Southwest Michigan BEHAVIORAL HEALTH

Section: **Compliance**	Procedure Name: **Ownership & Control Disclosures, Criminal Conviction Disclosures, and Exclusions Monitoring**	Procedure #: **P10.13.01**
Overarching Policy: **Operating Policy 10.13 Ownership & Control, Criminal Conviction Disclosures, and Exclusions Monitoring Requirements**		
Owner: **Chief Compliance Officer**	Reviewed By: **Mila C. Todd**	Total Pages: **5**
Required By: ☒ **BBA** ☒ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: Mila C. Todd Mila Todd (Mar 31, 2023 05:12 EDT)	Date Approved: Mar 31, 2023
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☐ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **3/23/20**

Policy: Southwest Michigan Behavioral Health (SWMBH) and its provider network shall comply with federal regulations to obtain, maintain, disclose, and furnish required information about ownership, control interests, business transactions, and criminal convictions as specified in 42 CFR §455. In addition, SMWBH and its provider network shall ensure that all contracts, agreements, purchase orders, and leases to obtain space, supplies, equipment or services provided with Medicare or Medicaid funds require compliance with 42 CFR §455.104-106. SWMBH will notify the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation and Contracts when disclosures are made by providers with regard to any offenses detailed in sections 1128(a) and 1128(b) (1), (2) or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. SWMBH and Participant Community Mental Health Service Providers (CMHSP) will perform ongoing exclusions monitoring of applicable individuals.

Purpose: To direct how SWMBH, Participant CMHSPs, and network providers will adhere to Federal and State of Michigan rules and regulations, and to avoid risk exposure to SWMBH, its participant CMHSPs, and providers.

Scope: SWMBH Compliance, SWMBH Provider Network Management, participant CMHSPs, all network providers.

Responsibilities: SWMBH and participant CMHSPs will collect Ownership & Control Disclosures, make any required disclosures, and perform on-going exclusions monitoring as outlined in this Procedure.
Providers will disclose all required information in accordance with this Procedure and any other applicable laws, rules, and regulations.

Definitions:

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

B. **Screened Person** means all officers, directors, any person with a direct or indirect Ownership interest of 5% or more of a Disclosing Entity; prospective and current employees, agents, practicing clinical staff (credentialed, consulting, or referring), allied health professionals, students, volunteers, contractors, and subcontractors. In addition, "Screened Persons" include immediate family members of, or a member of a person's household, to whom a transfer of ownership or control in a Disclosing Entity has been made in anticipation of or following a conviction, assessment of a CMP, or imposition of an exclusion. Finally, a "Screened Person" includes any person or entity under contract with SWMBH, a participant CMHSP, or a provider entity related to purchase orders, leases to obtain space, supplies, equipment or services provided under the Medicaid Agreement totaling more than $25,000 during a 12-month period.

C. **Immediate Family Member** means a person's husband or wife, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father/mother/son/daughter/brother/sister-in-law, grandparent or grandchild, or spouse of a grandparent or grandchild.

D. **ICO** means Integrated Care Organization under the MI Health Link duals demonstration program.

E. **Member of Household** means with respect to a person, any individual with whom they are sharing a common abode as part of a single-family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

F. **Excluded Individuals** are individuals or entities that have been excluded from participating, but not reinstatement, in Medicare, Medicaid, or any other Federal health care programs. Bases for exclusion include convictions for program related fraud and patient abuse, licensing board actions, and default on Health Education Assistance loans.

Procedure:

A. **Disclosure Statement Requirements**

1. SWMBH and its Provider Network shall complete the SWMBH Federally Funded Health Care Program Disclosure Form at intervals prescribed by the Federal Rules.
2. SWMBH and its Provider Network may complete the SWMBH Federally Funded Health Care Program Attestation Form if and when the following conditions are met:
   a. Provider Entity has submitted a complete Federally Funded Health Care Program Disclosure Form within the last 365 days; AND
   b. Provider Entity has reviewed the full form that was previously submitted for continued accuracy; AND
   c. There are no changes, additions, or deletions to any of the information previously disclosed.

B. **Time of Disclosure & Responsibility for Collection**

1. SWMBH/participant CMHSPs shall obtain Disclosure Forms from their providers and applicable contractors at any of the following intervals:
    a. When the provider submits a provider application;
    b. Upon execution of the provider agreement;
    c. During re-credentialing or re-contracting;
    d. Within 35 days of any change in ownership of a disclosing entity.
2. SWMBH shall collect Disclosure Forms from providers it directly contracts with (CMHSPs, SUD providers, and MI Health Link providers). Participant CMHSPs shall collect Disclosure Forms for their own providers and contractors. Shared providers' Disclosure Forms shall be collected by either SWMBH or the CMHSP assigned to perform that shared provider's Provider Network Site Review. Completed Disclosure Forms shall be provided to SWMBH.
3. Out of network provider entities who seek payment from SWMBH or a participant CMHSP must execute an "Attestation Confirming Debarment, Suspension and Exclusion Responsibilities" (Attached to this Policy), OR the same terms from the Attestation will be included in an executed Single Case Agreement/Letter of Agreement.

C. **Monitoring Staff, Contractors, and Provider Networks**

1. SWMBH monitors its provider network entities and all "Screened Persons" included on the Disclosure Forms collected for Region 4. These "Screened Persons" are monitored via monthly Exclusion Database searches to capture exclusions since the last search and at any time providers submit new disclosure information. The following databases are searched by SWMBH on a monthly basis:
    a. Michigan Sanctioned Provider List;
    b. OIG Exclusion Databases (LEIE and GSA); and
    c. System for Award Management (SAM).
2. In addition to monitoring "Screened Persons", SWMBH and its participant CMHSPs are each responsible for monitoring their own full staff and members of their Boards of Directors through the above referenced databases prior to hire or contracting, or the beginning of Board service, and monthly thereafter.
3. Contracted providers are responsible for monitoring their own full staff through the above referenced databases prior to hire or contracting, and as follows:
    a. For credentialed practitioners, monthly thereafter with verification available in the practitioner credentialing record.
    b. For non-credentialed staff, at a minimum annually thereafter.
4. Business process requirements: SWMBH HR must notify Compliance of staff changes; Provider Network Management must notify Compliance of network changes; SWMBH contracted Community Mental Health Service Programs must notify SWMBH of staff changes when SWMBH runs their exclusions.

D. **Excluded Persons**

1. An individual found to be excluded shall be immediately removed (e.g. through termination of employment or contract) from responsibility for, or involvement in, the following:
    a. Business operations related to any Federally Funded Health Care Programs;
    b. The provision of items or services directly, or indirectly, to Federally Funded Health Care Program beneficiaries;
    c. Any position for which the excluded individual's compensation, or the items or services furnished, ordered, or prescribed by the excluded individual are paid, in whole or in part, directly or indirectly, by Federally Funded Health Care Programs or otherwise with Federal funds.
2. Additionally, participant CMHSPs and providers must notify the SWMBH Director of Provider Network as soon as possible following discovery of an excluded individual, and must attest to SWMBH that any costs

and expenses related to the employment of or payment to the excluded individual are not submitted to SWMBH under its PIHP subcontract cost settlement process.

