**BUREAU OF TENNCARE**

Office of Contract Compliance

310 Great Circle Road

NASHVILLE, TENNESSEE 37202-1700

**DISCLOSURE FORM FOR MCCs AND FISCAL AGENTS**

**Directions:** Use this form if you are trying to get a new TennCare ID number for **a MCC or Fiscal Agent**, or if you are re-credentialing or re-contracting **a MCC or Fiscal Agent**, or if there have been significant changes to the information required on this form, for example an ownership change, the addition of a new managing employee or the change of your business location. A **MCC or Fiscal Agent** is a business entity. i.e. a partnership or corporation, that is contracted with the State of Tennessee, or is subcontracted with an **MCC or Fiscal agent** that is contracted with the State of Tennessee, and who pays claims for services covered by Tennessee’s Medicaid program, known as TennCare..

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Return the original to the Bureau of TennCare at the address above. Please retain a copy for your files. Completely answer the applicable questions. If a question is not applicable please respond **N/A** for that question. ***NO QUESTIONS SHOULD BE LEFT BLANK***. The SSN must be provided where requested. Tennessee Code Annotated § 4-4-125 creates an exception to the public records act by prohibiting state agencies from disclosing Social Security Numbers (SSN).

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| --- | --- |
| **Name of person Completing form** | **Phone number of person completing form** |
|  |  |

**I. Identifying Information**

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| --- | --- | --- |
| MCC/Fiscal Agent Name | MCC/Fiscal Agent DBA Name(if different from MCC/Fiscal Agent name) | MCC/Fiscal Agent Federal Tax Id number |
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| --- | --- | --- |
| MCC/Fiscal Agent NPI number(If you have one, if not indicate if applied for.) | MCC/Fiscal Agent TennCare ID number(If you have one, if not indicate if applied for.) | MCC/Fiscal Agent telephone Number |
|  |  |  |

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| --- | --- | --- | --- |
| MCC/Fiscal Agent Address-  |  City |  State |  Zip  |
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**II. OWNER OR CONTROL INFORMATION**

**Directions**: An “**Owner”** is a person or business entity which owns 5% or more of the assets, stock or profits of the **MCC/Fiscal Agent**. This 5% may be **Direct** ownership or **Indirect** ownership i.e, an individual might own 50% of a company that owns the actual **MCC/Fiscal Agent** meaning their indirect ownership is 50%. In addition to ownership of stock, an **Owner** is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the **MCC/Fiscal Agent**.

A person with **“Control**” is someone who directs the **MCC/Fiscal Agent**  and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership. If the **MCC/Fiscal Agent** is a non-profit entity, respond **N/A** in the column for % of ownership.

A **“Managing Employee”** is someone who makes the day to day decisions for the **MCC/Fiscal Agent**. These individuals include the heads of the major operating groups of the provider like, Head of Accounting, or Director of same day services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

An **“Agent”** is an individual who has the legal ability to bind the **MCC/Fiscal Agent** i.e.the **MCC/Fiscal Agent** may usean **Agent** to obtain contracts for it.

Please provide the following information for **Owners**, persons with **Control** interests, **Agents** and **Managing employees** of the **MCC/Fiscal Agent**. Attach a separate sheet if needed.

1. **Master List**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | Address (For *individuals* use Home address. For *business entities* that might have ownership interest use all street addresses (if more than one location), and P.O. Box address if any.) |  City |  State | ZIP | DOB | SSN or Tax ID for business entities | % ownership | Title |
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1. **Specific Questions**
2. Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent, child or sibling?

Yes [ ]  No [ ] . If yes, please provide the following information about the related persons:

|  |  |  |
| --- | --- | --- |
| Name of First related person | Name of Second related Person | Type of relation |
|  |  |  |

1. Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider/MCC/Fiscal Agent**?

Yes [ ]  No [ ] . If yes, please provide the following information about the other **Provider/MCC/Fiscal Agent** the person on the **Master List** has an interest in.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of other Provider/MCC/Fiscal Agent  | Address | City | State | Zip | Tax I.D. |
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1. Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person’s or entities’ involvement in any program under Medicare, Medicaid, Title XX or the CHIP services program since the inception of those programs? Yes [ ]  No [ ] . If yes, please provide the information requested below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name on Court records  | SSN /TIN | Matter of the Offense | Date of the Conviction | Sanction Period of the Offense if you were sanctioned by Federal Office of the Inspector general( OIG) |
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 4) Have any of the individuals or entities on the **Master List** ever been **Debarred** from participation in Federal Government contracts? **“Debarred”** means an individual is not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area.

