Who Uses This Packet

You should use this packet if:

Add / update / end date ownership

General Instructions

The following information is important. If you have questions, contact Gainwell Technologies Provider Enrollment at 1 (866) 686-4272 or e-mail idproviderenrollment@gainwelltechnologies.com

- All information is required. Be sure to fill out all fields. If there is a field that does not pertain, please enter "NA".
- Any required addenda or supporting documentation (such as a copy of a certification) must be submitted with the packet.
- Incomplete packets, including packets that are missing the required addenda or supporting documentation, will result in an e-mail from Provider enrollment asking for the missing information.
- The effective date of an applicant's affiliation to an existing provider is deemed to be the date the application has been fully reviewed and approved by IDHW and Gainwell Technologies Provider Enrollment.
- Providers are required to report any changes to their Idaho Medicaid provider file within 30 days of the date of the change (per the Idaho Medicaid Provider Agreement and the Idaho Medicaid Provider Handbook)
- All packet documents are interactive PDF files, allowing users to enter information into the fields directly from the computer screen. This information can then be saved to a file and printed for mailing. Using these interactive features facilitates both the packet's completion and review processes.

Next Steps

1) Print the completed packet.
2) Make a copy of the packet for your records.
3) Mail, fax, or e-mail the packet, including all required addenda and supporting documentation, to the following address:

Gainwell Technologies
PO Box 70082
Boise, ID 83707
Fax: 1 (877) 517-2041
E-Mail: idproviderenrollment@gainwelltechnologies.com

Current Provider and Contact Information

Current Provider Information	
Pay-To Name of Group, Organization, or Individual:	
National Provider Identifier (NPI) or Medicaid ID:	Tax ID (FEIN or SSN):
Contact Information	
The contact name and e-mail relate to the person who can answer questions about the information provided in this packet. E-mail addresses are used for IDHW business only and will not be sold or shared for other purposes.	
Contact Name (first name, last name):	Phone (with area code):
Contact E-mail Address:	
Billing Contact Name:	Billing Contact Phone (with area code):

Disclosure of Ownership/Controlling Interest and Conviction Information

☐ Add ☐ Update ☐ Terminate **Effective Date:**

The Disclosure of Ownership / Controlling Interest and Conviction form is located on the following page. In accordance with 42 CFR 455.100-106, please enter the following information.

- Owners or board members who own 5% or more in this provider entity *(42 CFR 104(a)(2))*
- **ALL** managing employees of the disclosing entity (provider) (*42 CFR 455.101)*
- Subcontractor in which you as a Provider have direct or indirect ownership of 5% of more *(42 CFR 104(a)(1))*
- List ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous 12-month period *(42 CFR 455.105 and 42 CFR 106)*
- List persons that are related to each other (spouses, parents, children, or siblings)
- Criminal Offense (*42 C.F.R. §455.100; 42 C.F.R. §455.106)*

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42 C.F.R. Sec. 455.101 Definitions

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

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

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the 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 XVIII);
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.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

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

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

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

Person with an ownership or control interest means a person or corporation that a. Has an ownership interest totaling 5 percent or more in a disclosing entity;

a. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
b. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
c. Is an officer or director of a disclosing entity that is organized as a corporation; or

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d. Is a partner in a disclosing entity that is organized as a partnership?
e. Is a Governmental/Tribal Organization: An Indian Tribe, Federal, State, County, City, or other level of government who is legally and financially responsible for Medicaid payments received must report the name of that Indian Tribe or Government under *Name* and check the *Owner* box. A letter on that government affiliates letterhead must be submitted attesting that the government or tribal organization will be legally and financially responsible in the event of any outstanding debt owed to the State of Idaho Medicaid. The letter must be signed by an "authorized official" of the tribe or governmental organization who has the authority to make the letter legally and financially binding.
f. Is a Charitable and Religious Organization: A non-profit organization that is charitable or religious in nature and is operated and/or managed by a Board of Trustees or other governing body. The name of the Board of Trustees or other governing body must be recorded, with the *Board Member* box checked, and the Conviction information and address provided. SSN/DOB not required for non-profit organizations.

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

Subcontractor means—

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

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

42 CFR § 455.102 Determination of ownership or control percentages

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.

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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.

With the Change of Ownership is there:

☐ New NPI

☐ New Tax ID (Include a new W-9)

☐ Change in Pay-To Name (Include a new W-9)

If any of these items are marked yes, a new application may be required and you will be contacted by Gainwell Technologies.

If terminating a current owner, please provide only the owner name and social security number below and disregard the remaining requested information on this page.

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Line #	Name	Owner	Board Member	Managing Employee	Sub contractor	Wholly Owned Supplier	5 percent or greater Ownership	Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program (42 CFR 455.104)? Check all that apply.	Related to Line #	Relationship (ie. Spouses, parents, children, or siblings)
1	**DOB**	☐	☐	☐	☐	☐	☐	**Sanctioned** ☐ Yes		
								Convicted ☐ Yes		
	SSN							**Excluded** ☐ Yes		
	Name							☐ None of the above		
	Address									
	Conviction Details or Exclusion Type									
2	**DOB**	☐	☐	☐	☐	☐	☐	**Sanctioned** ☐ Yes		
								Convicted ☐ Yes		
	SSN							**Excluded** ☐ Yes		
	Name							☐ None of the above		
	Address									
	Conviction Details or Exclusion Type									
3	**DOB**	☐	☐	☐	☐	☐	☐	**Sanctioned** ☐ Yes		
								Convicted ☐ Yes		
	SSN							**Excluded** ☐ Yes		
	Name							☐ None of the above		
	Address									
	Conviction Details or Exclusion Type									

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Provider Statement

I certify that I am the provider, or I am authorized on behalf of the provider to sign this documentation. I certify this is true, correct, and complete. If I become aware that any information in this document is not true, correct, and complete, I will notify Gainwell Technologies Provider Enrollment of this fact immediately. I authorize the Medicaid provider enrollment unit to verify the information contained herein. I understand that a change in the ownership of my organization or my status as an individual or group biller may require a new application.
Provider Name (print):
Title:
Provider Authorized Signature:
Date: