

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
DIVISION OF HOME HEALTH

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST
STATEMENT

These instructions are designed to clarify certain questions on the licensure form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION IS CURRENT.

Item A – Under identifying information, specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

Please answer all questions as of the current date. If the Yes block for any item is checked, list requested additional information under Remarks on Page 2, referencing the item. If additional space is needed, use an attached sheet.

Item C – List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination, amounting to an ownership interest of five percent (5%) or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any 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 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.

Controlling interest is defined as the operations 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 assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to a new ownership or control.

Item F – If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Changes in Provider Status. Change in provider status is 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 owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any changes of ownership.

If the Yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item G – If the answer is Yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. 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.

Item H – If the answer is Yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include the name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item I – A chain affiliate is any freestanding health care facility that is either owned, controlled or operated under lease or contract by an organization consisting of two or more freestanding health care facilities organized within or across State lines which is under the ownership, or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider based facilities, such as hospital-based home health care agencies, are not considered to be chain affiliates.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
DIVISION OF HOME HEALTH

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

A. Identifying Information		
Name of Entity	D/B/A	Telephone No.
Street Address	City, County, State	Zip Code

B. Answer the following questions by checking "Yes" or "No." If any of the questions are answered "yes", list names and address of individuals or corporations under Remarks on Page 2. Identify each item number to be continued.

1. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5% or more in the institution, organizations, or agency that have 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 XX?

Yes No

2. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes No

C. List names, address for individual, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under "Remarks."

Name	Address	EIN

D. Type of Entity: Sole Proprietorship Partnership Corporation
 Unincorporated Other
 Associations

1. If the disclosing entity is a corporation, list names, address of the Directors and EINs for the corporation under "Remarks."

E. Check appropriate box for each of the following questions:

1. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors) If "yes", list names, addresses of individuals and provider number

____Yes ____No

Name	Address	Provider Number
------	---------	-----------------

F. Has there been a change in ownership within the last year? Yes No

If yes, give date _____

Do you anticipate any change of ownership or control within the year? Yes No

If yes, when? _____

G. Is this facility operated by a management company, or leased in whole or part by another organization? Yes No

If yes, give date of change in operations _____

H. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? Yes No

I. Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) Yes No

Name EIN

Address

If the answer to the above question is No, was the facility ever affiliated with a chain? (If yes, list name, address of corporation and EIN) Yes No

Name EIN

Address

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 OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY.

Name of Authorized Representative (Typed) Title

Signature Date

Remarks