



JEREMIAH W. (JAY) NIXON, GOVERNOR • BRIAN KINKADE, DIRECTOR

MISSOURI MEDICAID AUDIT & COMPLIANCE  
P.O. BOX 6500 • JEFFERSON CITY, MO 65102-6500  
WWW.DSS.MO.GOV • 573-522-8689

Dear Provider Applicant:

Thank you for your interest in the Missouri Medicaid **PHYSICIAN ASSISTANT** Program.

A provider of a Missouri Medicaid Program must have a valid participation agreement with the Missouri Department of Social Services (DSS), Missouri Medicaid Audit and Compliance (MMAC). An investigation of the provider's professional background will be considered pursuant to 13 CSR 70.3.020(2). The validation of the participation agreement depends upon the Director of the Department of Social Services or his/her designee's acceptance of an application for enrollment.

In order to receive federal funds and participate in the Missouri Medicaid Program, all providers must comply with all applicable civil rights laws and regulations in the delivery of services. It is the provider's responsibility to review the civil rights information via the internet at [www.dss.mo.gov/mhd](http://www.dss.mo.gov/mhd).

All **Physician Assistant** applicants must complete and submit the following enrollment forms and documentation:

- Physician Assistant Provider Questionnaire
- Title XIX Participation Agreement;
- Missouri Medicaid Enrollment Application;
- Current permanent Physician Assistant license;

If you are an individual applicant and the payee indicated in field 11 of the Provider Questionnaire is either to yourself or a group that **is not** Missouri Medicaid enrolled, you must submit the following documents. If you are an individual applicant and the payee is a group that **is** enrolled with Missouri Medicaid, you do not need to submit the following documents.

- Ownership Disclosure; and
- Electronic Funds Transfer (EFT) Authorization Agreement

If you have questions or need assistance completing the enrollment forms, please contact the Provider Enrollment Unit via e-mail at [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov) before returning the enrollment packet.

Sincerely,

Provider Enrollment Unit  
Missouri Medicaid Audit and Compliance

Attachments

RELAY MISSOURI  
FOR HEARING AND SPEECH IMPAIRED  
1-800-735-2466 VOICE • 1-800-735-2966 TEXT PHONE

## General Information for Enrolling With Missouri Medicaid

### Keep for Future Information

Each provider application is reviewed as a new provider and must go through the same audit process even though a provider record may already exist for another location or provider type.

Review your completed packet to ensure all fields are completed, all forms are included and all required documents are included to avoid delays or the application being rejected.

Your application will be processed in the date order received by the Provider Enrollment Unit (PEU). The PEU is allowed 90 days from the application receipt date to either approve or deny an application.

### Enrollment Forms

When completing the enrollment forms,

- make sure fields 11 and 13 of the Provider Questionnaire are completed correctly. For IRS purposes, the payment name in field 11 must be completed with the exact name associated with the Federal Employer Tax ID number or Social Security Number indicated in field 13. This is also how 1099s will be issued at the end of the calendar year.
- All forms must be signed by the person indicated on the Title XIX Provider Participation Agreement.
- All required documents, as indicated on the enclosed enrollment letter, must be included.
- ALL applicable questions on the Enrollment Application must be completed.
- If service has already been provided to a Medicaid fee-for-service recipient and backdating is necessary, indicate the requested date in question 16 on the Enrollment Application and supply the requested information.

If your application is approved, notification stating the approved provider's name, address, NPI and effective date will be e-mailed to the e-mail address of the Contact Person indicated on the Enrollment Application. Provider information is confidential. It is the provider's responsibility to notify their biller of their NPI and any other information contained in the e-mail as well as any necessary claim filing instructions.

### Out-of-State Provider Enrollment

Missouri Medicaid participants are required to obtain services from Missouri or bordering state providers unless one of the below specific requirements is met. Submitting an enrollment application does not guarantee enrollment and being enrolled does not guarantee reimbursement.

If a claim DOES NOT meet one of the specific conditions listed below, the participant is responsible for the services and enrollment is not granted. If the claim DOES meet one of the specific conditions, you must submit the appropriate enrollment application.

Specific conditions for out-of-state state providers:

- If a Mo HealthNet participant is outside the state of Missouri and requires services, Missouri Medicaid will *consider* enrollment of the out-of-state provider and *consider* reimbursement for the services if one of the following conditions is met.
  - Services were a result of a MEDICAL EMERGENCY, including ambulance. Emergency services are defined as those services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care, after sudden onset of medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of *immediate* medical attention could

reasonably be expected to result in (a) placing the patient health in serious jeopardy; (b) serious impairment to bodily functions; or a serious dysfunction of any body organ or part. For a determination if the services meet the medical emergency criteria, you must submit a request for determination with all records and documentation regarding the services provided to:

MO HealthNet Division – Provider Education  
PO Box 6500  
Jefferson City, MO 65109

If the MO HealthNet Division (MHD) determines the services provided are eligible for reimbursement, they will send you an approval letter. You must submit a copy of the MHD approval letter with your enrollment application.

- Services were provided to a **MEDICARE/MO HEALTHNET PARTICIPANT** with Medicare as primary payor. Include a note with your enrollment application indicating the enrollment is for Medicare crossover claims.
  - Provider of service is located in a **STATE BORDERING THE STATE OF MISSOURI**. Services which routinely require prior authorization or have other limitations continue to require prior authorization and be subject to established limitations, policies and procedures applicable to the Missouri Medicaid programs.
  - Services were provided to a **FOSTER CARE CHILD** not residing in Missouri. Include with your enrollment application the name and DCN of the child.
  - Services were provided by an **INDEPENDENT LAB**.
  - Services were **PRIOR AUTHORIZED** by the Missouri State consultant. Include with your enrollment application an explanation of the prior authorization including the Missouri participant's name and DCN.
- If a MO HealthNet participant is in Missouri and receives services from an out-of-state provider, Missouri Medicaid will *consider* enrollment of the out-of-state provider and *consider* reimbursement for the services **if** one of the following conditions is met.
- Medicare coinsurance and/or deductible amounts on covered services are provided to participants who have both Missouri Medicaid and Medicare.
  - The item/services needed are not available in Missouri or a bordering state of Missouri. If prior authorization is approved and reimbursement is received for equipment, supplies, or services for a MO HealthNet participant who is not Medicare eligible, or for services that are available in Missouri or a bordering state, reimbursement may be recouped on any amounts paid.

If prior authorization is approved and reimbursement is received for equipment, supplies, or services for a MO HealthNet participant who does not meet one of the above conditions, reimbursement may be recouped on any amounts paid.

If a participant is enrolled with a Missouri MC+ health plan on the date(s) of service provided, the provider must contact the MC+ health plan concerning the services. It is not necessary to enroll with MO HealthNet unless the services are for participants who **ARE NOT** enrolled with a Managed Care Health Plan and one of the conditions stated above is met.

## **Change of Information**

Once a provider enrollment record is established, any future changes in your provider record must be reported on the Provider Update Request form available at <http://mmac.mo.gov/providers/provider-enrollment/provider-enrollment-forms/>. Be sure to complete all fields in Sections I and II of the form and sign the second page.

If the provider is licensed or certified by another state agency such as the Department of Health and Senior Services, Department of Mental Health, or Medicare, that agency must approve the change(s) prior to PEU approval.

New provider records are not created for any type of changes, including change of ownership. If a new provider record is created in error due to change information being withheld at the time of application, the new provider record is made inactive, the original provider record is updated, and you may be subject to sanctions.

## **Reimbursement**

Payments go to the provider currently indicated on the Provider Enrollment Master File at the time the claim is processed. The provider is responsible for, but not limited to, separating dates of service and payments, resubmitting denials, and submitting paper crossover claims for any Medicare/Medicaid services that do not crossover electronically, before and after the change is made to the Provider Enrollment Master File.

## **Backdating and Claim Submission**

If backdating the enrollment effective date is granted, this does not suspend the timely filing requirement for any claims, nor does it guarantee payment. Claims submitted after backdating the effective date and denied for timely filing, are not considered for reimbursement. An original claim must be received by the state agency within 12 months (365 days) from the date of service. Medicare crossover claims must be received within 12 months from the date of service or 6 months from the date of Medicare's notice of disposition.

## **Questions**

Information regarding Missouri Medicaid Audit and Compliance is available at [www.mmac.mo.gov](http://www.mmac.mo.gov). For questions regarding enrollment, please contact PEU at [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov).

For questions regarding Missouri Medicaid programs, you may contact the MO HealthNet Division.

- Provider Communications Unit at 573/751-2896 for billing questions.
- Provider Education Representative at 573/751-6683 for training information.
- Provider Manuals available at <http://manuals.momed.com/manuals/>.
- Website at [www.dss.mo.gov/mhd](http://www.dss.mo.gov/mhd)

## Tax Identification Number Information

**AVOID PROBLEMS** – use your correct name and number (this information is excerpted from a December 1993 IRS Alert)

### **MEDICAL SERVICE PROVIDERS HAVE HIGH RATE OF ERRORS**

If you are a medical service provider, double-check the name and taxpayer identification number (TIN) you give to organizations paying you for services (payers). These payers such as insurance companies must send your name, TIN and amount of payment to the Internal Revenue Service. The IRS has found that a high rate of name and taxpayer identification numbers of medical service providers do not match the name and TIN combinations in IRS records. (For individuals, the TIN is the social security number (SSN); for corporations, partnerships and similar entities, the TIN is the employer identification number (EIN).

### **MISTAKES MAY CAUSE WITHHOLDINGS FROM YOUR PAY**

When there is a name/number mismatch, IRS alerts the payer and the payer attempts to correct the information. The payer sends you a Form W-9, Request for Taxpayer Identification Number and Certification, or similar form to verify your correct name and TIN. If you fail to respond or supply the correct information, the payer must withhold federal income tax at a rate of 28 percent (“backup withholding”) from your payments.

### **AVOID BACKUP WITHHOLDING**

A good way to check the name and TIN you are giving to payers is to look at your medical service invoice. Payers generally use the information on the invoice in their reports to IRS. Make sure you are not making any of these common mistakes:

- **D/B/A foibles** – You are a sole proprietor using your “doing business as” (d/b/a/) name with your SSN or the EIN of your sole proprietorship. A sole proprietorship must always put his/her name first, the d/b/a name be listed second.
- **Name Changes** – You change your business name and fail to notify the IRS. Since you are still using the old TIN, your new name will cause a mismatch with IRS records.
- **SSN Only for Humans** – You are a partnership, corporation, hospital or clinic and you are using an individual medical provider’s SSN. You should use the EIN of the partnership, corporation, hospital or clinic. Only use a SSN with an individual’s name. –OR–
- **You are an individual medical provider who should be using your SSN**, but, instead you are using the EIN of the partnership, corporation, hospital or clinic of which you are a member. You should always use your SSN in combination with your name.
- **EIN Mix-ups** – You are an operating unit of a larger business entity and you are using your name with the EIN of the business entity. For example, you are Meadowview Hospital, an operating unit of Healthcare, Inc. You are using your name with the EIN of Healthcare, Inc. This will cause a mismatch with IRS records. You should apply for your own EIN or use the name Healthcare, Inc. –OR–
- **You are identifying your business with initials instead of your complete name.** For example, you originally obtained your EIN under the business name Immediate Care Clinic, P.C., but lately you’ve been using the initials ICC with your EIN. This will cause a mismatch of your name and EIN with IRS records. You should use your complete name. –OR–
- **You are a medical specialist group practicing at a hospital and you are using the EIN of the hospital.** For example, you are Orthopedic Group of Metropolis practicing at Metropolis General Hospital. You are using your name, Orthopedic Group of Metropolis, with the EIN of the hospital. You should be using your own EIN, or hospital as payment name.
- **Check with your Collection Agency** – Your collection agency is using its own name and your TIN. The agency should use either its name with its TIN or your name with your TIN.

**HELP IS AVAILABLE.** If you think you are using an incorrect name and TIN combination, IRS can help. Call 800-829-1040.

**Instructions for Completing PHYSICIAN ASSISTANT  
Missouri Medicaid Provider Questionnaire and Title XIX Participation Agreement**

**Please type or print all forms in medium black ink.  
Do NOT use highlighters or markers on any forms.**

**Provider Questionnaire**

1. **Provider Name:** Enter the name of the applying provider. If enrolling an individual practitioner, enter the individual's name as their license reads. If enrolling as a clinic, hospital, optical company, DME company, pharmacy, etc., use the name licensed or Medicaid certification name (if applicable), or business/DBA name if not licensed or certified.
2. **Business Phone:** Enter business telephone for applying provider. This number will be used by participants, providers, Missouri Medicaid employees, etc.
3. **Provider Address:** If enrolling a facility or clinic, enter the street address of facility or clinic/group. If enrolling as an individual practice, enter the street address of the individual's office. If enrolling an individual with a facility or clinic, enter the street address of the facility or clinic practice. You must use a street address in this field either alone or with a post office box or route number; a post office box alone is not an acceptable address as correspondence may be sent by a commercial carrier such as UPS. If mail is returned to our office, the provider enrollment record will be made inactive. If you participate with Medicare, each physical location that is issued a Medicare number must also enroll for a separate Medicaid enrollment record.
- 4.- 7. **City, County, State, Zip Code:** Enter appropriate information for provider address.
8. **Social Security Number:** Individual applicants must enter their SSN. This information is kept confidential and is not used for IRS reporting.
9. **Date Of Birth:** Individual applicants must enter their date of birth. This information is kept confidential.
10. **License Number:** Enter the applicant's permanent state license number.
11. **Payee Name:** Enter the name as registered with the IRS. The "Payment (entity) Name" MUST be the EXACT name as registered with the IRS whether using a Social Security Number or Federal Employer Tax ID number in field 13. This information must be entered correctly even if you participate in direct deposit. The name completed in this field will appear on your paper check (if applicable), remittance advices, and 1099 tax form at the end of the year. Enter entity name and doing business as (DBA) name if different. Name/number mismatches will result in the incorrect issuance of 1099 tax forms to the provider. Corrected 1099 tax forms are NOT issued by the MO HealthNet Division.
12. **Payment, Remittance and 1099 Address:** Enter the address that a paper check remittance advices, and 1099 tax form should be sent to. Providers cannot have checks or remittances sent to a bank address. Remittances will not be mailed to an address other than what is on the Provider Enrollment record. Provider Enrollment must be notified in writing of remittance address changes even if you participate in direct deposit.
13. **Tax Identification Number:** Enter the tax identification number or Social Security Number assigned to the name listed in field 11. This may be a Social Security Number or a Federal Employer Tax Identification Number depending on how you report income to the IRS. Tax ID name/number mismatches will result in the issuance of incorrect 1099 tax forms to the provider. Corrected 1099 tax forms WILL NOT be issued by the MO HealthNet Division. See Tax Identification Number Information for additional information.

14. **Type Of Practice:** Select the type of practice or business.
15. **Specialties:** Choose all specialties the provider is licensed/certified to perform. This information is needed for correct payment of claims.
- 15A. **National Provider Identifier:** Enter the National Provider Identifier (NPI) number for the applicant. This is the HIPAA standard unique health identifier for health care providers.
- 15B. **Taxonomy Code:** Enter the applicant's 10-digit HIPAA taxonomy code.
16. **CLIA:** Enter **C**linical **L**aboratory **I**mprovement **A**mendments Act (CLIA) Identification number issued to the practice location of enrollment. CLIA numbers are obtained from CMS and documentation of this number is required to bill for laboratory services. **(must also attach a copy of CLIA Certificate).**
17. **Varicella/SAFE/VFC:** Indicate whether the applicant is certified by the Department of Health and Senior Services to provide one or more of these services. This information is needed for correct payment of claims.
18. **Optical and Audiology/Hearing Aid Services:** If the applicant is an optical or audiology/hearing aid applicant, enter the type(s) of services the applicant will be providing.
19. **Rx Authority Certification:** Indicate if you have controlled substance Rx authority certification that allows you to prescribe drugs.
20. **Rural Health Clinic:** If the applicant provides services in a rural health clinic (RHC), answer YES to this question. The applicant needs to enroll only if providing non-RHC services. All RHC services must be billed using the RHC provider NPI. RHC and Non-RHC services must be documented. See the Rural Health Clinic Program requirements for additional information.
21. **Medicare Provider Number:** Enter the Medicare number assigned to the applicant's physical location address listed on this application. This information allows Medicare claims to crossover automatically to MO HealthNet. A copy of the letter from Medicare showing the Medicare number issued, the applicant name, and physical location(s) approved by Medicare must be sent to MMAC with the enrollment packet. If unable to provide the initial letter received, the applicant must contact the Medicare carrier to request written documentation to submit.
22. **Case Management:** Answer YES to this question if the applicant will be providing case management services according to the case management section (13.56) of the Physician Manual. The Physician Manual may be found at <http://manuals.momed.com/manuals/>. Review the manual reference before answering this question to ensure the applicant is eligible for these services.
23. **Rural Health Rate:** If the applicant answered YES to question 20, enter the applicant's rural health rate. Submit a copy of the rate letter MMAC with the enrollment packet.

