
| Attn: | | |
| Address: | City/State/Zip: | Phone: |
| Fax: | Email: | |
| If provider has more than one group NPI number – will all billing and mailing needs be serviced through the same address noted here? Yes ☐ No ☐ If "No", please attach additional addresses. | | |

## Primary Facility/Primary Office Information

| | | |
|---|---|---|
| Is this a participant service site? Yes ☐ No ☐<br>*(list all service sites separately below, if not enough room provide on separate sheet of paper)* | | |
| Name (Doing business as): | | |
| Telephone: | Primary Contact Name: | E-Mail: |
| Address (Street): | City/State/Zip: | County: |
| Credentialing/Billing Contact: | Fax: | E-Mail: |
| Website URL: | | Medicaid Number: |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **SERVICE HOURS** | Monday: | Tuesday: | Wednesday: | Thursday: | Friday: | Saturday: | Sunday: |
| | Are PAs, CNMs, and/or Nurse Practitioners used? Yes ☐ No ☐ | | | Will you be accepting any new participants? Yes ☐ No ☐ | | | |
| In addition to English -Please list all languages used to communicate with participants (including American Sign Language if applicable): | | | | | | | |
| Is a skilled medical interpreter available? Yes ☐ No ☐ | | | | Has staff been trained on cultural competency ? Yes ☐ No ☐ | | | |
| Is your practice limited to certain ages? Yes ☐ No ☐ | | | | *If yes, please list age/gender restrictions:* | | | |

## Are the following area(s) ADA compliant? (Check those that apply)

| | |
|---|---|
| ☐ Parking | ☐ ADA Compliant Signage |
| ☐ Interior Building | ☐ Medical Equipment |
| ☐ Restrooms | ☐ Exam Room |
| Are you located within walking distance of a public transportation route? Yes ☐ No ☐ | |

## Capacity on Certificate of Compliance

| | |
|---|---|
| Residential Facility-Capacity (# of residents): | Adult Day Care (# of participants): |
| Personal Assistance Service: Do you use Electronic Visit Verification? Yes ☐ No ☐ | If yes, vendor: |
| Home Health Service: Do you use Electronic Visit Verification? Yes ☐ No ☐ | If yes, vendor: |

## Malpractice Insurance Information (if applicable)

| | | |
|---|---|---|
| Carrier Name: | Insured Amount: | Effective Date: |
| Expiration Date: | Policy #: | |
| Aggregate Coverage Amount: | | |

## General Liability Insurance Information

| | | |
|---|---|---|
| Carrier Name: | Insured Amount: | Effective Date: |
| Expiration Date: | Policy #: | Coverage per Occurrence: |
| Aggregate Coverage Amount: | | |

## Secondary Facility/Primary Office Information

| | | |
|---|---|---|
| Is this a participant service site? Yes ☐ No ☐<br>(list all service sites separately below on page 6) | | |
| Name (Doing business as): | | |
| Telephone: | Primary Contact Name: | E-Mail: |
| Address (Street): | City/State/Zip: | County: |
| Credentialing/Billing Contact: | Fax: | E-Mail: |
| Website URL: | | Medicaid Number: |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **SERVICE HOURS** | Monday: | Tuesday: | Wednesday: | Thursday: | Friday: | Saturday: | Sunday: |
| | Are PAs, CNMs, and/or Nurse Practitioners used?<br>Yes ☐ No ☐ | | | Will you be accepting any new participants?<br>Yes ☐ No ☐ | | | |
| In addition to English -Please list all languages used to communicate with participants<br>(including American Sign Language if applicable): | | | | | | | |
| Is a skilled medical interpreter available?<br>Yes ☐ No ☐ | | | | Has staff been trained on cultural competency?<br>Yes ☐ No ☐ | | | |
| Is your practice limited to certain ages?<br>Yes ☐ No ☐ | | | | *If yes, please list age/gender restrictions:* | | | |