3. For MI Health Link, if an individual is found to be listed on the Medicare Preclusion List provided by the ICO(s) monthly, in addition to complying with Section (D)(1) above, SWMBH will notify the affected ICO(s).

E. **Reporting Criminal Convictions**

1. SWMBH will notify the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation and Contracts when disclosures are made by providers with regard to any offenses detailed in sections 1128(a) and 1128(b) (1), (2) or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act.
2. Additionally, participant CMHSPs must notify SWMBH's Director of Provider Network of the disclosure of any of the offenses referenced in Section E(1) above.
3. These offenses include convictions of program-related crimes, patient abuse, healthcare fraud, and controlled substances.

F. **Failure to Comply**

1. Failure to fully complete the Disclosure Form as required, or the submission of false or misleading information to SWMBH or a participant CMHSP may subject the Disclosing Entity to contractual sanctions or other action, up to and including immediate suspension of funding and termination of employment/contract termination.

References: SWMBH Operating Policy 10.13

Attachments:

A. SWMBH Federally Funded Health Care Program Disclosure Form – Individual
B. SWMBH Federally Funded Health Care Program Disclosure Form – Group
C. SWMBH Federally Funded Health Care Program Disclosure Attestation – Individual
D. SWMBH Federally Funded Health Care Program Disclosure Attestation – Group
E. Attestation Confirming Debarment, Suspension, and Exclusion Responsibilities

Southwest Michigan
BEHAVIORAL HEALTH

Revision Log

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	02/14/2020	Reformatted Procedure to new template; Added provisions applicable to checking the Medicare Preclusion List in Sections C(1)(d) and D(2).	Added provisions applicable to checking the Medicare Preclusion List provided by the ICO and notifying affected ICO of any positive hits. Added out of network provider attestation terms (Section B(3)).	Mila C. Todd
2	03/18/2020	Procedure Section B(3).	Added Attachment – Attestation Regarding Debarment, Suspension, and Exclusion Responsibilities.	Mila C. Todd
3	12/27/21	C (4) Business Processes	Added SWMBH, provider and CMH responsibilities	Mila C. Todd
4	03/23/2023	(C)(1)(d) – deleted (C)(3)(a) & (b) – added	Deleted Medicare Preclusion List in light of MHL extrication. Add C(3)(a) and (b) in line with MDHHS Credentialing Policy requirements for monthly exclusion monitoring for credentialed practitioners.	Mila C. Todd

P10.13.01 Ownership & Control Disclosures, Criminal Conviction Disclosures, and Exclusions Monitoring

Final Audit Report 2023-03-31

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Southwest Michigan
BEHAVIORAL HEALTH

Federally Funded Health Care Program Disclosure Form – Individual

WHAT IS SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health (SWMBH) is a Prepaid Inpatient Health Plan (PIHP). As a PIHP, SWMBH manages the Medicaid, MiChild, and MI Health Link behavioral health (mental health and substance use disorder) benefits for Region 4. Region 4 is made up of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren counties.

WHAT INFORMATION IS REQUIRED

The Federal Rules, the Medicaid Provider Manual, and SWMBH's contract with MDHHS require disclosures of information that includes, but is not limited to:

1) The identity of all owners and others with a controlling interest (direct or indirect) of 5% or greater;
2) Certain business transactions as described in 42 CFR §455.105;
3) The identity of managers and others in a position of influence or authority; and
4) Criminal conviction information for the provider, owners, and managers.

The information required includes, but is not limited to: name, address, date of birth, Social Security Number (SSN) and tax identification number (TIN).

WHY IS THIS INFORMATION REQUIRED

In order to comply with Federal law (42 CFR 420.200 – 420.206 and 455.100-455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding ownership and control of the entities with which the plan contracts for services paid for by Medicaid and/or Medicare.

This information is required to ensure that SWMBH and its participating Community Mental Health Service Providers (CMHSPs) are not contracting with a provider that has been excluded from participation in State and Federal health programs, or an entity that is owned or controlled by an individual who is excluded, has been convicted of certain criminal offenses, or has had civil monetary penalties imposed against them.

WHO IS REQUIRED TO PROVIDE THIS DISCLOSURE

All providers in SWMBH's managed care network who receive (directly or indirectly) Federally Funded Health Care Program funds.

HOW WILL THE INFORMATION BE COLLECTED

SWMBH contracts with the local CMHSPs in each of the counties in Region 4 to manage and provide mental health services paid for by Medicaid. SWMBH requires the CMHSPs to submit this disclosure for the CMHSP **and** its contracted providers.

SWMBH contracts directly with SUD providers and with MI Health Link providers, and will work directly with these providers to secure completed disclosures.

WHAT PROTECTIONS ARE IN PLACE FOR INFORMATION DISCLOSED

SWMBH implemented a policy specific to Social Security Numbers obtained pursuant to the Ownership and Control Disclosure requirements, as well as a tool to be used in assessing any potential breaches. SWMBH Operating Policy 10.17-Social Security Number Privacy Policy is based on and compliant with the Michigan Social Security Number Privacy Act, Act 454 of 2004. SWMBH Operating Policy Attachment 10.16A – Breach Response Risk Assessment Tool includes a response assessment that is compliant with the Michigan Identify Theft Protection Act, Act 452 of 2004.

In addition to administrative safeguards, there are physical and technical safeguards in place to protect the information gathered by this disclosure. The information is stored on an electronic device that is password protected, and kept in a locked container. The password is changed every 60 days. SWMBH's Chief Compliance & Privacy Officer and a single SWMBH Compliance Specialist hold keys to the locked container and know the password. The locked container is physically stored in a safe that is only accessible by SWMBH's Chief Financial Officer, and all accesses are recorded on an access log.

WHAT IF A PROVIDER DOES NOT COMPLETE THIS DISCLOSURE

The Federal Rules and the Medicaid Provider Manual independently require providers to disclose the information requested in this form. Completion and submission of this form is a condition of participation in SWMBH and each Community Mental Health Service Providers' provider network. ***Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider contract, or termination of existing provider contracts.***

42 CFR §455.104(e) Consequences for failure to provide required disclosures. *Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.*

HOW OFTEN DOES THIS FORM HAVE TO BE COMPLETED

The Medicaid Disclosure Form must be submitted at the following intervals:

1) Provider enrollment;
2) Initial contracting;
3) Annual contract renewal;
4) Within 35 days of a request for updated information from SWMBH;
5) Within 35 days of any changes to the information or change in ownership.

WHO DO I CONTACT WITH QUESTIONS?

Medicaid mental health services providers should contact either the Community Mental Health Service Provider who requested the information from you or the Southwest Michigan Behavioral Health Compliance Department with questions. SUD and MI Health Link providers should contact the Southwest Michigan Behavioral Health Compliance Department with questions.