### **Title XIX Participation Agreement**

Read the agreement carefully. The Title XIX Participation Agreement **MUST BE SIGNED**. If an individual practitioner is enrolling, the individual must sign ALL forms in the packet whether they are in an individual practice or employed by a facility, clinic/group, or other entity. If these forms are being completed to enroll a facility or clinic/group, an authorized representative of the owner may sign. Indicate the title of the person signing and the date signed.

<b>STATE OFFICE USE ONLY</b>	PROVIDER IDENTIFIER:	EFFECTIVE DATE
	CLINIC/GROUP #	END DATE
	STATUS	KEYED INITIALS



DEPARTMENT OF SOCIAL SERVICES  
MISSOURI MEDICAID AUDIT AND COMPLIANCE  
MISSOURI MEDICAID PHYSICIAN ASSISTANT PROVIDER QUESTIONNAIRE

(PLEASE TYPE OR PRINT ALL FORMS IN BLACK INK)

1. PROVIDER NAME AS LICENSED		2. BUSINESS TELEPHONE NUMBER		
3. PROVIDER ADDRESS AS LICENSED (do not use PO Box only)		4. CITY	5. STATE	6. ZIP CODE
7. COUNTY		10. LICENSE NUMBER		
8. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH		10. LICENSE NUMBER	
11. PAYEE NAME REGISTERED WITH IRS (USED TO REPORT INCOME)		DOING BUSINESS AS (DBA) NAME (IF APPLICABLE)		
12. PAYEE ADDRESS		PAYEE CITY	PAYEE STATE	ZIP CODE
13. TAX ID NUMBER OR SOCIAL SECURITY NUMBER AS REGISTERED WITH IRS (USED TO REPORT INCOME)				
TAX ID: - -		SSN: - -		
14. TYPE OF PRACTICE				
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Charitable <input type="checkbox"/> City, Municipal, County, District, State Owned <input type="checkbox"/> Privately Owned				
15. SPECIALTIES		15A. NATIONAL PROVIDER IDENTIFIER		
NA				
15B. TAXONOMY CODE		16. CLIA NUMBER		
		NA		
CERTIFIED BY THE DEPARTMENT OF HEALTH AND SENIOR SERVICES FOR THE FOLLOWING				
<input type="checkbox"/> VARICELLA <input type="checkbox"/> SAFE <input type="checkbox"/> VFC				
17. OPTICAL AND AUDIOLOGY/HEARING AID SERVICES		18. DO YOU HAVE A CONTROLLED SUBSTANCE Rx AUTHORITY CERTIFICATION		
NA		<input type="checkbox"/> YES <input type="checkbox"/> NO		
19. ARE YOU PART OF A RURAL HEALTH CLINIC		20. MEDICARE PROVIDER NUMBER (PTAN)		
NA		NA		
21. DO YOU PROVIDE CASE MANAGEMENT SERVICES ACCORDING TO 13.56 OF THE PHYSICIAN MANUAL		22. INDICATE YOUR RURAL HEALTH RATE AND SUBMIT A COPY OF YOUR RATE LETTER		
NA		NA		

**COMPLETE AND RETURN ALL FORMS TO**  
Missouri Medicaid Audit and Compliance – Provider Enrollment Unit  
Database Fax: 573/634-3105 (preferred method)

Mailing Address: PO Box 6500, Jefferson City, MO 65102-6500  
Physical Address: 205 Jefferson Street, 2<sup>nd</sup> Floor, Jefferson City, MO 65101  
Alternate Fax: 573/751-5065  
E-mail address: [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov)



**DEPARTMENT OF SOCIAL SERVICES  
MISSOURI MEDICAID AUDIT AND COMPLIANCE  
TITLE XIX PARTICIPATION AGREEMENT FOR PHYSICIAN ASSISTANT**

BY MY SIGNATURE BELOW, I, THE APPLYING PROVIDER, READ AND AGREE THAT, upon the acceptance of my enrollment, I will participate in the Vendor Payment plan for Physician Services. I am responsible for all services provided and all billing done under my provider number regardless to whom the reimbursement is paid. It is my legal responsibility to ensure that the proper billing code is used and indicate the length of time I actually spend providing a service regardless to whom the reimbursement is paid. I agree to be financially responsible for all services which are not documented. I agree the Missouri Title XIX Medicaid manual, bulletins, rules, regulations and amendments thereto shall govern and control my delivery of service, and further agree to the following terms.