## Are the following area(s) ADA compliant? (Check those that apply)

| | |
|---|---|
| ☐ Parking | ☐ ADA Compliant Signage |
| ☐ Interior Building | ☐ Medical Equipment |
| ☐ Restrooms | ☐ Exam Room |
| Are you located within walking distance of a public transportation route? Yes ☐ No ☐ | |

## Capacity on Certificate of Compliance

| | |
|---|---|
| Residential Facility-Capacity (# of residents): | Adult Day Care (# of participants): |
| Personal Assistance Service: Do you use Electronic Visit Verification? Yes ☐ No ☐ | If yes, vendor: |
| Home Health Service: Do you use Electronic Visit Verification? Yes ☐ No ☐ | If yes, vendor: |

## Malpractice Insurance Information (if applicable)

| | | |
|---|---|---|
| Carrier Name: | Insured Amount: | Effective Date: |
| Expiration Date: | Policy #: | |
| Aggregate Coverage Amount: | | |

## General Liability Insurance Information

| | | |
|---|---|---|
| Carrier Name: | Insured Amount: | Effective Date: |
| Expiration Date: | Policy #: | Coverage per Occurrence: |
| Aggregate Coverage Amount: | | |

## Arkansas Counties:

| | | | | |
|---|---|---|---|---|
| 01. Arkansas | 16. Craighead | 31. Howard | 46. Miller | 61. Randolph |
| 02. Ashley | 17. Crawford | 32. Independence | 47. Mississippi | 62. Saint Francis |
| 03. Baxter | 18. Crittenden | 33. Izard | 48. Monroe | 63. Saline |
| 04. Benton | 19. Cross | 34. Jackson | 49. Montgomery | 64. Scott |
| 05. Boone | 20. Dallas | 35. Jefferson | 50. Nevada | 65. Searcy |
| 06. Bradley | 21. Desha | 36. Johnson | 51. Newton | 66. Sebastian |
| 07. Calhoun | 22. Drew | 37. Lafayette | 52. Ouachita | 67. Sevier |
| 08. Carroll | 23. Faulkner | 38. Lawrence | 53. Perry | 68. Sharp |
| 09. Chicot | 24. Franklin | 39. Lee | 54. Phillips | 69. Stone |
| 10. Clark | 25. Fulton | 40. Lincoln | 55. Pike | 70. Union |
| 11. Clay | 26. Garland | 41. Little River | 56. Poinsett | 71. Van Buren |
| 12. Cleburne | 27. Grant | 42. Logan | 57. Polk | 72. Washington |
| 13. Cleveland | 28. Greene | 43. Lonoke | 58. Pope | 73. White |
| 14. Columbia | 29. Hempstead | 44. Madison | 59. Prairie | 74. Woodruff |
| 15. Conway | 30. Hot Spring | 45. Marion | 60. Pulaski | 75. Yell |

**Services** – Check each that applies. For "Service County", list corresponding county number from above.

| Service | Service County | Address | Location ID |
|---|---|---|---|
| ☐ Adult Daily Living (261QA0600X) | | | |
| ☐ Assistive Technology | | | |
| ☐ Benefits Counseling | | | |
| ☐ Career Assessment (261QA0600X) | | | |
| ☐ Community Integration (251S00000X) | | | |
| ☐ Community Transition Svcs (251J00000X) | | | |
| ☐ Employment Skills Development (251E00000X) | | | |
| ☐ Financial Management Services Services My Way (251X00000X) | | | |
| ☐ Financial Management Services Start UP (251X00000X) | | | |
| ☐ Home Adaptations (171WH0202X) | | | |
| ☐ Home Delivered Meals (332U00000X) | | | |
| ☐ Home Health Aide (374U00000X) | | | |
| ☐ Home Health-Nursing (LPN) | | | |
| ☐ Home Health-Nursing (RN) | | | |