SWMBH
Mila Todd
mila.todd@swmbh.org
(269) 488-6794

Barry County Community Mental Health Authority
Brenna Ellison
brleedy@bccmha.org
(269) 948-8041

Pines Behavioral Health (Branch County CMHA)
Megan Daws
mdaws@pinesbhs.org
(517) 278-2129

Riverwood Center (Berrien County CMHA)
Sara Doyle
sxd@riverwoodcenter.org
(269) 925-0585

Summit Pointe (Calhoun County CMHA)
Mandi Quigley
meq@summitpointe.org
(269) 441-6112

Woodlands Behavioral Health Network (Cass County CMHA)
Steve Waller
stevew@woodlandsbhn.org
269-228-4445

Kalamazoo Community Mental Health and Substance Abuse Services
Ashley Esterline
esterline@kazoocmh.org
(269) 364-6986

Van Buren Community Mental Health
Megan Salziger
msalziger@vbcmh.com
(269) 655-3304

Community Mental Health and Substance Abuse Services of St. Joseph
Cameron Bullock
cbullock@stjoecmh.org
(269) 467-1001

Individual Provider Information

Instructions

Please fill out the entire section. ***Every field must be complete.*** If fields are left blank, the form will not be processed and will be returned for corrections/completions. If the form is unreadable due to illegible handwriting, the form will not be processed.

<table>
<tr><td rowspan="5">Please choose appropriate category:
___Individual Member of a Medical Group
___ Individual Contracted Provider
___Sole Proprietor
___ HCBS Provider
___Other:

<u>If Affiliated with a Group, do you have a</u>

<u>Private Practice as well? Yes No NA</u></td><td colspan="4">Name of Person Completing the Form (First/Middle/Last)</td></tr>
<tr><td colspan="4">Title</td></tr>
<tr><td colspan="4">Phone Number</td></tr>
<tr><td colspan="4">Fax</td></tr>
<tr><td colspan="4">Email</td></tr>
<tr><td colspan="5">Legal Name of Individual (“Individual Provider”): Name of Group (if applicable):</td></tr>
<tr><td colspan="5">Physical Address
STREET CITY STATE ZIP</td></tr>
<tr><td colspan="5">+Additional Addresses (list all Practice locations – attach a separate sheet if necessary):</td></tr>
<tr><td>SSN #:</td><td>*Medicaid ID #:</td><td colspan="2">*National Provider ID (NPI) #:</td><td></td></tr>
<tr><td colspan="2">*If billing under an Entity: Federal Tax Identification #:</td><td colspan="3">*If billing under an Entity: Billing Entity’s NPI #:</td></tr>
<tr><td colspan="2">*If billing under an Entity: Billing Entity’s Medicaid ID#:</td><td colspan="3"></td></tr>
</table>

These fields cannot be left blank; “N/A” non-applicable and “applied for” are acceptable responses.
Individual providers please use social security number; field cannot be left blank: “N/A” non-applicable and “applied for” are acceptable responses

+ Please list “consumers’ homes” or “public community locations” if services are provided in these locations

Section I: Individual Provider Ownership Information

Are there any individuals or organizations with a Direct or Indirect Ownership or Controlling Interest of 5% or more in the Individual Provider? _____**Yes** ___**No**

If yes, list the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Controlling Interest in the Individual Provider of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership or Controlling Interest of 5% or greater. (42 CFR §455.104) ***Attach additional sheet as necessary***

Name of Owner (first/middle/last; any alias)	**DOB (mm/dd/yyyy)**	**Complete Address (Street/City/State/Zip)**	**** SSN (individual) and/or TIN (entity)** *List both as applicable*

***** SSN and TIN required under §455.104; see Sect 4313 of Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No. 22***

Section II: Ownership in Providers & Entities

Does the Owner ***identified in Section I*** have an Ownership or Controlling Interest in ***any other*** *provider or entity*? ___**Yes** ____ **No**

If Yes, list the name and the SSN or TIN of **the other provider or entity** in which the Owner identified in **Section I** also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3)) ***Attach additional sheets as necessary***

Name of Owner from Section I	**Name of *Other Provider or Entity***	**Other Provider or Entity's SSN (individual) or TIN (entity)**

Section III: Subcontractor Ownership

Do you have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor? ___**Yes** ___**No**
If Yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor? ___**Yes** ___**No**
If Yes, list information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you *also have* Direct or Indirect Ownership Interest of 5% or more. (42 CFR §455.104) ***Attach additional sheets as necessary***

Legal Name of Subcontractor			
Name of Subcontractor's Other owner			
Other Owner's complete Address (Street/City/State/ZIP)			
***Other Owner's* TIN:**	***Other Owner* SSN:**	***Other Owner's DOB*** (mm/dd/yyyy)	**% Interest in Subcontractor**

Section IV: Familial Relationships of All Owners

Are any of the individuals identified in Sections I, II or III related to each other? _____**Yes** _____**No**
If Yes, list the individuals identified and the relationship to each other (e.g., spouse, domestic partner, sibling, parent, child) (42 CFR §455.104(b)(2)) ***Attach additional sheets as necessary***

Name of Owner 1:	**Name of Owner 2:**	**Relationship**

Section V: Management & Control

Managing Employees: Individual Provider have any Managing Employees? _____**Yes** _____ **No**

If Yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day- to-day operations of your Individual Provider Practice (general manager, business manager, administrator or director), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104) ***Attach additional sheets as necessary.***

Name (first/MI/last)	DOB mm/dd/yyyy	Complete Address (Street/City/State/Zip)	SSN	Title

Agents: Do you, as an Individual Provider, have any Agents? _____**Yes** ___**No**

If yes, list all Agents that have been delegated the authority to obligate or act on behalf of you, the Individual Provider, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104) ***Attach additional sheets as necessary.***

Name (first/MI/last)	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN

Board of Directors: Do you, as an Individual Provider, have a Board of Directors? __**Yes** __**No**

If yes, list each member of the Board of Directors or Governing Board for corporations, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104) ***Attach additional sheets as necessary.***

Name (first/MI/last)	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN

Section VI: Criminal Convictions, Sanction, Exclusions, Debarment, and Terminations*

1. Have you (the Individual Provider), or any person listed in Section I and/or Section V ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title XX program? ____ YES ____NO ____

If Yes, list those persons and the required information below. (42 CFR §455.106) ***Attach documentation and additional sheets as necessary.***

Name		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	**State of Conviction**
Complete Address (Street/City/State/Zip)		
Matter of the Offense		
State and Date of Conviction(mm/dd/yyyy)	**Date of Reinstatement**(mm/dd/yyyy)	

2. Have you, or any person listed in Section I and/or Section V ever been **sanctioned, excluded or debarred** from Medicaid, Medicare, CHIP or a Title XX program? _____YES _____ NO

If Yes, list those persons and the required information below. (42 CFR §455.436)
Attach documentation and additional sheets as necessary.

Name		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	
Complete Address (Street/City/State/Zip)		
Reason for Sanction, Exclusion or Debarment		
Date(s) of Sanctions, Exclusions or Debarments (mm/dd/yyyy)	**Date of Reinstatement** (mm/dd/yyyy)	**List all States where currently excluded:**

3. Have you, or any person listed in Section I and/or Section V ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? _____YES _____NO

If Yes, list those persons and the required information below. (42 CFR §455.416)
Attach documentation and additional sheets as necessary.