1. I (the provider) agree that it is my responsibility to access manual materials that are available from the MO HealthNet Division (MHD) over the internet. I will comply with the Medicaid manual, bulletins, rules and regulations as required by the MHD and the United States Department of Health and Human Services in the delivery of services and merchandise and in submitting claims for payment. I understand that in my field of participation, I am not entitled to Medicaid reimbursement if I fail to so comply and that I can be terminated from the program for failure to comply.
2. The rate of reimbursement for services will be based on charges established and determined by the MHD Medicaid manual, bulletins and amendments thereto in accordance with the Vendor Payment Program and that charges will not exceed those to the general public for the same services.
3. Signing this agreement will allow the provider to use either a paper or electronic claim processing method. Providers who choose to use electronic claim processing must have their electronic claim processing program tested by the fiscal agent before electronic processing can be approved.  
The provider agrees that the selection of an electronic claim processing method in no way modifies any requirements of the Missouri Medicaid program policies or procedures except those dealing with claim submission. All data elements required by DSS for paper claims are required for claims submitted electronically. Those claims not meeting required specifications will not be processed.  
In the event that the provider is placed on prepayment review by DSS, as authorized by State Regulation 13 CSR 70-3.030, the provider agrees to submit all claims on paper until notified by DSS that electronic billing can resume.
4. No collection for Title XIX covered services will be made from the recipient/patient, his or her spouse, parent, guardian, relative or anyone else receiving public assistance, and, if any payment is received or assured from any other source on the recipient/patient's account, that amount will be deducted from the claim filed with Title XIX Medicaid. Any payment so received after provider payment is made by Title XIX shall be reported to MHD for appropriate adjustment action.
5. All parties agree to comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable federal and state laws which prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.
6. All providers are required to maintain fiscal and medical records to fully disclose services rendered to Title XIX Medicaid recipients. These records shall be retained for five (5) years and shall be made available on request by an authorized representative of the Department of Social Services or the U.S. Department of Health and Human Services. Documents retained must include all records and documents required by applicable regulation and Medicaid manual and bulletin provisions. All services billed through the Medicaid program are subject to post-payment review. This may include unannounced on-site review of records. Failure to submit or failure to retain documentation for all services billed to the Medicaid program may result in recovery of payments for Medicaid services and may result in sanctions to the provider's Medicaid participation.
7. Medicaid participation under this agreement may be terminated by either party upon written notice mailed to either the provider's most recent address recorded in the Medicaid enrollment files or MHD. The written notice shall state the reason(s) for the termination. Such reason(s) could include the provider being in violation of (a) this agreement, (b) Medicaid claim certification statement, (c) rules, regulations, policies or procedures of MHD, or (d) state or local regulations or laws which also apply, i.e., fire codes and health codes. All corporations must be registered with the Secretary of State, Corporate Division, and be certified in good standing. The provider must be in compliance with all other applicable state or federal laws or regulations. Violation of any law or regulation may result in this agreement being terminated immediately upon mailing of the written notice from MHD.
8. If at any time state or federally appropriated funds available to MHD for payment to the provider for covered services under this agreement are insufficient to pay the full amount due, the provider agrees to accept payments reduced in proportion to the funding deficiency.

SIGNATURE OF PHYSICIAN ASSISTANT

DATE SIGNED

TYPE OR PRINT NAME OF PHYSICIAN ASSISTANT



DEPARTMENT OF SOCIAL SERVICES  
MISSOURI MEDICAID AUDIT AND COMPLIANCE  
MISSOURI MEDICAID ENROLLMENT APPLICATION

THIS FORM IS MANDATORY FOR ALL PROVIDERS. Read and answer all questions carefully. Failure to provide this information is grounds for denial of the application and/or termination of provider participation. A SEPARATE form MUST be completed for each provider type. Attach an additional sheet to provide complete information for any question. Enrollment inquiries may be directed to the Provider Enrollment Unit via e-mail at [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov).

Applicant's Full Name

Contact Person's Name (Indicate person to contact if there are questions regarding this enrollment application.)

Contact Person's Phone Number

( ) -

Ext.

Contact Person's E-mail Address

1. Is this application being made as a result of one or more of the following changes?  Yes  No

If yes, check all that apply and complete required section below:

Ownership  Merger  Asset  New Clinic/Group Formed at Same Location

Corporate Structure  Replacement Facility

Other (explain):

FORMER OWNER'S NAME(S) AND PROVIDER IDENTIFIER(S), AND CLINIC/FACILITY NAME(S):

NEW OWNER'S NAME AND ADDRESS, CLINIC/FACILITY NAME(S)

Effective Date of Change: / /

A new Missouri Medicaid provider record is not created for changes, the preceding record is updated. Receiving new identifiers from other agencies/sources does not constitute creating a new provider record. Payments go to the provider currently indicated on the Provider Enrollment Master File at the time the claim is processed. The provider is responsible for resubmitting any denials and/or crossover claims for any Medicare/Missouri Medicaid services that do not crossover electronically, before and after the change is made to the Provider Enrollment Master File. If a new provider record is created in error due to provider information being withheld at the time of application, the new record will be made inactive, the preceding record will be updated, and the provider may be subject to sanctions.

2. For services provided under this application, in which setting(s) will you see participants?

Office  Hospital  Nursing Home  School  Participant's Home

Other (explain):

3 THRU 15: IF AN ANSWER IS YES TO ANY OF THESE QUESTIONS, A COMPLETE EXPLANATION, DATE, STATE, CITY AND COUNTY MUST BE COMPLETED. INCLUDE ATTACHMENTS, IF NECESSARY.

3. Has the applying provider ever been personally terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare, Medicaid, MO HealthNet, or ANY federal programs in ANY state? Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.  Yes  No

4. Has the applying provider ever had an ownership, indirect ownership, controlling interest, or been administrator of a facility or agency that has been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare, Medicaid, MO HealthNet or ANY federal programs in ANY state? Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.  Yes  No

5. Has the applying provider's license ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by ANY licensing authority in ANY state?  Yes  No

6. Is there any proceeding currently pending to revoke, suspend, censure or restrict by probation or agreement, the applying provider's license in Missouri OR in ANY state?  Yes  No

