OSS ENROLLMENT PACKAGE

Form Number	Name	Revision Date
	CRCF Cover Letter	03/2011
Form 219-RCF	OSS Medicaid Enrollment Form (two pages)	04/2010
	DHHS Levels of Sanctioning	04/2010
	EFT Authorization Agreement	03/2011
Form 1514	Disclosure of Ownership and Control Interest Statement-Medicaid Provider Enrollment (seven pages)	12/2011
W-9	Request for Taxpayer Identification Number and Certification	10/2007

South Carolina Department of
Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

_____
Date

Dear Community Residential Care Provider:

On behalf of the Department of Health and Human Services (DHHS), we would like to thank you for your interest in participating in South Carolina's Optional State Supplementation Program (OSS) for Community Residential Care Facilities (CRCF).

Enclosed you will find an OSS Enrollment Form and Authorization Agreement for Electronic Funds Transfer (EFT - direct deposit of funds). Please complete all required fields on both forms. Be sure to include a bank letter with the EFT Authorization Agreement Form. A DHHS Levels of Sanctioning for CRCFs, a Disclosure of Ownership and Control Interest Statement and a Request for Taxpayer Identification Number and Certification (Form W-9) also are enclosed. Accurate completion of these forms is mandatory for participation in the OSS Program. They must be signed and dated, making certain that you have read and understand all points of the Participation Agreement and the DHHS Levels of Sanctioning for CRCFs. Please retain copies of all documents for your records. Return forms to:

OSS Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

As soon as your OSS Enrollment Form and EFT Form are processed, you will be notified by letter. You will also receive further information regarding the OSS Program at that time. If you have any questions or need additional information, please contact OSS Provider Enrollment at 1-888-289-0709.

Sincerely,

OSS Provider Enrollment

Indicate one of the following reasons for enrollment:

☐ New facility, no previous owner.

☐ Change in ownership, same facility name: Give old OSS/CRCF ID Number: _____

☐ Same owner, change in license number. Give old OSS/CRCF ID Number: _____

Old Name: _____

☐ Change in ownership, change in facility name. Give old OSS/CRCF ID Number: __ _____

Old Name: _____

_____
Provider's Signature

Medicaid Claims Control System
OSS Provider Enrollment
Post Office Box 8809, Columbia, South Carolina 29202-8809
1-888- 289-0709 FAX (803) 870-9022

South Carolina
Department of Health and Human Services

MAIL COMPLETED FORM TO:
Medicaid Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

OSS MEDICAID ENROLLMENT DATA
Community Residential Care Facility

SHADED ITEMS ARE FOR AGENCY USE ONLY AND NO INFORMATION SHOULD BE ENTERED BY THE CRCF PROVIDER.
ITEMS IN **BOLD CAPITALS** MUST BE COMPLETED OR THIS FORM WILL BE RETURNED TO YOU.
ITEMS MARKED WITH AN ASTERISK (*) SHOULD BE COMPLETED BASED ON THE CODES LISTED ON THE BACK OF THIS FORM.

1 Medicaid No. RC
2 Provider Type 00
3 1099 Ind. Y
4 Sort Key

5 **NAME OF FACILITY**
6 Chain Name
7 Tax Payer Identification Name (If different from name of facility)
8 **IRS EMPLOYER ID NO.**

Physical Location Address
9 **NUMBER AND STREET**
10 **CITY**
11 **STATE**
12 **ZIP + 4**

Payment Address (If different from mailing address)
13 In care of, Attention, Building Name, etc.
14 Number and Street, PO Box or Route No.
15 City
16 STATE
17 ZIP + 4

18 **COUNTY***
19 **TELEPHONE (INCLUDE AREA CODE)** ( )

20 Type Owner
21 Number of Beds
22 Type 8
23 **LICENSE NO.**
24 **LICENSE ISSUE DATE**
25 State License Board 40

26 Certification
Start End
27 Enroll Status 7
28 Enroll Date

29 Category of Svc. 05
30 NPI Type A
31 EC Ind. N

ATTENTION: A statistically valid random sampling technique with extrapolation may be used for determining overpayments/underpayments to medical providers.