Name			
DOB (mm/dd/yyyy)		**SSN**(individual) or TIN (entity)	
Complete Address (Street/City/State/Zip)			
Reason for Termination			
Date of Termination (mm/dd/yyyy)	**State that originated Termination**	**Date of Reinstatement** (mm/dd/yyyy)	

At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (See Fed. Register, Vol. 44, No. 138)

Section VII: Business Transaction Information

Business Transactions - Subcontractors: Have you, the Individual Provider, had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? ____**YES** ____**NO**

If Yes, list the information for Subcontractors with whom the Individual Provider has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) ***Attach additional sheets as necessary.***

Name of **Subcontractor**:		Subcontractor's SSN (individual) or TIN (entity):	
Subcontractor's Street Address	City:	State:	ZIP
Name of Subcontractor's Owner:	Subcontractor's Owner's SSN/TIN:		
Subcontractor's Owner's Street Address	City:	State:	ZIP

Significant Business Transactions – Wholly Owned Suppliers: Have you, the Individual Provider, had any *Significant Business Transactions* with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? ____**YES** ___**NO**

If Yes, list the information for any Wholly Owned Supplier with whom the Individual Provider has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (42 CFR §455.105(b)(2)). ***Attach additional sheets as necessary. See Glossary for definition.***

Name of **Supplier**:		Supplier's SSN (individual) or TIN (entity):	
Supplier's Street Address	City:	State:	ZIP

Significant Business Transactions – Subcontractors: Have you, the Individual Provider, had any *Significant Business Transactions* with a Subcontractor exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? ____**YES** ___**NO**

If Yes, list the information for Subcontractor with whom the Individual Provider has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (42 CFR §455.105(b)(2)). ***Attach additional sheets as necessary. See Glossary for definition.***

Name of **Subcontractor**:			Subcontractor's SSN (individual) or TIN (entity):
Subcontractor's Street Address	City:	State:	ZIP
Name of Subcontractor's Owner:	Subcontractor's Owner's SSN/TIN:		
Subcontractor's Owner's Street Address	City:	State:	ZIP

This information must be provided and/or updated within 35 days of a request. *Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received.* (42 CFR §455.105)

Section VIII: Provider Attestation

Through signing below, I hereby certify that the information provided herein, is true, accurate, and complete. Additions or changes to the information above will be submitted no later than 35 days after any change to the information or change in ownership. Additionally, I understand that any misleading, inaccurate, or incomplete data may result in denial of participation, denial of claims, and contract termination. Individual Provider must sign the form.

_____	_____
Signature	Title
_____	_____
Printed Full Name	Date

Phone Number:_____ Fax Number: _____

Email: _____

Please indicate all Organizations with whom your entity holds a contract:

Southwest Michigan Behavioral Health ☐

Barry County Community Mental Health Authority: ☐

Riverwood Center (Berrien County): ☐

Pines Behavioral Health (Branch County): ☐

Summit Pointe (Calhoun County): ☐

Woodlands Behavioral Health Network (Cass County): ☐

Kalamazoo County Community Mental Health and Substance Abuse Services: ☐

Community Mental Health and Substance Abuse Services of St. Joseph: ☐

Van Buren Community Mental Health: ☐

Instructions for Disclosure of Ownership/Controlling Interest and Management Statement

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. (For example: Section I Ownership Information, continued). Please see Glossary for definitions of capitalized terms.

Section I: Provider Entity Ownership Information:
Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Controlling Interest in your entity. If the Owner is a corporation: the primary business address must be listed and every business location and P.O. Box address. Provider members of a group practice who have ownership or a controlling interest in Provider Entity must submit a separate Statement.

Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104; The Balanced Budget Act of 1997 (BBA) (Public Law 105-33) section 4313, amended sections 1124(a)(1) and 1124A of the Act to require disclosure of both the Employer Identification Number (EIN) and Social Security Number (SSN) of each provider or supplier, each person with ownership or control interest in the provider or supplier, as well as any managing employees. The Secretary of Health and Human Services (the Secretary) signed and sent to the Congress a "Report to Congress on Steps Taken to Assure Confidentiality of Social Security Account Numbers as Required by the Balanced Budget Act" on January 26, 1999, with mandatory collection of SSNs and EINs effective on or about April 26, 1999.

Section II: Ownership in Other Providers & Entities:
Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section I that has an Ownership or Controlling Interest in your entity. This information is to identify shared and interconnected ownership and controlling interests.

Section III: Subcontractor Ownership:
If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

Section IV: Familial Relationships of All Owners:
Report whether any of the persons listed in Sections I, II, and III are related to each other and identify the parties and their relationship. For a definition of domestic partner, refer to your state's laws. Provider members of a group practice who are related to the Provider Entity's owners or those with a controlling interest must submit a separate Statement.

Section V: Management & Control:
1. List the required information for all employees that hold a position of Managing Employee within your entity.
2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.
3. List the required information for all individuals on the governing board or board of directors if your entity is organized as a corporation. CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

Section VI: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations:
List your own criminal convictions, exclusions, sanctions, debarments and terminations, ***and*** for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information:

1. Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at https://oig.hhs.gov/exclusions/index.asp

2. Sanction information is available in the GSA's SAM (System for Award Management) database, www.sam.gov

3. State specific exclusion/sanction databases may be accessed through the State Agency's website, www.michigan.gov/medicaidproviders (Billing and Reimbursement/List of Sanctioned Providers)

Section VII: Business Transaction Information:

1. List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2. List any ***Significant Business Transaction*** between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any ***Significant Business Transaction*** between your entity and any Subcontractor during the past 5 years.

Remember that a ***Significant Business Transaction*** is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year.

This information must be available within 35 days of a request by the U.S. Department of Health and Human Services (HHS), the State Medicaid Agency, and the Medicaid Managed Care Organization responding to an HHS or State request.

GLOSSARY

Agent: any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

CAQH: Council for Affordable Quality Health. (Credentialing database that some health care providers may use).

CHIP: The Federal insurance program for children, Child Health Insurance Program, in Michigan this is known as MIChild.

Controlling Interest: defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Determination of ownership or control 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 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.
(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.

Direct Ownership Interest: the possession of equity in the capital, the stock, or the profits of the disclosing entity.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

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

Ownership or Control Interest: an individual 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.

Other Entity: 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, XV III, 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 XV III); (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.

Provider Entity: an individual or entity who operates as a Medicaid provider 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. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing entity.

Significant Business Transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand ($25,000) or five percent (5 %) of a Provider Entity's total operating expenses.

Subcontractor: (a) an individual, agency, or organization to which a Provider 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 to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity.

Federally Funded Health Care Program Disclosure Form – Organization/Group

WHAT IS SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

Southwest Michigan Behavioral Health (SWMBH) is a Prepaid Inpatient Health Plan (PIHP). As a PIHP, SWMBH manages the Medicaid, MiChild, and MI Health Link behavioral health (mental health and substance use disorder) benefits for Region 4. Region 4 is made up of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren counties.

WHAT INFORMATION IS REQUIRED

The Federal Rules, the Medicaid Provider Manual, and SWMBH's contract with MDHHS require disclosures of information that includes, but is not limited to:

1) The identity of all owners and others with a controlling interest (direct or indirect) of 5% or greater;
2) Certain business transactions as described in 42 CFR §455.105;
3) The identity of managers and others in a position of influence or authority; and
4) Criminal conviction information for the provider, owners, and managers.