<p>7. Does a person having direct or indirect ownership or a controlling interest have any outstanding criminal fines, restitution orders or overpayments pertaining to health care in Missouri or ANY other state? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>														
<p>8. Has the applying provider ever been convicted of a crime (excluding minor traffic violations)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list conviction(s), the date and where:</p>														
<p>9. Are there any criminal proceedings currently pending for the applying provider or anyone having direct or indirect ownership, controlling interest or any individual involved with the applying provider's practice, clinic, group, corporation or any other association? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list pending charge(s), the date and where:</p>														
<p>10. Is the applying provider related, including, but not limited to, spouse, parent, child, sibling, etc., to any owner, officer, agent, managing employee, director or shareholder that has been convicted of a crime pertaining to health care services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list conviction(s), the date and where:</p>														
<p>11. Does the applying provider now hold a certificate to dispense controlled substances from the Federal Drug Enforcement Agency (DEA), the Missouri Department of Health and Senior Services, Bureau of Narcotics and Dangerous Drugs (BNDD), or any other state? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all states, enter the numbers requested, AND QUESTION 12 MUST BE COMPLETED.</p> <p>DEA # _____ BNDD # _____ DEA # _____ BNDD # _____</p>														
<p>12. Have any of the DEA or BNDD certificates ever been suspended, revoked, surrendered, or in any way restricted by probation or agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain, give date, state, city, county and include attachments.</p>														
<p>13. Does the applying provider have any pending enrollment applications with any state or federal program, other than this application? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the state and program:</p>														
<p>14. Does the applying provider have any pending complaint investigations being reviewed by any professional boards? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:</p>														
<p>15. Does the applying provider or anyone having ownership, controlling interest, or any individual involved with the applying provider's practice, clinic, group, corporation or any other association, have any outstanding overpayments? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the state and program:</p>														
<p>16. Has the applying provider rendered services to a MO HealthNet participant in reference to this location? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the information below and submit a copy of the license or required documentation covering these dates of service IN ADDITION to your current license or required documentation.</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Participant's Full Name</th> <th style="width:15%;">Participant ID #</th> <th style="width:20%;">Participant SSN</th> <th style="width:32%;">Date of Service</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td style="text-align:center;">/ /</td> <td style="text-align:center;">/ /</td> </tr> <tr> <td></td> <td></td> <td style="text-align:center;">/ /</td> <td style="text-align:center;">/ /</td> </tr> </tbody> </table>			Participant's Full Name	Participant ID #	Participant SSN	Date of Service			/ /	/ /			/ /	/ /
Participant's Full Name	Participant ID #	Participant SSN	Date of Service											
		/ /	/ /											
		/ /	/ /											
<p>To the best of my knowledge, the information supplied on this application is accurate, complete and is hereby released to the Missouri Medicaid Audit and Compliance Unit.</p>														
<p>Signature of Applicant</p> <p>➔</p>														
Type or Print Name of Person Signing	Title of Person Signing	Date Signed												
		/ /												

Missouri Department of Social Services

# MISSOURI MEDICAID AUDIT AND COMPLIANCE



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# OWNERSHIP APPLICATION

## PROVIDER ENROLLMENT

Visit us at: [www.mmac.mo.gov](http://www.mmac.mo.gov)

Email: [MMAC.ProviderEnrollment@dss.mo.gov](mailto:MMAC.ProviderEnrollment@dss.mo.gov)

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## OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION

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### INSTRUCTIONS AND EXAMPLES

This application is to be completed with information about any individual or organization that has direct or indirect ownership of, a partnership interest in, and/or managing control of the provider. If there is more than one individual or organization, copy and complete this section for each. Note that the provider must have at least one managing employee.

If adding, deleting, or changing information on an existing owner, partner, or managing organization, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement.

### OWNERSHIP

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

The following ownership interests (individual and organizational) must be reported:

- 5% or greater ownership in a disclosing entity
- 5% or greater direct ownership interest
- 5% or greater indirect ownership interest
- Combination of direct and indirect ownership interest equaling 5% or greater
- 5% or greater mortgage or security interest (includes deed of trust, note, or obligation secured by entity)
- All general partnership interests, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.
- Limited partnership interest if the individual's interest in the partnership is at least 10%.
- Officers and Directors, if the entity is organized as a corporation.

#### **1. Ownership**

Organizational type/structure and ownership

#### **2. Individual ownership interest information**

All managing employees of the provider must be reported. The term "*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 operations of the provider, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the provider.

#### **3. Organizational ownership interest information**

Organizational disclosures are mandated by Federal and State Regulation. The disclosures shall include the name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. (§455.104 -455.106 CFR).

#### **4. Ownership/Managing Control Information**

##### **A. Direct Ownership Interest**

Examples of direct ownership are as follows:

- The provider is a skilled nursing facility that is wholly (100%) owned by Company A. As such, the provider would have to report Company A in this section.

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## OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION

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- A hospice wants to enroll in Medicare. Company X owns 50% of the hospice. Company X would have to be reported in this section.

In the first example, Company A is considered a direct owner of the skilled nursing facility, in that it actually owns the assets of the business. Similarly, Company X is a direct owner of the hospice mentioned in the second example. It has 50% actual ownership of the hospice.

### B. Indirect Ownership Interest

Many organizations that directly own a provider are themselves wholly or partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered to be “indirect” owners of the provider. Using the first example in #1 above, if Company B owned 100% of Company A, Company B is considered to be an indirect owner of the provider. In other words, a direct owner has an actual ownership interest in the provider (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an organization that owns the provider.

Consider the following example of indirect ownership:

#### EXAMPLE 1: OWNERSHIP

<b>LEVEL 3</b>	<b>Individual X</b>	<b>Individual Y</b>
	<b>5%</b>	<b>30%</b>
<b>LEVEL 2</b>	<b>Company C</b>	<b>Company B</b>
	<b>60%</b>	<b>40%</b>
<b>LEVEL 1</b>	<b>Company A</b>	
	<b>100%</b>	

- Company A owns 100% of the Enrolling Provider
- Company B owns 40% of Company A
- Company C owns 60% of Company A
- Individual X owns 5% of Company C
- Individual Y owns 30% of Company B

In this example, Company A (Level 1) is the direct owner of the provider identified in this application. Companies B and C, as well as Individuals X and Y, are indirect owners of the provider. To calculate ownership shares using the above-cited example, utilize the following steps:

#### **LEVEL 1**

The diagram above indicates that Company A owns 100% of the Enrolling Provider. Company A must be reported.