I certify that I have read the Facility Participation Agreement for the SC Optional State Supplementation (OSS) Program on the reverse side of this form, and I understand and agree to the conditions of participation. I certify that I will obtain authorization from each OSS Medicaid Patient to release to SCDHHS information necessary for processing OSS payments. I further certify that the enrollment information I have furnished is true, accurate, and complete and that I will report any changes affecting my enrollment.

Print or Type Name of Authorized Agent: _____ Title of Authorized Agent: _____

Signature of Authorized Agent: _____ Date _____

A facsimile stamp is not acceptable.

FACILITY PARTICIPATION AGREEMENT FOR THE SOUTH CAROLINA OPTIONAL STATE SUPPLEMENTATION (OSS) PROGRAM

'he State of South Carolina funds an Optional State Supplementation (OSS) Program that supplements the income of a limited number of eligible individuals /ho reside in community residential care facilities (CRCF's). The OSS Program is administered by the South Department of Health and Human Services DHHS), which has developed policies and procedures governing the administration of this program. In order for the OSS Program to operate effectively and onsistently, these polices and procedures must be followed by all CRCF's participating in the program.

- **LICENSING**. The facility must be licensed as a Community Residential Care Facility by the South Carolina Department of Health and Environmental Control (DHEC), and must maintain that license in good standing. Any change in licensing status must be reported by the facility to DHHS within five (5) business days of the change. If the facility receives notification from DHEC suspending or revoking its license, such license is not considered to be in good standing for the purpose of participating in the OSS Program.

- **DISCLOSURE**. The provider shall disclose full and complete information as to ownership, business transactions, and criminal activity in accordance with 42CFR 455.104 through 455.106 (1999). Furthermore, the provider shall disclose any felony convictions under Federal or State law in accordance with 42 CFR 1001.101 subpart B through 1001.1701 Subpart C (1999).

- **PAYMENT OF MONTHLY OSS BENEFITS**. Each month, DHHS will issue one (1) electronic deposit to the facility that includes the OSS benefit payments for all OSS recipients currently residing in the facility. This deposit will be accompanied by a remittance advice of the individuals covered and the amount of the payment for each individual. The facility must maintain adequate records of the OSS funds received for each OSS recipient, and must be able to account accurately for the disposition of each resident's money.

- **PAYMENT IN FULL**. OSS payment based on the recipient's countable income is considered payment in full, and the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the resident or any other person, family member, relative, organization or entity for care or services on behalf of the resident.

- **RESIDENT FUNDS, PERSONAL NEEDS ALLOWANCES**. The OSS recipient has the option to manage his/her personal finances, including the funds paid by the OSS Program. The facility and the OSS recipient must work out an arrangement acceptable to each for such activities as the receipt and disbursement of funds, the crediting of payments received by the facility on behalf of the recipient, and the allocation of the individual's personal needs funds required under the OSS Program. Substantiated finding of the failure to follow policy for the administration of the recipient's personal needs accounts for the OSS Program may result in the withholding of the OSS reimbursements and/or the loss of the facility's eligibility to participate in the OSS Program. See the DHHS Sanctioning Process.

- **UNDERPAYMENT, OVERPAYMENTS, ADJUSTMENTS**. At its sole discretion, DHHS may issue additional electronic deposits during the month to cover necessary adjustments, and may also require the immediate refund of any overpayments as soon as the overpayment is identified. Alternatively, DHHS may elect to remedy any underpayments or recover any overpayments through adjustments to further electronic deposits.

- **PROMPT NOTIFICATION OF ADMISSIONS/ DISCHARGES/TRANSFERS/DEATHS**. The facility MUST notify the OSS Program via the DHHS CRCF-01 Form in the manner specified in the Program policies and procedures of the admission, transfer, discharge, or death of an OSS recipient within seventy-two hours of the action. The failure to properly notify the OSS Program of such actions may result in the withholding of OSS reimbursements and/or the loss of the facility's eligibility to participate in the OSS Program. See the DHHS Sanctioning Process.