| Service | Service County | Address | Location ID |
|---|---|---|---|
| ☐ Home Health-Occupational Therapy (225X00000X) | | | |
| ☐ Home Health-Occupational Therapy-Assist (225X00000X) | | | |
| ☐ Home Health-Physical Therapy (225X00000X) | | | |
| ☐ Home Health-Physical Therapy-Assist (225100000X) | | | |
| ☐ Home Health-Speech & Language Therapy | | | |
| ☐ Job Coaching (251E00000X) | | | |
| ☐ Non-medical Transportation (343900000X) | | | |
| ☐ Nursing Facility Services | | | |
| ☐ Participant-Directed Community Supports (251X00000X) | | | |
| ☐ Participant-Directed Goods & Services (251X00000X) | | | |
| ☐ Personal Care Attendant (3747P1801X) | | | |
| ☐ Personal Emergency Response System (33300000X) | | | |
| ☐ Prevocational Services (251S00000X) | | | |
| ☐ Residential Habilitation (320900000X) | | | |
| ☐ Respite (Agency) (253Z00000X) | | | |
| ☐ Respite (Consumer) (385H00000X) | | | |
| ☐ Service Coordination | | | |
| ☐ Specialized Medical Equipment and Supplies | | | |
| ☐ Structured Day Habilitation (320900000X) | | | |
| ☐ Support Employment | | | |
| ☐ Transition Service Coordination | | | |
| ☐ Vehicle Modifications (171WV0202X) | | | |
| ☐ Other | | | |
| ☐ Other | | | |

**Confidential Information** | Have you, any agent, or managing employee ever:

| | | |
|---|---|---|
| Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time? | **Yes** ☐ | **No** ☐ |
| Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)? | **Yes** ☐ | **No** ☐ |
| Had a controlled drug license withdrawn? | **Yes** ☐ | **No** ☐ |
| Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation? | **Yes** ☐ | **No** ☐ |
| In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? | **Yes** ☐ | **No** ☐ |

**Signature of authorized designee**

**Title**

**Name (Print)**

**Date**

# Attestation Statement

**INSTRUCTIONS: Please complete either Section A or Section B for consideration to participate in the Health Plan provider network. For any "Yes" response to one or more of the questions in Section B, please provide separate page with explanations for all "Yes" responses.**

**This attestation pertains to all employed and contracted provider(s) authorized to provide or supervise care provided by _____ (the "Agency").**

**I, _____, the undersigned representative of Agency, on its behalf, understand and agree that as part of the credentialing process for participation in the Health Plan provider network,**

**Section A**

...attest that the Agency has conducted the following on each caregiver prior to allowing each to provide care to a Health Plan member:

- Conducted Criminal Background Check and;
- Reviewed State Child Maltreatment Registry and;
- Reviewed State Adult Maltreatment Registry and;
- Successfully Passed Drug Screening
- Confirmed Active Driver's License (if applicable)
- A completed job application that contains any required credentials for the position
- Completed reference checks

**Section B**

...assure through a background check and other reasonable means the following with respect to each caregiver providing care and each attendant supervising care on behalf of the Agency:

| | | |
|---|---|---|
| Have applicable license(s) held by caregiver(s) and/or attendant(s) been revoked, refused, restricted or voluntarily surrendered? | **Yes** ☐ | **No** ☐ |
| Have caregiver(s) and/or attendant(s) been convicted of, or pled guilty to, a felony? | **Yes** ☐ | **No** ☐ |
| Has any caregiver or attendant been terminated, suspended, barred, sanctioned or voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program? | **Yes** ☐ | **No** ☐ |
| Is/Are caregiver(s) and/or attendant(s) unable to perform the essential functions of his or her job with reasonable accommodation? | **Yes** ☐ | **No** ☐ |
| Is the Agency aware of any reason why caregiver(s) and/or attendant(s) may pose a threat to the person or property of individuals receiving care provided by caregiver(s) or supervised by attendant(s)? | **Yes** ☐ | **No** ☐ |

**Signature of authorized designee**

**Title**

**Name (Print)**

**Date**

**Tax ID**

## Disclosure of Ownership and Control Interest Statement Instructions

The instructions below provide guidance on how to complete the Disclosure of Ownership and Control Interest Statement. The Individual Practitioner, Group Practice or Disclosing Entity with respect to which the Disclosure of Ownership and Control Interest Statement is being completed is referred to herein as the "Provider". For each Section of the Statement, attach a separate sheet if necessary to provide complete information.