#### **LEVEL 2**

To calculate the percentage of ownership held by Company C of the Enrolling Provider, multiply:

- The percentage of ownership the LEVEL 1 owner has in the Enrolling Provider **MULTIPLIED BY** The percentage of ownership the LEVEL 2 owner has in that LEVEL 1 owner
- Company A, the LEVEL 1 (or direct) owner, owns 100% of the provider. The diagram also indicates that Company C, a LEVEL 2 owner, owns 60% of Company A. As such, multiply 100% (or 1.0) by 60% (.60). The result is .60. Therefore, Company C indirectly owns 60% of the provider, and must be reported.
- Repeat the same procedure for Company B, the other LEVEL 2 owner. Because Company B owns 40% of Company A, multiply this figure by 100% (again, the ownership stake Company A has in the Enrolling

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## OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION

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Provider). Company B thus owns 40% of the Enrolling Provider, and must be reported.

- This process is continued until all LEVEL 2 owners have been accounted for.

### LEVEL 3

To calculate the percentage of ownership that Individual X has in the Enrolling Provider, multiply:

- The percentage of ownership the LEVEL 2 owner has in the Enrolling Provider

#### **MULTIPLIED BY**

The percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner

- Company C owns 60% of the provider. According to the example above, Individual X (Level 3) owns 5% of Company C. Therefore, multiply 60% (.60) by 5% (.05), resulting in .03. This means that Individual X owns 3% of the provider and does not need to be reported in this application.
- Repeat this process for Company B, which owns 40% of the provider. The diagram states that Individual Y (Level 3) owns 30% of Company B. We thus multiply 40% (.40) by 30% (.30). The result is .12, or 12%. Because Individual Y owns 12% of the provider, Individual Y must be reported in this application (Individuals).

This process is continued until all owners in LEVEL 3 have been accounted for. This process must be repeated for Levels 4 and beyond.

### C. Mortgage Interest

All entities with at least a 5% mortgage, deed of trust, or other security interest in the provider must be reported in this section. To calculate whether this interest meets the 5% threshold, use the following formula:

- Dollar amount of the mortgage, deed of trust, or other obligation secured by the provider or any of the property or assets of the provider

#### **DIVIDED BY**

Dollar amount of the total property and assets of the provider

Example: Two years ago, a provider obtained a \$20 million loan from Entity X to add a third floor to its facility. Various assets of the provider secure the mortgage. The total value of the provider's property and assets is \$100 million.

Using the formula described above, divide \$20 million (the dollar amount of the secured mortgage) by \$100 million (the total property and assets of the Enrolling Provider). This results in .20, or 20%. Because Entity X's interest represents at least 5% of the total property and assets of the Enrolling Provider, Entity X must be reported in this section.

### D. Security Interest

See Mortgage Interest

### E. Partnerships

All general partnership interests—regardless of the percentage—must be reported. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.

### F. Limited Partnerships

All general partnership interests—regardless of the percentage—must be reported. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.

For limited partnerships, all limited partners must be reported if their interest in the partnership is at least 10%. To illustrate, assume a provider is a limited partnership. The general partner has a 60% interest in the entity, while the 4

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## OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION

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limited partners each own 10%. The general partnership must be reported in this application. Likewise, the 4 limited partners must be reported, as they each own at least 10% of the limited partnership.

### G. Additional Information on Ownership

All entities that meet any the requirements above must be reported in this section, including, but not limited to:

- Entities with an investment interest in the provider (e.g., investment firms)
- Banks and financial institutions (e.g., mortgage interests)
- Holding companies
- Trusts and trustees
- Governmental/Tribal Organizations: If a Federal, State, county, city or other level of government, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government must be reported as an owner. The provider must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare.
- Charitable and Religious Organizations: Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be reported in this section.

In addition to furnishing the information in this section, the provider must submit:

- An organizational diagram identifying all of the entities listed in this section and their relationships with the provider and with each other.
- If the provider is a skilled nursing facility, a diagram identifying the organizational structures of all of its owners, including owners that were not required to be listed in this section or individual section.

### H. Operational/Managerial Control

Any organization that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider, is a managing organization and must be reported. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. For instance, it could be a management services organization under contract with the provider to furnish management services for the business.

### 5. Adverse Legal History

This section is to be completed with any adverse legal history information about any ownership organization, partnership and/or organization with managing control of the provider identified in this application.

IF YOU ARE COMPLETEING AN **ONLINE APPLICATION FAX THE COMPLETED FORM** WITH YOUR ADDITIONAL APPLICATION FORMS.

OTHERWISE PLEASE MAIL FORM TO:

MISSOURI MEDICAID AUDIT & COMPLIANCE UNIT  
P.O. BOX 6500  
JEFFERSON CITY, MO 65102

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## OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION

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### **OWNERSHIP APPLICATION** (use for new, reactivation, update, or change)

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete **all** the appropriate following section(s).