 Yes [ ]  No[ ]  If ‘yes’ is checked, provide the following information:

|  |  |  |
| --- | --- | --- |
| When individual or entity was debarred | Length of Debarment | Reason for Debarment |
|  |  |  |

1. Has any individual or entity on the **Master List** ever been excluded from participation in Federal health care programs ( Medicare, Medicaid, CHIP or Tricare) in the past

Yes [ ]  No[ ]  If “Yes” please supply the following information:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Individual or Entity | Beginning date of exclusion or termination | End date of exclusion or termination | Reason for exclusion or termination |
|  |  |  |  |

1. Has any person or Entity on the **Master List** ever had Civil Monetary Penalties (CMPs) assessed against them?

Yes [ ]  No[ ]  If “Yes” please supply the following information:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name Of Individual or Entity | State where practicing when CMP assessed | Reason for CMP | Amount of CMP | Date of CMP |
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1. Did anyone on the **Master List** obtain their **Ownership** interest in anticipation of or as a result of, an action of exclusion or termination taken against the original **Owner**, where the original **Owner** is or was a member of the **current Owner‘s** **Immediate Family** or M**ember of** the current owner’s H**ousehold**, while the original **Owner** was participating in a Federal health care program? [ **Immediate Family**

 is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister;

 father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. **Membe**r

 **of** **Household** is defined as 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.]

Yes [ ]  No [ ]  If “Yes” please supply the following information:

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| --- | --- | --- | --- |
| Name of original **Owner** |  SSN or TAX ID of original **Owner** |  Place of Transfer | Date of Transfer |
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 8a) List any **Subcontractor** in which this **MCC/Fiscal Agent**  has a direct or indirect **Ownership** interest of at least a 5%. A **Subcontractor** is a person or company that this **MCC/Fiscal Agent**  has contracted with to do some of the **MCC/Fiscal** **Agent’s** business functions, i.e., billing agent, or medical functions i.e. provide vision services.

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| --- | --- | --- | --- | --- | --- |
| Name of Subcontractor | Address | City |  State | Zip | Tax I.D. |
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 8b) For each **Subcontractor(s)** listed above please provide the following information for the individuals with an **Ownership** or **Control** interest in the **Subcontractor.** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | Address (for individuals use Home address, for business entities that might have ownership interest use business street address, and P.O. Box address if any.) | City | State | Zip | DOB | SSN or Tax ID for business entities | % of owner-ship | Title |
|  |  |  |  |  |  |  |  |  |
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 8c) Is anybody in this list in 8b list related to any person in the **Master List** above? Yes [ ]  No[ ]

 If yes, please supply the following information about the related persons:

|  |  |  |
| --- | --- | --- |
| Name of First related person | Name of Second related Person | Type of relation |
|  |  |  |

**III. Business transactions**

1. Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your MCC or Fiscal Agent’s total operating expenses or $25,000 whichever is less. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.8a. that you have an ownership interest in. A **Subcontractor** is a person or company that this **MCC/Fiscal Agent**  has contracted with to do some of the **MCC or Fiscal Agent’s** management functions, i.e., billing agent or provide vision services.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name  | Address | City | State  | Zip |
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 2) Does the **MCC/Fiscal Agent**  *wholly own* a **Supplier**? **Supplier** means an individual, agency, or organization from which the **MCC/Fiscal Agent**  *purchases goods and services* used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmacy).

Yes [ ]  No [ ] . If yes, supply the following information about the **Supplier:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name  | Address | City | State  | Zip | NPI | TIN |
|  |  |  |  |  |  |  |

**IV Transaction with Party in Interest 42 USCA1396b(m)(4)(a)[ ONLY Applies to MCCs that are *not* Qualified Health Maintenance Insurance organizations under 42USCA300e-9(c)]**

 If you check YES for any of the following transactions list on a separate sheet of paper ,for each transaction checked, the name of the Party in Interest, a description of each transaction, including the number of units involved, the accrued dollar value of the transaction in your current fiscal year, and a justification of the reasonableness of the transaction**.** A party in interest is defined in 42 USCA 300e-17(b).

🞎 No🞎 YesHas there been any sale, exchange or lease of any property between you and a person in interest in this fiscal year?

🞎 No🞎 Yes Has there been any lending of money or other extension of credit between you and a Party in interest?

🞎 No🞎 Yes Has there been any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

**V ITEM VI Conflict of Interest**

[ ]  No [ ]  Yes Are any of the officers or directors of your company officials in or employees of Tennessee state government?

[ ]  No [ ]  Yes Is any individual with a greater than 5% ownership interest in your company an official in or employee of Tennessee state government?

If yes, to either of the above please supply the following information:

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| --- | --- | --- | --- |
| Name of Individual | Address | Role in your company | Role in State Government |
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**V I Signature**

The State or Federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a entity if it is determined that the entity did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of an individual who can legally bind this **MCC/Fiscal Agent**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Person (Printed) | Signature of Person |  Title |  Date |
|  |  |  |  |