The information required includes, but is not limited to: name, address, date of birth, Social Security Number (SSN) and tax identification number (TIN).

WHY IS THIS INFORMATION REQUIRED

In order to comply with Federal law (42 CFR 420.200 – 420.206 and 455.100-455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding ownership and control of the entities with which the plan contracts for services paid for by Medicaid and/or Medicare.

This information is required to ensure that SWMBH and its participating Community Mental Health Service Providers (CMHSPs) are not contracting with a provider that has been excluded from participation in State and Federal health programs, or an entity that is owned or controlled by an individual who is excluded, has been convicted of certain criminal offenses, or has had civil monetary penalties imposed against them.

WHO IS REQUIRED TO PROVIDE THIS DISCLOSURE

All providers in SWMBH's managed care network who receive (directly or indirectly) Federally Funded Health Care Program funds.

HOW WILL THE INFORMATION BE COLLECTED

SWMBH contracts with the local CMHSPs in each of the counties in Region 4 to manage and provide mental health services paid for by Medicaid. SWMBH requires the CMHSPs to submit this disclosure for the CMHSP **and** its contracted providers.

SWMBH contracts directly with SUD providers and with MI Health Link providers, and will work directly with these providers to secure completed disclosures.

WHAT PROTECTIONS ARE IN PLACE FOR INFORMATION DISCLOSED

SWMBH implemented a policy specific to Social Security Numbers obtained pursuant to the Ownership and Control Disclosure requirements, as well as a tool to be used in assessing any potential breaches. SWMBH Operating Policy 10.17-Social Security Number Privacy Policy is based on and compliant with the Michigan Social Security Number Privacy Act, Act 454 of 2004. SWMBH Operating Policy Attachment 10.16A – Breach Response Risk Assessment Tool includes a response assessment that is compliant with the Michigan Identify Theft Protection Act, Act 452 of 2004.

In addition to administrative safeguards, there are physical and technical safeguards in place to protect the information gathered by this disclosure. The information is stored on an electronic device that is password protected, and kept in a locked container. The password is changed every 60 days. SWMBH's Chief Compliance & Privacy Officer and a single SWMBH Compliance Specialist hold keys to the locked container and know the password. The locked container is physically stored in a safe that is only accessible by SWMBH's Chief Financial Officer, and all accesses are recorded on an access log.

WHAT IF A PROVIDER DOES NOT COMPLETE THIS DISCLOSURE

The Federal Rules and the Medicaid Provider Manual independently require providers to disclose the information requested in this form. Completion and submission of this form is a condition of participation in SWMBH and each Community Mental Health Service Providers' provider network. ***Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider contract, or termination of existing provider contracts.***

42 CFR §455.104(e) Consequences for failure to provide required disclosures. *Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.*

HOW OFTEN DOES THIS FORM HAVE TO BE COMPLETED

This form must be submitted at the following intervals:

1) Provider enrollment;
2) Initial contracting;
3) Annual contract renewal;
4) Within 35 days of a request for updated information from SWMBH;
5) Within 35 days of any changes to the information or change in ownership.

WHO DO I CONTACT WITH QUESTIONS?

Medicaid mental health services providers should contact either the Community Mental Health Service Provider who requested the information from you or the Southwest Michigan Behavioral Health Compliance Department with questions. SUD and MI Health Link providers should contact the Southwest Michigan Behavioral Health Compliance Department with questions.

SWMBH
Mila Todd
mila.todd@swmbh.org
(269) 488-6794

Barry County Community Mental Health Authority
Brenna Ellison
brleedy@bccmha.org
(269) 948-8041

Pines Behavioral Health (Branch County CMHA)
Megan Daws
mdaws@pinesbhs.org
(517) 278-2129

Riverwood Center (Berrien County CMHA)
Sara Doyle
sxd@riverwoodcenter.org
(269) 925-0585

Summit Pointe (Calhoun County CMHA)
Mandi Quigley
meq@summitpointe.org
(269) 441-6112

Woodlands Behavioral Health Network (Cass County CMHA)
Steve Waller
Stevew@woodlandsbhn.org
269-228-4445

Kalamazoo Community Mental Health and Substance Abuse Services
Ashley Esterline
esterline@kazoocmh.org
(269) 364-6986

Van Buren Community Mental Health
Megan Salziger
msalziger@vbcmh.com
(269) 655-3304

Community Mental Health and Substance Abuse Services of St. Joseph
Cameron Bullock
cbullock@stjoecmh.org
(269) 467-1001

Contracted Provider Entity Information

Instructions

Please fill out the entire form. ***Every field must be complete.*** If fields are left blank, the form will not be processed and will be returned for corrections/completions. If the form is unreadable due to illegible handwriting, the form will not be processed.

As applicable, if Provider is a medical group or facility, please attach a roster of individual providers covered under this Disclosure. Please include provider name, address, date of birth, and social security number.

<table>
<tr><td rowspan="5">Type of disclosing entity.
Please choose appropriate category:
___Partnership
___ Non-Profit
___ Corporation
___ Limited Liability Corporation (LLC)
___ Government/Public Entity
___ HCBS Provider
___Other:_____</td><td colspan="3">Name of Person Completing the Form (First/Middle/Last)</td></tr>
<tr><td colspan="3">Title</td></tr>
<tr><td colspan="3">Phone Number</td></tr>
<tr><td colspan="3">Fax</td></tr>
<tr><td colspan="3">Email</td></tr>
<tr><td colspan="4">Legal Name (“Provider Entity”): DBA Name (if different from Provider Entity Legal Name):</td></tr>
<tr><td colspan="4">Complete Address (must include at least one street address; corporations must include the primary business address and every business location and P.O. Box address):
STREET CITY STATE ZIP</td></tr>
<tr><td colspan="4">Additional Addresses (list all Practice locations – attach a separate sheet if necessary):</td></tr>
<tr><td>**Federal Tax ID/SSN #:</td><td>*Medicaid ID #:</td><td>*National Provider ID (NPI) #:</td><td>*CAQH #:</td></tr>
</table>

These fields cannot be left blank; “N/A” non-applicable and “applied for” are acceptable responses.
****Individual providers please use social security number; field cannot be left blank: “N/A” non-applicable and “applied for” are acceptable responses***

Section I: Provider Entity Ownership Information

Are there any individuals or organizations with a Direct or Indirect Ownership or Controlling Interest of 5% or more in the Provider Entity? ___YES ___NO

If yes, list the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Controlling Interest in the Provider Entity of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership or Controlling Interest of 5% or greater. (42 CFR §455.104) ***Attach additional sheet as necessary***

Name of Owner (first/middle/last; any alias)	**DOB (mm/dd/yyyy)**	**Complete Address (Street/City/State/Zip)**	**** SSN (individual) and/or TIN (entity)** *List both as applicable*

***** SSN and TIN required under §455.104; see Sect 4313 of Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No. 22***

Section II: Ownership in Other Providers & Entities

Does the Provider Entity's Owner ***identified in Section I*** have an Ownership or Controlling Interest in ***any other*** *provider or entity*?
_____ **YES** _____**NO**

If Yes, list the name and the SSN or TIN of **the other provider or entity** in which the Owner identified in **Section I** also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3)) ***Attach additional sheets as necessary***

Name of Owner from Section I	**Name of *Other Provider or Entity***	**Other Provider or Entity's SSN (individual) or TIN (entity)**

Section III: Subcontractor Ownership *(Attach additional sheets as necessary)*

Does the Provider Entity have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor?_____ **YES** _____ **NO**
If Yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor?
_____ **YES** _____ **NO**
If Yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which the Provider Entity also has Direct or Indirect Ownership Interest of 5% or more. (42 CFR § 455.104).