### Practice Information Section

**Check one that describes you** – Check the box that most closely describes how you are contracted with the Health Plan. See the Definitions section of these instructions for assistance in determining if you are an Individual Practitioner, Group Practice or Disclosing Entity. An "Individual Practitioner" is a practitioner that hold a direct contract with the Health Plan, and not a practitioner that is participating indirectly through the contract of a Group Practice or Disclosing Entity.

**Name of Individual Practitioner, Group Practice or Disclosing Entity** – Provide the name of the Individual Practitioner, Group Practice or Disclosing Entity. If you are an individual who is participating through a Group Practice or Disclosing Entity, enter your name.

**DBA Name** – If you are a Disclosing Entity or Group Practice, enter any doing business as or "DBA" name (e.g., fictitious or trade name). If you are an individual participating through a Group Practice or Disclosing Entity, enter the Group Practice or Disclosing Entity name.

**Address** – Enter your main physical address.

**TIN or SSN** – If you are a Disclosing Entity or Group Practice, enter the Federal Tax Identification Number (TIN). If you are an Individual Practitioner who is participating through a Group Practice or Disclosing Entity, enter the TIN of the Group Practice or Disclosing Entity. If you are an Individual Practitioner, enter your TIN or Social Security Number (SSN).

**NPI** – Enter your National Provider Identifier.

**Section I: Provider Ownership and Control Interest** – Provide the information requested for any individual or entity with an ownership or controlling interest in the Provider. Please refer to the Determination of Ownership or Control Interest Section below for assistance in reporting such interests. The address for any corporate entities must include, as applicable, primary business address, every business location and every post office box address. Write "None" or "Not applicable" if you are an Individual Practitioner or if there are no ownership or control interests in the Provider that require reporting.

**Section II: Subcontractor Ownership and Control Interest** – Indicate whether or not the Provider has a 5% or more direct or indirect ownership or control interest in a subcontractor by checking the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each subcontractor in which the Provider has such an interest.

**Section III: Relationships** – Indicate whether or not any individuals listed in Section I or Section II are related to each other by checking the "Yes" or "No" box as applicable. If "Yes" is checked, list the individuals that are related to each other and the type of relationship.

**Section IV: Convictions** – Indicate whether or not there are any persons who have an ownership or control interest in the Provider, or is an agent or managing employee of the Provider who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Social Security Title XX services program since the inception of those programs by checking the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each person.

**Section V: Business Transactions** – Indicate by checking either the Yes or No box whether or not the Provider has had any financial transaction with a subcontractor totaling more than $25,000 in the 12 months prior to the completion date of this Statement or any significant business transaction (see the Definitions Section below) between the Provider and a wholly owned supplier or between Provider and any subcontractor in the 5 years prior to the completion date of this Statement. If "Yes", provide the requested information.

**Section VI: Managing Employees** – If the Provider has any managing employees, check the "Yes" box and list each member of the Board of Directors or Governing Board and each managing employee with their name, date of birth, address, SSN and percent of interest. If the Provider has no managing employees, check the "No" box.

**Signature/Title/Date** – Provide the printed name, signature and title of the individual completing the Statement either as an Individual Practitioner or on behalf of the Provider. In the date field, enter the date the Statement was completed. If the individual completing the Statement is completing it on behalf of physicians and/or practitioners that are part of a Group Practice or Disclosing Entity, attach a list as "Exhibit A" identifying such physicians and/or practitioners, including their names, addresses, specialty and NPI.

## Definitions

Terms used in the Disclosure of Ownership and Control Interest Statement have the meanings set forth at 42 C.F.R § 455.101. Such definitions, effective as of the date of these Instructions, are set forth below for your convenience.

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

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

**Other disclosing entity** means 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 Social Security Act (the "Act"). This includes: 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); any Medicare intermediary or carrier; and 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.

As used in the Disclosure of Ownership and Control Interest Statement, "Disclosing Entity" includes a "disclosing entity" and a "other disclosing entity", as those terms are defined above.

**Group practice or group of practitioners** means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

**Indirect ownership interest** means 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** means 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.

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

**Person with an ownership or control interest** means 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; or
f) is a partner in a disclosing entity that is organized as a partnership.

**Significant business transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

**Subcontractor** means:

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; or
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.

**Supplier** means an individual, agency, or organization from which a provider purchases goods and 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** means 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.

## Determination of Ownership or Control Percentages

Guidance regarding the determination of certain ownership or control percentages is set forth in 42 C.F.R. § 455.102. Such guidance, effective as of the date of these Instructions, is set forth below for your convenience.

**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 which 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 which 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.

**Person with an ownership or control interest**. Please also refer to the Definition Section. 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.

## Provider Type Scenarios

The scenarios below are examples of how the Disclosure of Ownership and Control Interest Statement may be completed.

**Individual Practitioner** – An individual practitioner would check the “Individual Practitioner” checkbox in the Practice Information Section, indicate “None” in Section I: Provider Ownership and Control Interest, indicate “Yes” or “No” in the remaining check boxes as appropriate then sign and date the Statement.

**Group of Practitioners** – A group practice would check the “Group Practice” checkbox in the Practice Information Section, and complete a Disclosure of Ownership and Control Interest Statement for the Group Practice. Each individual participating under the Group Practice’s contract with the Health Plan that is either an employee or co-owner would fill out a Disclosure of Ownership and Control Interest Statement as an individual and list the Group Practice name in the “DBA Name” field in the Practice Information Section, use the Group Practice address and use the practitioner’s individual TIN or SSN. As an alternative to each individual completing a Statement, the Group Practice may complete, execute and submit a Statement on his or her behalf as long as the person executing the Statement is legally authorized, as an agent or attorney-in-fact, to do so.

**Hospital or Hospital System** – A hospital would check the “Disclosing Entity” checkbox in the Practice Information Section, and complete a Disclosure of Ownership and Control Interest Statement for the hospital. Each individual participating under the hospital’s contract with the Health Plan that is either an employee or co-owner would fill out a Disclosure of Ownership and Control Interest Statement as an individual and list the hospital name in the “DBA Name” field in the Practice Information Section, use the hospital address and use the practitioner’s individual TIN or SSN. As an alternative to each individual completing a Statement, the hospital may complete, execute and submit a Statement on his or her behalf as long as the person executing the Statement is legally authorized, as an agent or attorney-in-fact, to do so.

**Independent Clinical Lab** – An independent clinical laboratory would check the “Disclosing Entity” checkbox in the Practice Information Section, and complete a Disclosure of Ownership and Control Interest Statement for the laboratory. Each individual participating under the

laboratory's contract with the Health Plan that is either an employee or co-owner would fill out a Disclosure of Ownership and Control Interest Statement as an individual and list the laboratory name in the "DBA Name" field in the Practice Information Section, use the laboratory address and use the practitioner's individual TIN or SSN. As an alternative to each individual completing a Statement, the laboratory may complete, execute and submit a Statement on his or her behalf as long as the person executing the Statement is legally authorized, as an agent or attorney-in-fact, to do so.

**Disclosure of Ownership and Control Interest Statement for the NovaSys Health network maintained by Arkansas Health and Wellness**

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The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are executing a provider agreement or submitting a provider application to disclose to managed care organizations that contract with the state Medicaid agency: 1) the identity of all persons with an ownership or control interest (e.g., has an ownership interest of 5% or more in a disclosing entity, is an officer or director of a disclosing entity organized as a corporation or a partner of a disclosing entity organized as a partnership, owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity under certain circumstances, etc.), 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this Statement, an updated Statement should be completed and submitted to the NovaSys Health network maintained by Arkansas Health and Wellness within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network.