- **PROMPT NOTIFICATION OF CHANGES IN PROVIDER ENROLLMENT – CHANGES IN ADDRESS/OWNER/PHONE NUMBER/ ADMINISTRATOR/BED SIZE/BANK ACCOUNTS/ETC.** The facility MUST notify the OSS Program in writing of any changes in provider enrollment- including, but not limited to changes in address, owner, phone number, administrator, and bed size within seventy-two hours of the action. The failure to properly notify the OSS Program of such actions may result in the withholding of OSS reimbursements and/or the loss of the facility's eligibility to participate in the OSS Program. See the DHHS Sanctioning Process.

- **MONTHLY ADMINISTRATIVE ACTIVITIES**. In order to participate in the OSS Program, a facility must comply with the Program's administrative requirements for furnishing information necessary for DHHS to issue monthly OSS payments. Failure to comply with the Program's administrative requirements, including the timely submission of Turn Around Documents (TADS) for payment may result in the withholding of OSS reimbursements. See DHHS Sanctioning Process.

- **APPROVALS REQUIRED FOR PAYMENTS, EFFECTIVE DATE.** A written notification of OSS Approval from DHHS must be obtained before the OSS Program will make payment for an individual. Payments will only be made from the effective date shown on the Approval, or the date that the OSS recipient entered the facility, whichever is later.

- **TEMPORARY ABSENCE OF RESIDENTS DUE TO MEDICAL CONFINEMENT: CONTINUATION OF OSS BENEFIT PAYMENTS**. An individual's OSS payment may continue in the event that the recipient is temporarily absent from the facility because of a medical confinement (hospitalization, temporary admission to nursing facility, etc.) provided that the recipient and facility comply with the OSS Program's policies and procedures for such continuation. Continuation of OSS payments during a temporary absence for a medical confinement is limited to a maximum of thirty (30) days.

- **QUALITY AND SCOPE OF SERVICES.** All services rendered by the facility to its residents (regardless of whether the resident is an OSS recipient) MUST be in compliance with the state's licensing laws and regulations. Failure to comply with these provisions may result in a loss or reduction of the facility's eligibility to participate in the OSS Program. See the DHHS Sanctioning Process.

- **FREEDOM OF CHOICE FOR OSS RECIPIENTS.** An OSS recipient has the freedom to reside in any participating CRCF that is willing to accept him/her.

- **COST REPORTS.** The facility must submit a notarized cost report to DHHS in a format specified or approved by DHHS. Cost reports must be submitted on a time schedule established by DHHS. The failure to submit a cost report, or the failure to adhere to the time schedule, may result in the withholding of OSS reimbursement, the denial of new admissions, and readmissions, and ultimately may result in the facility losing its eligibility to participate in the OSS Program. See DHHS Sanctioning Process.

- **RECORDS.** The facility must keep accurate records that adequately document the admissions, discharges and transfers of OSS recipients. During normal business hours these records must be made available upon request to DHHS, it representative, and/or designees. See the DHHS Sanctioning Process.

- **COMPLIANCE WITH OSS POLICIES AND PROCEDURES.** As a condition of participating in the OSS Program, the facility must agree to comply with the policies and procedures of the Program, as issued in handbooks, manuals, program advisories, or regulations (Code Section 44-6-90).

- **TERMINATION.** The facility may terminate its participation in the OSS Program upon thirty (30) days written notice to DHHS and to all affected OSS recipients. DHHS may terminate a facility's participation for cause based upon the DHHS Sanctioning Process. Such termination shall be sent by Certified Mail, Return Receipt Requested, and be effective thirty (30) days after the date of receipt.

- **COMPLAINTS RELATED TO THE PHYSICAL CONDITIONS AND/OR QUALITY OF CARE IN THE FACILITY.** DHHS may deny reimbursement for new admissions and readmissions when substantiated complaints related to the physical conditions and/or quality of care are received from one or more than one of the following entities: DHHS; Long Term Care Ombudsman; Protection & Advocacy, DHEC, South Carolina Department of Mental Health; South Carolina Department of Social Services, South Carolina Department of Labor, Licensing and Regulations; Attorney General's Office; and any law enforcement agency. Denial of payment will continue until the facility develops and adheres to an approved corrective action plan, which adequately addresses the concerns raised in the complaints.