Legal Name of Subcontractor			
Name of Subcontractor's *Other Owner*			
***Other Owner's* Complete Address (Street/City/State/Zip)**			
***Other Owner* TIN**	***Other Owner* SSN**	***Other Owner* DOB (mm/dd/yyyy)**	**% Interest in Subcontractor**
Legal Name of Subcontractor			
Name of Subcontractor's *Other Owner*			
***Other Owner's* Complete Address (Street/City/State/Zip)**			

Other Owner TIN	*Other Owner* SSN	*Other Owner* DOB (mm/dd/yyyy)	% Interest in Subcontractor

Section IV: Familial Relationships of All Owners

Are any of the individuals identified in Sections I, II or III related to each other? ____YES ____NO

If yes, list the individuals identified and the relationship to each other (e.g., spouse, domestic partner, sibling, parent, child)

(42 CFR §455.104(b)(2)) ***Attach additional sheets as necessary***

Name of Owner 1:	Name of Owner 2:	Relationship

Are any provider members of the group related to the listed owners or those with a controlling interest? _____ YES _____ NO

If Yes, list the following information for each group provider member related to the listed owners and those with a controlling interest.

Attach additional sheets as necessary

NOTE: Each provider member listed must submit a signed Medicaid Disclosure Statement - Individual.

Name of group provider	Relationship	DOB (mm/dd/yyyy)	SSN

Section V: Management & Control

Managing Employees: Does the Provider Entity have any Managing Employees? _____**YES** _____**NO**

If yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day- to-day operations of Provider Entity (general manager, business manager, administrator or director), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104) ***Attach additional sheets as necessary***

Name (first/MI/last)	DOB mm/dd/yyyy	Complete Address (Street/City/State/Zip)	SSN	Title

Agents: Does the Provider Entity have any Agents? _____**YES** _____**NO**

If yes, list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104) ***Attach additional sheets as necessary***

Name (first/MI/last)	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN

Board of Directors: Does the Provider Entity have a Board of Directors? _____**YES** _____**NO**

If yes, list each member of the Board of Directors or Governing Board for corporations, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104) ***Attach additional sheets as necessary***

Name (first/MI/last)	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN

Section VI: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations*

1. Has the **Provider Entity, or any person listed in Section I and/or Section V** ever been **convicted of a crime** related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title XX program? **YES** _____ **NO** _____

If yes, list those persons and the required information below. (42 CFR §455.106)

Attach documentation and additional sheets as necessary

Name		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	**State of Conviction**
Current Address (Street/City/State/Zip)		
Nature of the Offense		
Date of Conviction(mm/dd/yyyy)	**Date of Reinstatement**(mm/dd/yyyy)	

2. Has the **Provider Entity, or any person listed in Section I and/or Section V** ever been **sanctioned, excluded or debarred** from Medicaid, Medicare, CHIP or a Title XX program? _____ **YES** _____**NO**

If yes, list those persons and the required information below. (42 CFR §455.436)

Attach documentation and additional sheets as necessary

Name		
DOB (mm/dd/yyyy)	**SSN (individual) or TIN (entity)**	
Current Address (Street/City/State/Zip)		
Reason for Sanction, Exclusion or Debarment		
Date(s) of Sanctions, Exclusions or Debarments (mm/dd/yyyy)	**Date of Reinstatement** (mm/dd/yyyy)	**List all States where currently excluded:**

3. Has the **Provider Entity, or any person listed in Section I and/or Section V** ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? _____**YES** _____ **NO**

If yes, list those persons and the required information below. (42 CFR §455.416)

Attach documentation and additional sheets as necessary

Name			
DOB (mm/dd/yyyy)	**SSN(individual) or TIN (entity)**		
Current Address (Street/City/State/Zip)			
Reason for Termination			
Date of Termination (mm/dd/yyyy)	**State that originated Termination**	**Date of Reinstatement** (mm/dd/yyyy)	**Terminated from Medicare?** Yes_____ No_____

**At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (See Fed. Register, Vol. 44, No. 138)*

Section VII: Business Transaction Information (CMHSPs see Instructions)

Business Transactions – Subcontractors: Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period?
_____**YES** _____**NO**

IF YES, list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)). ***Attach additional sheets as necessary.***

Name of **Subcontractor**:		Subcontractor's SSN (individual) or TIN (entity):	
Subcontractor's Street Address	City:	State:	ZIP
Name of Subcontractor's Owner:	Subcontractor's Owner's SSN/TIN:		
Subcontractor's Owner's Street Address	City:	State:	ZIP

Significant Business Transactions – Wholly Owned Suppliers: Has the Provider Entity had any *Significant Business Transactions* with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? _____**YES** _____**NO**

IF YES, list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past five (5) year period (42 CFR §455.105(b)(2)). ***Attach additional sheets as necessary.***

Name of **Supplier**:		Supplier's SSN (individual) or TIN (entity):	
Supplier's Street Address	City:	State:	ZIP

Significant Business Transactions – Subcontractors: Has the Provider Entity had any *Significant Business Transactions* with a Subcontractor exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? _____**YES** _____**NO**

IF YES, list the information for Subcontractor with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past five (5) year period (42 CFR §455.105(b)(2)). ***Attach additional sheets as necessary.***

Name of **Subcontractor**:			Subcontractor's SSN (individual) or TIN (entity):
Subcontractor's Street Address	City:	State:	ZIP
Name of Subcontractor's Owner:	Subcontractor's Owner's SSN/TIN:		
Subcontractor's Owner's Street Address	City:	State:	ZIP

This information must be provided and/or updated within 35 days of a request. *Medicaid payments may be denied for services furnished during the period beginning the day following the date the information was due, until it is received.* (42 CFR §455.105).

Section VIII: Excluded Provider Screening Attestation

Through signature below, I certify that any employees or contractors providing services pursuant to a contract with Southwest Michigan Behavioral Health and/or a Community Mental Health Service Provider (CMHSP), are screened with the applicable background check. This includes, but is not limited to, verification against the OIG's List of Excluded Individuals and Entities (https://oig.hhs.gov/exclusions/index.asp), the System for Award Management (SAM) (www.sam.gov), the Michigan Sanctioned Provider List (www.michigan.gov), and any other applicable state, federal, or other governmental exclusion or sanction databases and that the information provided herein is true, accurate, and complete. Additions or changes to the information above will be submitted no later than 35 days after any change to the information or change in ownership. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of a claim and/or termination of the contract(s).

