



Your Extended Family.



March 5, 2019

Dear Credentialing Department:

In accordance to the contractual agreement between Molina Healthcare of South Carolina, LLC and SCDHHS, we must perform an annual validation of the Disclosure of Ownership and Control Interest Statement SCDHHS Form 1514.

After several attempts to obtain a signed attestation or SCDHHS Form 1514, our records indicate the form has not been returned per the original deadline of February 11, 2019.

Please review, sign and return the attached document(s) that applies to your organization. The final deadline to return the document(s) is **March 21, 2019**. Please return the completed form to Fax: 843-740-1748 or email documents to: MSC-CREDENTIALING@MolinaHealthCare.Com.

If there have been no changes to SCDHHS Form 1514 for your practice, kindly sign and return only the attestation page indicating no changes have been made. The attestation requires signature, practice name, TIN and the date of signature.

If there have been changes, you must complete and return the attached OD Form 1514.

Not returning the attached document may cause a delay in our members receiving services from your practice/providers, as a non-participation flag could be placed on your record.

If you have any questions, please do not hesitate to contact the credentialing department at the following email address: MSC-CREDENTIALING@MolinaHealthCare.Com.

Sincerely,

Maeella M. Yates

Maeella Yates, CPCS
Credentialing Supervisor

Disclosure of Ownership and Control Interest (OD form) Attestation

Please indicate below by checking the appropriate box

I am attesting that there have not been any changes to SCDHHS Form 1514 for our practice.

Practice Name:	Tax ID Number:
Name of Authorized Representative (Printed or Typed):	Title:
Phone:	Fax:
Signature:	Date:

There have been changes in the SCDHHS Form 1514 for our practice.

I have completed and attached a new OD Form 1514 (12-16-11) in accordance to the guidelines outlined below.

Requirements:

- Disclosure forms must include date of birth and social security numbers where indicated.
- Sections that do not pertain to you or your entity must be marked as "N/A".
- Sections that require a "Yes" or "No" response must be marked.
- Disclosure information must be updated with Molina Healthcare within 35 days of information changes by submitting a new OD Form.
- The signature must be that of an individual with the power and authority to legally bind the entity, such as an owner or officer.

Return the completed form to: Fax: 843-740-1748
Or email to: MSC-CREDENTIALING@MolinaHealthCare.Com

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)			
<input type="checkbox"/> Limited Liability Corporation (LLC)			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> Business Proprietorship or Company			
<input type="checkbox"/> Sole Proprietor			
<input type="checkbox"/> Governmental Unit			
<input type="checkbox"/> 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

[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, are not 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: