



## Iowa Medicaid - Provider Enrollment Application

**Please complete and return this Provider Enrollment Application along with a signed Provider Agreement. We appreciate your effort in providing this information and your participation in the Iowa Medicaid Program. Thank you!**

**Questions in completing this application: Iowa Medicaid Enterprise Provider Services Unit at (800) 338-7909 or (515) 256-4609.**

### Section A: General Information

#### Practice Information

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           |                  |           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------------|-----------|
| 1. Legal Name (as it appears on your income tax return)                                                                                                                                                                                                                                                                                                                                                                                                                                       |           |                  |           |
| <b>2. Taxpayer Identification Number (TIN):</b> enter the nine-digit Federal Employer Identification Number (FEIN) of the business OR the Social Security Number (SSN) of the individual for which this application is being filed. This is the number under which all income will be reported to the Internal Revenue Service for Federal 1099 purposes.<br><br><i>Indicate type:</i> <input type="checkbox"/> FEIN or <input type="checkbox"/> SSN (check one) <b>List the number here:</b> |           |                  |           |
| 3. For Healthcare Providers: Primary Organizational NPI                                                                                                                                                                                                                                                                                                                                                                                                                                       |           |                  |           |
| 4a. Primary Physical Location*                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           | 4b. Suite Number |           |
| 4c. City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4d. State | 4e. Zip Code     | 5. County |
| 6. Phone Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           | 7. Fax Number    |           |
| <b>8. Check Appropriate Box</b><br><input type="checkbox"/> Individual/Sole Proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____                                                                                                                                                                                                                                                                                         |           |                  |           |
| 8b. Is your organization a participating "340B" provider? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                            |           |                  |           |
| 9a. Mailing Address (Medicaid Related Correspondence, if different from above)                                                                                                                                                                                                                                                                                                                                                                                                                |           |                  |           |
| 9b. City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 9c. State | 9d. Zip Code     |           |
| 10. E-Mail Address for Medicaid Related Correspondence                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |                  |           |

**Payment Information**

|                                                                                                                                                                                                                                                                                                                                      |       |              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--------------|
| <p>11. Payment Method: <input type="checkbox"/> *Electronic Funds Transfer <input type="checkbox"/> **Debit Card</p> <p><b>NOTE: *EFT REQUIRES COMPLETION OF AUTHORIZATION FORM (470-4202)</b></p> <p><b>** Debit Card is <u>only</u> an option if an individual is doing business under a Social Security Number (in box 2)</b></p> |       |              |
| 11a. Pay to Address (only used for debit card mailing and 1099's )                                                                                                                                                                                                                                                                   |       |              |
| Address                                                                                                                                                                                                                                                                                                                              |       | Suite Number |
| City                                                                                                                                                                                                                                                                                                                                 | State | Zip          |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| 12a. <b>For Pharmacies Only:</b> Enter the National Association of Boards of Pharmacy (NABP) number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                       |
| <p>12b. <b>Acknowledgement for pharmacies located outside the State of Iowa:</b> According to the Iowa Administrative Code 657-19.2(155A), a pharmacy located outside of Iowa shall apply for and obtain, pursuant to provisions of 657-8.35(155A), a nonresident pharmacy license from the board prior to providing prescription drugs, devices, or pharmacy services to an ultimate user in this state. Please complete the acknowledgement below.</p> <p><b>Check one:</b></p> <p><input type="checkbox"/> The rule listed above does not apply to the pharmacy that is applying to be a provider with the Iowa Medicaid Program.</p> <p><input type="checkbox"/> The rule listed above does apply to this pharmacy; please attach a copy of the Iowa nonresident pharmacy license.</p> |                       |
| 13a. 10-digit Clinical Laboratory Improvement Amendments (CLIA) Number.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                       |
| 13b. Effective Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 13c. Termination Date |

**THE PROVIDER CERTIFIES THAT THE INFORMATION SUBMITTED ON THIS ENROLLMENT FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. THE PROVIDER ALSO UNDERSTANDS THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW**

|                                                     |                      |
|-----------------------------------------------------|----------------------|
| 14a. Printed Name of Legal Entity                   |                      |
| 14b. Printed Name and Title of Authorized Signatory |                      |
| 14c. Signature of Authorized Signatory              | 14d. Signature Date: |

**Please mail this completed Provider Application and all applicable attachments to: Iowa Medicaid Enterprise, Attn: Provider Enrollment, PO Box 36450, Des Moines, Iowa 50315**

## Section B: Organizational Data – Master Provider Listing

Use this list to identify your provider type code. Enter the type code in Box 16

- Declare all individual professionals and institutional categories (from the listing below) that are part of this business and subject to the Iowa Medicaid Provider Agreement.
- Attach current certification document(s) as indicated on the list below
- Only the individuals or institutional categories listed by the business on this form are eligible for Medicaid reimbursement.

| Type Code | Category                               | Primary Certification                           | Additional Certification  |
|-----------|----------------------------------------|-------------------------------------------------|---------------------------|
| 1         | GENERAL HOSPITAL                       | CMS certification                               | License *CLIA             |
| 2         | PHYSICIAN MD                           | License                                         | Medicare Enrollment *CLIA |
| 3         | PHYSICIAN DO                           | License                                         | Medicare Enrollment *CLIA |
| 4         | DENTIST                                | License                                         |                           |
| 5         | PODIATRIST                             | License                                         | Medicare Enrollment       |
| 6         | OPTOMETRIST                            | License                                         | Medicare Enrollment       |
| 7         | OPTICIAN                               |                                                 |                           |
| 8         | PHARMACY                               | License                                         | Medicare Enrollment       |
| 9         | HOME HEALTH AGENCY                     | CMS certification                               |                           |
| 10        | INDEPENDENT LAB                        | CLIA Certificate                                | Medicare Enrollment       |
| 11        | AMBULANCE                              | License                                         | Medicare Enrollment       |
| 12        | MEDICAL SUPPLES                        | Medicare Enrollment                             |                           |
| 13        | RURAL HEALTH CLINIC                    | CMS certification                               |                           |
| 14        | ESRD                                   | CMS certification                               |                           |
| 15        | PHYSICAL THERAPIST                     | License                                         | Medicare Enrollment       |
| 16        | CHIROPRACTOR                           | License                                         | Medicare Enrollment       |
| 17        | AUDIOLOGIST                            | License                                         | Medicare Enrollment       |
| 18        | SKILLED NURSING FACILITY               | DIA/CMS certification                           | License                   |
| 19        | REHAB AGENCY                           | CMS certification                               |                           |
| 20        | INTERMEDIATE CARE FACILITY             | DIA/CMS certification                           | License                   |
| 21        | COMMUNITY MENTAL HEALTH                | Bureau of Community Services                    |                           |
| 22        | FAMILY PLANNING                        | Dept Public Hlth approval                       |                           |