If you do not perform your own screening, please list who does: _____

_____ _____

Signature Title (indicate if authorized agent)

_____ _____

Printed Name Date

Phone Number:_____ Fax Number: _____

Email: _____

Please indicate all Organizations with whom your entity holds a contract:

Southwest Michigan Behavioral Health ☐

Barry County Community Mental Health Authority: ☐

Riverwood Center (Berrien County): ☐

Pines Behavioral Health (Branch County): ☐

Summit Pointe (Calhoun County): ☐

Woodlands Behavioral Health Network (Cass County): ☐

Kalamazoo County Community Mental Health and Substance Abuse Services: ☐

Community Mental Health and Substance Abuse Services of St. Joseph: ☐

Van Buren Community Mental Health: ☐

Instructions for Disclosure of Ownership/Controlling Interest and Management Statement

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued.

Section I: Provider Entity Ownership Information

Please list the required information for EACH individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Controlling Interest in your entity. If the Owner is a corporation, the primary business address must be listed and every business location and P.O. Box address. Provider members of a group practice who have ownership or a controlling interest in Provider Entity must submit a separate Statement.

Providing the SSN or TIN (as applicable) is required under 42 CFR §455.104; please see Section 4313 of the Balanced Budget Act of 1997, amended Section 1124, and the Federal Register Vol. 76 No. 22. ***Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.***

Section II: Ownership in Other Providers & Entities

Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section I that has an Ownership or Controlling Interest in your entity. This information is to identify shared and interconnected ownership and controlling interests.

Section III: Subcontractor Ownership

If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

Section IV: Familial Relationships of All Owners

Report whether any of the persons listed in Section I, II, and III are related to each other and identify the parties and their relationship. For a definition of domestic partner, refer to state law. Provider members of a group practice who are related to the Provider Entity's owners or those with a controlling interest must submit a separate Statement.

Section V: Management & Control

1) List the required information for all employees that hold a position of Managing Employee within your entity
2) List the required information for all Agents that have the authority to obligate or act on behalf of your entity
3) List the required information for all individuals on the governing board or board of directors if your entity is organized as a corporation. CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

Section VI: Criminal Convictions, Sanctions, Exclusions, Debarment, and Terminations

List YOUR OWN criminal convictions, exclusions, sanctions, debarments, and terminations **AND** any for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person's or entity's

involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information.

1) Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at https://oig.hhs.gov/exclusions/index.asp

2) Sanction information is available in the GSA's SAM (System for Award Management) database at www.sam.gov

3) The Michigan Sanctioned Provider List can be located at http://www.michigan.gov

Section VII: Business Transaction Information

1) List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2) List any *Significant Business Transaction* between your entity and any Wholly Owned Supplier during the past 5 years.
3) List any *Significant Business Transaction* between your entity and any Subcontractor during the past 5 years.

Remember that a *Significant Business Transaction* is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year.

This information must be available within 35 days of a request by the U.S. Department of Health and Human Services, the State Medicaid Agency (Michigan Medicaid Services Administration), and the Medicaid Managed Care Organization (SWMBH) responding to an HHS or State request.

CMHSPs

1) Provide a list identifying Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request. It is **NOT NECESSARY** to list the Ownership of any Subcontractors included in the above list **IF** those Subcontractors are also a Disclosing Entity and have completed a Medicaid Disclosure Form submitted to you and to SWMBH.
2) List any *Significant Business Transaction* between your entity and any Wholly Owned Supplier during the past 5 years.
3) List any *Significant Business Transaction* between your entity and any Subcontractor during the past 5 years. It is **NOT NECESSARY** to list the Ownership of any Subcontractors included in the above list **IF** those Subcontractors are also a Disclosing Entity and have completed a Medicaid Disclosure Form submitted to you and to SWMBH.

GLOSSARY

Agent: any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

CAQH: Council for Affordable Quality Health. (Credentialing database that some health care providers may use).

CHIP: The Federal insurance program for children, Child Health Insurance Program, in Michigan this is known as MiChild.

Controlling Interest: defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Determination of ownership or control 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 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.
(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.

Direct Ownership Interest: the possession of equity in the capital, the stock, or the profits of the disclosing entity.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

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

Ownership or Control Interest: an individual 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.

Other Entity: 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, XV III, 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 XV III); (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.

Provider Entity: an individual or entity who operates as a Medicaid provider 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. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing entity.

Significant Business Transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand ($25,000) or five percent (5 %) of a Provider Entity's total operating expenses.

Subcontractor: (a) an individual, agency, or organization to which a Provider 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 to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity.

Southwest Michigan
BEHAVIORAL HEALTH

Medicaid Disclosure Form Attestation – Individual

PURPOSE

This form may be used when the following conditions are met:

1. Individual Provider has submitted a complete Medicaid Disclosure Form – Individual within the last 365 days; AND
2. Individual Provider has reviewed the form that was previously submitted for continued accuracy; AND
3. There are no changes, additions, or deletions to any of the information previously disclosed.

WHAT IF A PROVIDER DOES NOT COMPLETE A MEDICAID DISCLOSURE

The Federal Rules and the Medicaid Provider Manual independently require providers to provide the information requested in this form. SWMBH is required to collect this information by its contracts in addition to the governing laws. Completion and submission of a Provider Disclosure Form is a condition of participation in SWMBH's provider network. ***Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider contract, or termination of existing provider contracts.***

42 CFR §455.104(e) Consequences for failure to provide required disclosures. *Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.*

HOW OFTEN DOES THE MEDICAID DISCLOSURE FORM HAVE TO BE COMPLETED

The Medicaid Disclosure Form must be submitted at the following intervals:

1) Credentialing;
2) Initial contracting;
3) Annual contract renewal;
4) Within 35 days of a request for updated information from SWMBH;
5) Within 35 days of any changes to the information or change in ownership.

Individual Provider Information

Instructions

Please fill out the entire section. ***Every field must be complete.*** If fields are left blank, the form will not be processed and will be returned for corrections/completions. If the form is unreadable due to illegible handwriting, the form will not be processed.

<table>
<tr><td rowspan="4">Please choose appropriate category:
___Individual Member of a Medical Group
___ Individual Contracted Provider
___Sole Proprietor
___HCBS Provider
___Other:

<u>If Affiliated with a Group, do you have a</u>

<u>Private Practice as well? Yes No NA</u></td><td colspan="3">Name of Person Completing the Form</td></tr>
<tr><td colspan="3">Title</td></tr>
<tr><td colspan="3">Phone Number</td></tr>
<tr><td colspan="3">Fax</td></tr>
<tr><td colspan="4">Email</td></tr>
<tr><td colspan="5">Legal Name of Individual (“Individual Provider”): Name of Group (if applicable):</td></tr>
<tr><td colspan="5">Physical Address
STREET CITY STATE ZIP</td></tr>
<tr><td colspan="5">+Additional Addresses (list all Practice locations – attach a separate sheet if necessary):</td></tr>
<tr><td>SSN #:</td><td>*Medicaid ID #:</td><td colspan="2">*National Provider ID (NPI) #:</td><td></td></tr>
<tr><td colspan="2">*If billing under an Entity: Federal Tax Identification #:</td><td colspan="3">*If billing under an Entity: Billing Entity’s NPI #:</td></tr>
<tr><td colspan="2">*If billing under an Entity: Billing Entity’s Medicaid ID#:</td><td colspan="3"></td></tr>
</table>

These fields cannot be left blank; “N/A” non-applicable and “applied for” are acceptable responses.
Individual providers please use social security number; field cannot be left blank: “N/A” non-applicable and “applied for” are acceptable responses

+ Please list “consumers’ homes” or “public community locations” if services are provided in these locations

PROVIDER ATTESTION

By signing below, I hereby certify that on [date] _____, I reviewed the attached Medicaid Disclosure Form – Individual that was submitted by me on [date] _____ _____. The information contained in that form continues to be accurate and no additions, deletions, corrections, or changes are necessary at this time. I understand that additions or changes to the information submitted must be submitted by me within 35 days of the change. Additionally, I understand that misleading, inaccurate, or incomplete data may result in denial of participation, denial of claims, and contract termination. (Individual Provider must sign).