- **RECOUPING OF PAYMENTS.** DHHS may recoup payments from facilities for cause including, but not limited to, the following: failure to adhere to the bed hold policy; billing for more residents than the facility has licensed beds; billing for a resident(s) who has left the facility or has died, resident income changes and possible provider rate reductions. If fraudulent intent by the facility is indicated, the appropriate law enforcement officials will be notified. Failure to follow the agency Policies and Procedures will be subject to the DHHS Sanctioning Process.

- **LEVEL OF PROVIDER PARTICIPATION.** The facility understands and agrees that even though the execution of this Facility Participation Agreement makes the facility ELIGIBLE to participate in the OSS Program the facility is NOT guaranteed any specific level of participation

- **CIVIL RIGHTS ACT.** In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) and regulations pursuant thereto, (45 C.F.R Part 80, 1996. as amended). In accordance with Title VI of the Civil Rights Act of 1964, (42 U.S.C. 2000d et seq.) and its implementing regulation at 45 C.F.R Part 80, the provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefit and services provided under this agreement.

- **APPEALS.** If the facility disagrees with any action taken by DHHS concerning the facility's participation in the OSS Program, the facility's sole and exclusive remedy shall be an administrative appeal und the terms of the DHHS appeal regulations found at S.C Code Ann. Reg. 126-150, et seq. (as amended).

COUNTY CODES (ITEM 16)

01	Abbeville	24	Greenwood
02	Aiken	25	Hampton
03	Allendale	26	Horry
04	Anderson	27	Jasper
05	Bamberg	28	Kershaw
06	Barnwell	29	Lancaster
07	Beaufort	30	Laurens
08	Berkeley	31	Lee
09	Calhoun	32	Lexington
10	Charleston	33	McCormick
11	Cherokee	34	Marion
12	Chester	35	Marlboro
13	Chesterfield	36	Newberry
14	Clarendon	37	Oconee
15	Colleton	37	Orangeburg
16	Darlington	39	Pickens
17	Dillon	40	Richland
18	Dorchester	41	Saluda
19	Edgefield	42	Spartanburg
20	Fairfield	43	Sumter
21	Florence	44	Union
22	Georgetown	45	Williamsburg
23	Greenville	46	York

DHHS LEVELS OF SANCTIONING FOR CRCF'S

*The offense will determine the sanctioning level. Appeals with the Department of Health and Environmental Control (DHEC) are not exempt from DHHS sanctioning.

1. **Denial of Payment for New Admissions and Readmissions/Approval – Division Level**

   A. Multiple substantiated complaints from various agencies such as Long Term Care Ombudsman, Protection & Advocacy, DHEC, etc., related to the physical conditions and/or quality of care in the facility. This sanction will be imposed until the facility develops and adheres to a corrective action plan to adequately address these concerns.

2. **Holding of OSS Reimbursement/Approval Level – Bureau Level**

   A. Failure to submit a notarized cost report within the scheduled time frames to DHHS.

   B. Failure to submit a Turn Around Document (TAD) for payment by the due date.

   C. Failure to promptly notify the DHHS eligibility worker and area DHHS Regional Office.

   D. Substantiated finding of failure to follow policy for the administration of the beneficiary's personal needs accounts.