| 23        | RESIDENTIAL CARE FACILITY              | License (DIA)                                   |                           |
| 25        | ICF MR STATE                           | DIA/CMS certification                           | License                   |
| 26        | MENTAL HOSPITAL                        | CMS certification                               | License                   |
| 27        | COMMUNITY BASED ICF/MR                 | DIA/CMS certification                           | License                   |
| 29        | PSYCHOLOGIST                           | License                                         | Medicare Enrollment       |
| 30        | SCREENING CENTER                       | Dept Public Health approval                     |                           |
| 31        | HEARING AID DEALER                     | License                                         | Medicare Enrollment       |
| 32        | OCCUPATIONAL THERAPISTS                | License                                         |                           |
| 34        | ORTHOPEDIC SHOE DEALER                 |                                                 |                           |
| 35        | MATERNAL HEALTH CENTER                 | DHS Approval                                    |                           |
| 36        | AMBULATORY SURGICAL CENTER             | CMS certification                               |                           |
| 38        | CERTIFIED NURSE MIDWIFE                | License                                         | *CLIA                     |
| 39        | BIRTHING CENTER                        | DHS Approval                                    |                           |
| 40        | AREA EDUCATION AGENCY                  | IA Dept of Education Agreement                  |                           |
| 41        | PSYCH MEDICAL INST. CHILDREN (PMIC)    | DIA License                                     |                           |
| 42        | CASE MANAGER                           | DHS Approval                                    |                           |
| 44        | CRNA                                   | License                                         | Medicare Enrollment       |
| 45        | HOSPICE                                | CMS certification                               | *CLIA                     |
| 48        | CLINICAL SOCIAL WORKER                 | License                                         | Medicare Enrollment       |
| 49        | FEDERAL QUALIFIED HEALTH CENTER (FQHC) | CMS certification                               |                           |
| 50        | NURSE PRACTITIONER                     | License                                         | Medicare Enrollment *CLIA |
| 52        | NURSING FACILITY - MENTAL ILL          | DIA/CMS certification                           | License                   |
| 54        | COUNTY RELIEF                          | DHS Approval                                    |                           |
| 55        | LEAD INVESTIGATION AGENCY              | Dept Public Hlth approval                       |                           |
| 56        | LOCAL EDUCATION AGENCY                 | IA Dept of Education Agreement                  |                           |
| 57        | EARLY ACCESS SERVICE COORDINATOR       | IA Dept of Education Agreement                  |                           |
| 58        | PACE                                   | CMS PACE Agreement                              |                           |
| 62        | BEHAVIORAL HEALTH                      | License                                         |                           |
| 63        | REMEDIAL SERVICE                       | Magellan Enrollment welcome letter              |                           |
| 64        | HABILITATIVE SERVICES                  | Applicable certification/accreditation          |                           |
| 67        | Assertive Community Treatment (ACT)    | License                                         |                           |
| 71        | Health Home                            | TransforMED self-assessment or NCQA recognition | Health Home Agreement     |
| 99        | WAIVER                                 | HCBS application required                       |                           |