Previously submitted Disclosure Form MUST BE ATTACHED

_____ _____

Signature Title

_____ _____

Printed Full Name Date

Phone Number:_____ Fax Number: _____

Email: _____

Please indicate all Organizations with whom your entity holds a contract:

Southwest Michigan Behavioral Health ☐

Barry County Community Mental Health Authority: ☐

Riverwood Center (Berrien County): ☐

Pines Behavioral Health (Branch County): ☐

Summit Pointe (Calhoun County): ☐

Woodlands Behavioral Health Network (Cass County): ☐

Kalamazoo County Community Mental Health and Substance Abuse Services: ☐

Community Mental Health and Substance Abuse Services of St. Joseph: ☐

Van Buren Community Mental Health: ☐

Southwest Michigan
BEHAVIORAL HEALTH

Medicaid Disclosure Form Attestation – Organization/Group

PURPOSE

This form may be used when the following conditions are met:

1. Provider Entity has submitted a complete Medicaid Disclosure Form – Organization/Group within the last 365 days; AND
2. Provider Entity has reviewed the form that was previously submitted for continued accuracy; AND
3. There are no changes, additions, or deletions to any of the information previously disclosed.

WHAT IF A PROVIDER DOES NOT COMPLETE A MEDICAID DISCLOSURE

The Federal Rules and the Medicaid Provider Manual independently require providers to provide the information requested in this form. SWMBH is required to collect this information by its contracts in addition to the governing laws. Completion and submission of a Provider Disclosure Form is a condition of participation in SWMBH's provider network. ***Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider contract, or termination of existing provider contracts.***

42 CFR §455.104(e) Consequences for failure to provide required disclosures. *Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.*

HOW OFTEN DOES THE MEDICAID DISCLOSURE FORM HAVE TO BE COMPLETED

The Medicaid Disclosure Form must be submitted at the following intervals:

1) Credentialing;
2) Initial contracting;
3) Annual contract renewal;
4) Within 35 days of a request for updated information from SWMBH;
5) Within 35 days of any changes to the information or change in ownership.

Contracted Provider Entity Information

Instructions

Please fill out the entire section. ***Every field must be complete.*** If fields are left blank, the form will not be processed and will be returned for corrections/completions. If the form is unreadable due to illegible handwriting, the form will not be processed.

Type of disclosing entity. **Please choose appropriate category:** **___Partnership** **___Non-Profit** **___Corporation** **___Limited Liability Corporation (LLC)** **___Government/Public Entity** **___HCBS Provider** **___Other:_____**	**Name of Person Completing the Form** Title Phone Number Fax Email
Legal Name ("**Provider Entity**"):	DBA Name (if different from Provider Entity Legal Name):
Complete Address (must include at least one street address; corporations must include the primary business address *and* every business location and P.O. Box address): STREET CITY STATE ZIP	
Additional Addresses (list **all** Practice locations – attach a separate sheet if necessary):	

**Federal Tax ID/SSN #:	*Medicaid ID #:	*National Provider ID (NPI) #:	*CAQH #:

These fields cannot be left blank; "N/A" non-applicable and "applied for" are acceptable responses.
****Individual providers please use social security number; field cannot be left blank: "N/A" non-applicable and "applied for" are acceptable responses***

PROVIDER ENTITY ATTESTION

By signing below, I hereby certify that on [date] _____, I reviewed the attached Medicaid Disclosure Form – Organization/Group that was submitted by me on [date] _____. The information contained in that form continues to be accurate and no additions, deletions, corrections, or changes are necessary at this time. I understand that additions or changes to the information submitted must be submitted by me within 35 days of the change. Additionally, I understand that misleading, inaccurate, or incomplete data may result in denial of participation, denial of claims, and contract termination.

Previously submitted Disclosure Form MUST BE ATTACHED

_____ _____

Signature Title (indicate if authorized agent)

_____ _____

Printed Full Name Date

Phone Number:_____ Fax Number: _____

Email: _____

Please indicate all Organizations with whom your entity holds a contract:

Southwest Michigan Behavioral Health ☐

Barry County Community Mental Health Authority: ☐

Riverwood Center (Berrien County): ☐

Pines Behavioral Health (Branch County): ☐

Summit Pointe (Calhoun County): ☐

Woodlands Behavioral Health Network (Cass County): ☐

Kalamazoo County Community Mental Health and Substance Abuse Services: ☐

Community Mental Health and Substance Abuse Services of St. Joseph: ☐

Van Buren Community Mental Health: ☐

Attestation Confirming Debarment, Suspension and Exclusion Responsibilities

Section 438.610 of the Code of Federal Regulations (42 CFR §438.610) prohibits Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Providers (CMHSPs) from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participation in any federal health care program or with anyone who is an affiliate of such individual. A PIHP/CMHSP may not have as a director, officer, partner, or person with a beneficial ownership of 5% or more of the PIHP/CMHSP or have an employment, consulting or other agreement with an individual or entity that provides items or services that are significant and material to the PIHP's/CMHSP's obligations under its Medicaid Agreement with the Michigan Department of Health and Human Services (or with the PIHP for CMHSPs) for Medicaid Specialty Services (the "Medicaid Agreement") who is debarred, suspended, or excluded from any health care program, including the Medicaid program.

Section 438.610 further requires that all PIHP/CMHSP directors, officers, employees, contractors and subcontractors be screened to determine whether they have been listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in a federal health care program, such as Medicaid.

I hereby attest that [INSERT AGENCY NAME]:

- Is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in Federally Funded Health Care Programs;
- Does not employ or contract with providers or consultants excluded from participation in Federal Health Care Programs. Federally Funded Health Care Programs are any plans or programs that provide health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program) (section 1128B(f) of the Act).
- Shall check the Exclusions Database at **www.oig.hhs.gov** and the System for Award Management at **www.sam.gov** before offering employment; and
- Shall utilize the Exclusions Database at **www.oig.hhs.gov** and the System for Award Management at **www.sam.gov** to check a director, officer, partner, or person with a beneficial ownership of 5% or more of the Contractor's equity, and any person serving as a consultant or other arrangement with the agency for the provision of items and services that are significant and material to the agency's services submitted to Southwest Michigan Behavioral Health or one of its participant CMHSPs for Medicaid payment.

Further, I certify that within the last twelve months the above named agency has verified that all current employees, applicable directors and officers, and consultants are not debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in Federally Funded Health Care Programs. Documentation of the same is available at the agency and will be provided upon request.

_____
Name

_____
Title

_____
Date