3. **Recoupment of Payment/Approval Level – Bureau Level**

   A. Failure to follow the Agency Policies and Procedures.

   B. Billing for more residents than the facility has licensed beds.

4, **Termination of OSS Participation Agreement/Approval Level – Executive Level**

   A. DHEC Health Licensing Division sends a notice to suspend or revoke the license.

   B. DHEC or law enforcement substantiates life threatening physical conditions.

   C. Continuous substantiated complaints and/or violations of licensing regulations.

_____ _____

Authorized Signature Date

Revised: 04/09/10

South Carolina
Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name _____

Medicaid Provider Number _____

Provider NPI Number _____

Provider Address _____

City _____ State _____ Zip _____

BANKING INFORMATION (*Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).*

Financial Institution Name _____

Financial Institution Address _____

City _____ State _____ Zip _____

Routing Number (nine digit) _____

Account Number _____

Type of Account (check one) ☐ Checking ☐ Savings

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.
I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.
I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: _____ Phone Number: _____

Signed _____ *(Signature)*

_____ *(Print)*

Title _____ Date _____

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

RETURN COMPLETED FORM & BANK VERIFICATION DOCUMENT TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022

INSTRUCTIONS TO APPLICANTS FOR MEDICAID PROVIDER ENROLLMENT REGARDING REQUIRED DISCLOSURES
Part 1

1. If you are an individual practitioner or in a group of practitioners that is not organized as a business proprietorship, limited liability corporation, partnership, or corporation, whether it be for profit or not for profit, you are not required to complete Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please indicate if you are enrolling only as an individual practitioner and are exempt from these disclosure requirements.

☐ **Yes** ☐ **No**

By answering "Yes", you are enrolling as an individual only and therefore exempt from disclosure requirements as required by Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please complete all of Part 1. If "No" is checked, proceed to Part 2.

2. Provide the following information about yourself (individual practitioner only).
PLEASE NOTE: If you are not required to have a National Provider Identifier (NPI), please indicate "NA" in the NPI Field below.

*Full Name: First	M.I.	Last	Suffix	Title (MD, etc.)
*SSN:	*Date of Birth (mm/dd/ccyy): / /		*Gender:	
Provider Number: (If Known)	*NPI:	Email address:		
*Primary Practice Location Name and Address:		*Telephone Number:		
Name	Street Address	City	State	Zip + 4

Fields marked with an * must be completed.

3. Have you ever been convicted of a criminal offense in relation to Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP)? ☐ **Yes** ☐ **No**

If "Yes", list the charge(s), where convicted, the date, and disposition status of the conviction.
(Attach additional page(s) if necessary.)

Charge(s)	City/State of Conviction	Conviction Date	Disposition Status
		/ /	
		/ /	

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE IN MEDICAID, OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF THE AGREEMENT OR CONTRACT WITH the SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (SCDHHS).

*Print or Type Full Name: _____

*Signature: _____ *Date: _____

Please send this page (Part 1) with your completed Medicaid enrollment application. Do not send Part 2 of the Disclosure form if you are exempt from Disclosure requirements. All other applicants for Medicaid enrollment must complete and submit only Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT
PART 2

General Instructions

Federal Medicaid regulations (42 CFR 455.100 – .106) require that all Medicaid providers disclose the name, address, and other identifying information for each person with an ownership or control interest in the provider and any subcontractor in which the provider has a 5% or more interest. All applicants, except an individual practitioner or group of practitioners as defined in 42 CFR 455.101, must complete this form in order to enroll as a provider in the Medicaid program. The provider must also screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) and/or all federal health care programs. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.

Please answer all questions as of the **current date**. If the **"Yes"** block for an item is checked, list the requested additional information in the area provided; attach additional pages and/or documentation as needed, referencing the item number to which the information corresponds. Return the original to the South Carolina Department of Health and Human Services (SCDHHS); retain a copy for your files. Failure to provide this form and/or incomplete information will result in a refusal by SCDHHS to enter into an agreement or contract with any such provider or institution or in termination of existing agreements.

This form is to be completed for all programs established by Title XIX and Title XXI and **must be submitted within 35 days of any changes to provider information.** Completion and submission of this form is a condition of approval or renewal of a contract or agreement between the disclosing entity and SCDHHS. Any substantial delay in completing the form should be reported to SCDHHS.