## Practice Information

| | |
|---|---|
| Check one that describes you: ☐ Individual Practitioner ☐ Group Practice ☐ Disclosing Entity | |
| Name of Individual Practitioner, Group Practice, or Disclosing Entity ("Provider") | |
| DBA Name: | |
| Address: | |
| TIN or SSN: | NPI: |
| Medicare Number: | Medicaid Number: |

## Section I: Provider Ownership and Control Interest

For individuals with an ownership or control interest in the Provider (e.g. an ownership interest of 5% or greater, an officer or director of a Disclosing Entity that is a corporation, etc. – refer to the Definition of "person with ownership or control interest" in the Instructions), list the name, address, date of birth (DOB) and Social Security Number (SSN) for each such individual.

For entities with an ownership or control interest in the Provider, list the name, Tax Identification Number (TIN), and each address of each entity. (42 CFR 455.104) Attach a separate sheet if necessary.

| Name | DOB (if an individual) | Address | SSN (if an individual) TIN (if an entity) |
|---|---|---|---|
| | | | |
| | | | |

## Section II: Subcontractor Ownership and Control Interest

Are there any subcontractors in which the Provider has an ownership or control interest of 5% or more? ☐ Yes ☐ No

If yes, list the name, address, DOB and SSN for each individual having an ownership or control interest in such subcontractor(s), and list the name, TIN and each address for each entity having an ownership or control interest in such subcontractor. (42 CFR 455.104) Attach a separate sheet if necessary.

| Name | DOB (if an individual) | Address | SSN (if listing an individual) TIN (if listing an entity) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Section III: Relationships

Are any of the individuals listed in Section I or Section II above related to each other? ☐ Yes ☐ No

If yes, list the individuals who are related to each other, and the type of relationship (spouse, sibling, parent, child). (42 CFR 455.104) Attach a separate sheet if necessary.

| Names | Type of relationship |
|---|---|
| | |
| | |
| | |

## Section IV: Convictions

Has any person who has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?

☐ Yes ☐ No (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106) Attach a separate sheet if necessary.

| Name/Title | DOB | Address | SSN |
|---|---|---|---|
| | | | |
| | | | |

## Section V: Business Transactions

Has the Provider had any financial transactions with any subcontractors totaling more than $25,000 with any subcontractors during the previous 12 months? ☐ Yes ☐ No

Has the Provider had any significant business transactions between it and any wholly owned supplier or any subcontractor during the previous 5 years? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the previous twelve month period, and any significant business transactions between the Provider and any wholly owned supplier or between the Provider and any subcontractor during the past 5-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

| Name Supplier/Subcontractor | Address | Transaction Amount |
|---|---|---|
| | | |
| | | |

## Section VI: Managing Employees

Does the Provider have any managing employees? ☐ Yes ☐ No

If yes, list each member of the Board of Directors or Governing Board and each managing employee with their name, DOB, address, SSN, and percent of interest. (42 CFR 455.104) Attach a separate sheet if necessary.

| Name/Title | DOB | Address | SSN | % Interest |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If "Group Practice" or "Disclosing Entity" is checked in the Practice Information section above, the undersigned hereby represents that he, she or it is providing the information in this Statement on behalf of the Group Practice or Disclosing Entity, as appropriate, and on behalf of each physician and practitioner listed on Exhibit A attached to this Statement, and the undersigned represents that he, she or it is legally authorized, as an agent or attorney-in-fact, to provide such information and execute this Statement on behalf of the Group Practice or Disclosing Entity and each listed physician and practitioner.

The undersigned certifies that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately after such change. Additionally, the undersigned understands that misleading, inaccurate, or incomplete data may result in a denial of participation for the affected providers.

Signature _____ Title (or indicate if authorized Agent) _____

Name (please print) _____ Date _____

Please return by fax to **844-357-7890**, by email to **arkcredentialing@centene.com**, or by mail in the enclosed postage paid envelope to:
**P.O. Box 25538**
**Little Rock, AR 72212**