**PLEASE COPY THIS PAGE AND COMPLETE ONE FOR EACH INDIVIDUAL PROFESSIONAL AND INSTITUTIONAL CATEGORY THAT IS PART OF THIS BUSINESS AND SUBJECT TO THE IOWA MEDICAID PROVIDER AGREEMENT**

|                                                                                                                                                                                                                         |                              |                              |                                          |                                  |     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------|------------------------------------------|----------------------------------|-----|
| 16. Type Code                                                                                                                                                                                                           |                              | 17. Licensee or DBA Name     |                                          | 18a. Tax ID (for billing entity) |     |
| 19. Requested Effective Date of Enrollment*                                                                                                                                                                             |                              | 18b. Social Security Number  |                                          | 18c. Date of Birth               |     |
| 20a. Primary Service Address                                                                                                                                                                                            |                              | City                         |                                          | State                            | Zip |
| 20a1. Primary Address Phone Number                                                                                                                                                                                      |                              | Fax                          | Email                                    |                                  |     |
| 20b. Additional Service Address                                                                                                                                                                                         |                              | City                         |                                          | State                            | Zip |
| 20b1. Additional Service Address Phone Number                                                                                                                                                                           |                              | Fax                          | Email                                    |                                  |     |
| 20c. Additional Service Address*                                                                                                                                                                                        |                              | City                         |                                          | State                            | Zip |
| 20c1. Additional Service Address Phone Number                                                                                                                                                                           |                              | Fax                          | Email                                    |                                  |     |
| 21. Pay-to Address                                                                                                                                                                                                      |                              | City                         |                                          | State                            | Zip |
| 22. Mailing Address                                                                                                                                                                                                     |                              | City                         |                                          | State                            | Zip |
| 23a. National Provider Identifier (NPI)                                                                                                                                                                                 |                              |                              | 23b. Taxonomy Code-(if applicable)       |                                  |     |
| 24a. Primary Professional License or Certification Number – <b>PLEASE ATTACH A COPY OF YOUR LICENSE/CERTIFICATION DOCUMENTS</b>                                                                                         |                              | 24b. 10-Digit CLIA Number    |                                          | 24c. State Issued                |     |
| 24d. Initial Effective Date                                                                                                                                                                                             | 24e. Current Expiration Date | 24f. CLIA Effective Date     |                                          | 24g. CLIA Expiration Date        |     |
| 25. Drug Enforcement Agency (DEA) Number. If the provider does not have a DEA Number, enter N/A.                                                                                                                        |                              |                              |                                          |                                  |     |
| 26. Primary Specialty* (if applicable)                                                                                                                                                                                  |                              |                              | 27. Secondary Specialty* (if applicable) |                                  |     |
| 28. Has there ever been disciplinary action against this provider's license by a licensing board in any state?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF "YES" PLEASE ATTACH AN EXPLANATION</b> |                              |                              |                                          |                                  |     |
| 29. Has the provider ever been sanctioned by Medicare or any state health program?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF "YES" PLEASE ATTACH AN EXPLANATION</b>                             |                              |                              |                                          |                                  |     |
| <b>Payment Method Information: EFT is Required when billing under a Federal Tax ID Number. Debit Card is only an option if an individual is doing business under a Social Security Number</b>                           |                              |                              |                                          |                                  |     |
| <b>Group Linkage Information*</b><br>Individual professionals may be associated with an organization. If that is the case, identify the organization in the boxes below:                                                |                              |                              |                                          |                                  |     |
| 30a. Organizational NPI                                                                                                                                                                                                 |                              | 30b. Organizational Taxonomy |                                          | 30c. Organization location zip   |     |
| Name of Person Completing This Form                                                                                                                                                                                     |                              |                              | Signature of Person Completing This Form |                                  |     |

## ATTACHMENT A-OWNERSHIP & CONTROL DISCLOSURE

Disclosing Entities (definition attached) must complete Section A. All providers (**except individual CDAC**) must complete Sections B and C (indicate “yes” or “no” in C). Only one form is required per tax id. **All providers must sign and date the form at the bottom.** Pursuant to Section 1.6 and Section 3 of the Provider Agreement, it is the provider’s responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                               |       |            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|-------|------------|
| Provider Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | Date of Birth (if applicable) |       |            |
| County/State/Country of Birth (if applicable)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | Federal Tax ID or SSN         |       | NPI Number |
| <p><b>A.</b> Pursuant to 42 CFR sec. 455.104 and 455.105, <i>Disclosing Entities</i> (see attached definitions) must disclose below the following information. Please attach additional pages if necessary. Disclosure must be made at the time of contracting with the Department, at the time of survey, or within 35 days of request by the Department of the Secretary of HHS:</p> <p>(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;</p> <p>(2) Whether any of the persons named, in compliance with paragraph (1) is related to another as spouse, parent, child, or sibling.</p> <p>(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person.</p> <p>(4) The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.</p> <p>(5) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.</p> |  |                               |       |            |
| <p><b>B.</b> Pursuant to 42 CFR sec. 455.106, <i>Providers</i> (see attached definitions) must disclose below the identity of any person who:</p> <p>(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider named above, and</p> <p>(2) Has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid or the title XX services program since the inception of these programs:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                               |       |            |
| <p><b>C. Parent/Joint Venture Information</b> Is your organization a subsidiary company or joint venture? <input type="checkbox"/> No (You may skip this section) <input type="checkbox"/> Yes If yes, fill in the following information about your parent company/joint business.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                               |       |            |
| Legal Business Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Employer ID No                |       | NPI Number |
| Business Street Address Line 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                               |       |            |
| Business Street Address Line 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                               |       |            |
| City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | County                        | State | Zip        |
| Phone Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Fax Number                    |       |            |
| Name (please print):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                               |       |            |
| Provider Signature:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                               | Date: |            |

## 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;
- (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.

*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.

(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.