Disclosure of Social Security Number (SSN): Disclosure of a SSN is used for the purpose of determining whether persons and entities named in an application are federally excluded parties and to verify licensure. **Refusal to provide a SSN will result in rejection of the provider's application to participate in the Medicaid program or termination of any existing provider agreement or contract.**

I. Instructions / Definitions: Providers that must have a National Provider Identifier (NPI) must include the NPI. If currently enrolled in South Carolina Medicaid with multiple NPI numbers, a separate Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514) must be completed for each NPI number.

I. Identifying Information			
[a] Name of Provider (Disclosing Entity): Doing Business As (trade or company name):			
Street Address		City, State, Zip + 4	
County	Provider Number(If Known)	NPI	Telephone Number
[b] Federal Employer Identification Number (FEIN):			
[c] Type of Entity (Applies to either For Profit or Non-Profit) ☐ Limited Liability Corporation (LLC) ☐ Partnership ☐ Corporation ☐ Business Proprietorship or Company ☐ Sole Proprietor ☐ Governmental Unit ☐ Other (Please specify)_____			

II. Instructions / Definitions:

Providers must disclose ownership and control information as required by 42 CFR 455.101 - 104.
Ownership interest is defined as the possession of equity in the capital, the stock or the profits of the disclosing entity. ***A disclosing entity*** is a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Control interest is defined as the 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 (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Therefore, ***a person with an ownership or control interest*** is a ***person*** or ***corporation*** that –

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest totaling 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interest 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.

Subcontractor means (a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

II. Individuals and Organizations with Ownership or Control Interest

[a] List names, addresses, date of birth and SSN for individuals, or list names, addresses and the FEIN for organizations, having direct or indirect ownership or control interest, **as defined on pg. 2,** in the entity listed in Section I. Attach additional pages, if needed, for any additional names and addresses. **If Sole Proprietor or Business Proprietorship or company is checked in Section I, skip this section.**

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] Are any persons / entities with ownership or control interest in the provider also owners of other Medicare / Medicaid providers? If yes, list name of the owner from Section II [a] and the name and NPI and/or FEIN for each facility or SSN if an individual provider.

☐ Yes ☐ No

Name of Owner from Section II [a]	Name of Other Provider or Entity	NPI/SSN	FEIN

III. Subcontractors

[a] Please list any subcontractors of the disclosing entity (provider), **as defined on pg. 2**, in which the disclosing entity has a direct or indirect ownership of 5% or more.

☐ Not Applicable

Name of Subcontractor	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] List the following information for individuals or organizations having direct or indirect ownership or a control interest, **as defined on pg. 2,** in any subcontractor in which the disclosing entity (provider) has a direct or indirect ownership of 5% or more. Attach additional pages, if needed, for additional names.

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

IV. Relationships

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 (spouse, sibling, parent, child, etc).

Name of Person 1	Name of Person 2	Relationship

V. Managing Employees

[a] List current managing employees as indicated below. "Managing employee" means general manager, office or business manager, administrator, director, or other individual who exercises operational or managerial control over the institution, agency, or organization, or who directly or indirectly conducts the day-to-day operations.
Attach additional pages, if needed, for additional names.

Name/Title	Address	SSN	Date of Birth

[b] Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
☐ Yes ☐ No
If Yes, give date for change: Date / / . List names, titles, and SSN of the prior Administrator, Director of Nursing, or Medical Director.

Name	Title	SSN

VI. Management Company

A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility. If the answer is yes, list the name of the management firm as well as the managing employees of the firm (i.e., CEO, CFO, etc). Attach additional pages, if needed, for additional names.

Is the provider/entity/facility operated by a management company?
☐ Yes ☐ No
If Yes, what is the term of the agreement?
Beginning Date / / to Ending Date / /

Name of Management Co.	Address	FEIN

Name(s) of Managing Employee(s)	SSN	Date of Birth

VII. Instructions / Definitions: Criminal Offenses related to the delivery of services or items under Medicare or Medicaid programs include convictions relating to patient neglect or abuse in connection with the delivery of a health care item or service; felony and/or misdemeanor convictions related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; and felony and/or misdemeanor convictions related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

VII. Criminal Offenses

If any of the questions are answered "Yes", list names, addresses, and SSNs for individuals and names, addresses, and FEINs for organizations, or attach documentation or additional pages if needed.

[a] As listed in **Sections II or III**, have any individuals and organizations with a direct or indirect ownership of 5% or more in the disclosing entity (provider), or any subcontractor(s) in which the provider has a direct or indirect ownership of 5% or more, been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)?

☐ Yes ☐ No

[b] As listed in **Sections V or VI**, have any directors, officers, agents, or managing employees of the disclosing entity (provider) ever been convicted of a criminal offense related to their involvement in such program established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)? ☐ Yes ☐ No

Name	Address	SSN/FEIN

VIII. Instructions / Definitions: Sanctions and other adverse actions include any revocation or suspension of a license to provide health care by any State licensing authority; any revocation or suspension of accreditation; and/or any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

VIII. Sanctions and Other Adverse Actions

Has your organization, under any current or former name or business identity, or any individuals and organizations listed in **Sections II, III, V, or VI,** ever had a final adverse action imposed against it? If yes, report the individual(s) or organization(s) involved, each final adverse action, when it occurred, and the Federal or State agency or the court/administrative body that imposed the action. ☐ Yes ☐ No

Individual/Organization	Adverse Action	Date	Taken by

IX. Instructions/ Definitions: Changes in provider status are defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership, including changes in any partnership arrangement, or any changes of ownership.

IX. Changes in Provider Status

If there has been a change in ownership /partnership within the last year or if you anticipate a change, indicate the date in the appropriate space. If there are no owners (i.e., the provider is a sole proprietorship), check Not Applicable.

[a] Has there been a change in ownership or controlling interest within the last year? If Yes, give date.
☐ Yes - Date: / / ☐ No ☐ Not Applicable

X. Instructions / Definitions: A chain affiliate is any free-standing health care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other devices, control and direction of a private, charitable or propriety. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, <u>are not</u> considered to be chain affiliates.

X. Chain Affiliation

[a]. Is this facility chain-affiliated? If Yes, list name, address and FEIN of parent Corporation below.
☐ Yes ☐ No

Name	Address	FEIN

[b]. If the answer to part [a] of this item was "No", was the facility ever affiliated with a chain? If Yes, list name, address and FEIN of parent Corporation.
☐ Yes ☐ No

Name	Address	FEIN

Certification Statement

You MUST sign and date the certification statement below in order to be enrolled in the Medicaid program. In doing so, you are attesting to meeting and maintaining the Medicaid requirements stated below.

I, the undersigned, certify to the following:

1. I have read the contents of this form, and the information contained herein is true, correct, and complete. If I become aware that any information listed on this form is not true, correct, or complete, I agree to notify Medicaid of this fact within thirty-five (35) days of discovery.

2. I authorize Medicaid to verify the information contained herein. I agree to notify Medicaid of a change in ownership, practice location and/or Final Adverse Action within 35 days of the reportable event. In addition, I agree to notify Medicaid of any other changes to the information on this form within 35 days of the effective date of change. I understand that any change in business structure of this provider may require the submission of a new application.

3. I understand that any deliberate omission, misrepresentation, or falsification of any information contained on this form or contained in any communication supplying information to Medicaid, or any deliberate alteration of any text on this form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicaid billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.

4. I agree to abide by the Medicaid laws, regulations and program instructions that apply to me or to the organization. The Medicaid laws, regulations, and program instructions are available through SCDHHS. I understand that payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, and on the provider's compliance with all applicable conditions of participation in Medicaid.

5. Neither I, nor any managing employee listed on this form, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicaid or other Federal program beneficiaries.

6. I agree that any existing or future overpayment made to me or to the organization(s) listed on this form, by the Medicaid program, may be recouped by Medicaid through the withholding of future payments.

7. I understand that the Medicaid identification number issued to me can only be used by me or by a provider to whom I have reassigned my benefits under current Medicaid regulations, when billing for services rendered by me.

8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

Name of Authorized Representative (Printed or Typed):	Title:
Signature:	Date:

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ _____
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,