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NEW	UPDATE	CHANGE OF OWNERSHIP (CHOW)
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EFFECTIVE DATE:

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### **1. OWNERSHIP**

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<b>How would you describe the ownership? *</b>	Self (Individual filing under a SSN)	Single-Owner, LLC
Sole -Proprietor (Individual filing under an EIN)	Partnership	Corporation
Bank or Other Financial Institution	Consulting Firm	Investment Firm
Limited Liability Company	For-Profit	Non-Profit
Holding Company	Management Services Company	Medical Provider/Supplier
Medical Staffing Company	Other (please specify): _____	

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#### **Corporations, Partnerships, and Sole Proprietors:**

Does anyone have direct or indirect ownership or control interest of 5% or more in the organization/entity?	Yes	No
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If you answered yes to the above question you must list ownership information for each owner who owns 5% or more.

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### **2. INDIVIDUAL INFORMATION**

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#### **Ownership 1**

Last Name	First Name	Middle Initial	Suffix
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Social Security Number ( <i>required</i> )	Date of Birth	Place of Birth (State)	Country of Birth
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Address Line 1 (Street Name and Number)

Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code + 4	Ownership %
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Contact Person:	Contact E-mail:
-----------------	-----------------

Phone:	Business Phone:	Fax Number:
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## OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION

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Business Relationship to Enrolling Provider (Title)      Familial Relationship to Enrolling Provider (i.e. Mother, Father, Sister, Brother, etc)\*

National Provider Identifier -NPI (required *-if issued*)

Tax Identification Number (required)

Medicare I.D. Number(s) (*if issued*)

Provider Number (if applicable)

State Issued

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### 3. ORGANIZATIONAL INFORMATION

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Legal Business Name as Reported to the Internal Revenue Service

“Doing Business As” Name (if applicable)

Address Line 1 (Street Name and Number)

Address Line 2 (Suite, Room, etc.)

City/Town

State

ZIP Code + 4

Ownership %

Contact Person:

Contact E-mail:

Business Phone:

Fax Number:

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National Provider Identifier -NPI (required *-if issued*)

Tax Identification Number (required)

Medicare I.D. Number(s) (*if issued*)

Provider Number (if applicable)

State Issued

CLIA Number (*if issued*)

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## OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION

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### 4. OWNERSHIP/MANAGING CONTROL INFORMATION

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Identify the type of ownership and/or managing control the individual or organization identified in the above sections has in the provider identified in the provider enrollment application. Check all that apply. Complete all information for each type of ownership and/or managing control applicable.

---

#### A. DIRECT OWNERSHIP INTEREST

---

5% or greater direct ownership interest

---

Effective date of 5% or greater direct ownership interest (mm/dd/yyyy)

---

Exact percentage of direct ownership this organization has in the provider

---

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

YES      NO

---

If this organization also provides contracted services to the provider, describe the types of services furnished (e.g., managerial, billing, consultative, medical personnel staffing).

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#### B. INDIRECT OWNERSHIP INTEREST

---

5% or greater indirect ownership interest

---

Effective date of 5% or greater indirect ownership interest (mm/dd/yyyy)

---

Exact percentage of indirect ownership this organization has in the provider

---

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

YES      NO

---

If this organization also provides contracted services to the provider, describe the types of services furnished (e.g., managerial, billing, consultative, medical personnel staffing).

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#### C. MORTGAGE INTEREST

---

5% or greater MORTGAGE interest

---

Effective date of 5% or greater mortgage ownership interest (mm/dd/yyyy)

---

Exact percentage of mortgage interest this organization has in the provider

---

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

YES      NO

---

If this organization also provides contracted services to the provider, describe the types of services furnished (e.g., managerial, billing, consultative, medical personnel staffing).

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## OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION

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### D. SECURITY INTEREST

---

5% or greater SECURITY interest

---

Effective date of 5% or greater security interest (mm/dd/yyyy)

---

Exact percentage of security interest this organization has in the provider

---

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

YES      NO

---

If this organization also provides contracted services to the provider, describe the types of services furnished (e.g., managerial, billing, consultative, medical personnel staffing).

---

### E. GENERAL PARTNERSHIP INTEREST

---

5% or greater GENERAL PARTNERSHIP interest

---

Effective date of general partnership interest (mm/dd/yyyy)

---

Exact percentage of general partnership interest this organization has in the provider

---

Was this general partnership solely created to acquire/buy the provider and/or the provider's assets?

YES      NO

---

If this general partnership also provides contracted services to the provider, describe the types of services furnished (e.g., managerial, billing, consultative, medical personnel staffing).

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### F. LIMITED PARTNERSHIP INTEREST

---

5% or greater LIMITED PARTNERSHIP interest

---

Effective date of limited partnership interest (mm/dd/yyyy)

---

Exact percentage of limited partnership interest this organization has in the provider

---

Was this limited partnership solely created to acquire/buy the provider and/or the provider's assets?

YES      NO

---

If this limited partnership also provides contracted services to the provider, describe the types of services furnished (e.g., managerial, billing, consultative, medical personnel staffing).

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### G. OPERATIONAL/MANAGERIAL CONTROL

---

5% or greater OPERATIONAL/MANAGERIAL CONTROL

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Effective date of the operational/managerial control (mm/dd/yyyy)

---

Exact percentage of operational/managerial control this organization has in the provider

---

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

YES      NO

---

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## OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION

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If this limited partnership also provides contracted services to the provider, describe the types of services furnished (e.g., managerial, billing, consultative, medical personnel staffing).

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### H. OTHER OWNERSHIP OR CONTROL/INTEREST (please specify)

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5% or greater OTHER OWNESHIP OR CONTROL/INTEREST

Effective date of other ownership or control/interest control (mm/dd/yyyy)

Exact percentage of ownership or control/interest control this organization has in the provider

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

YES      NO

If this organization also provides contracted services to the provider, describe the types of services furnished (e.g., managerial, billing, consultative, medical personnel staffing).

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### 5. FINAL ADVERSE LEGAL ACTION HISTORY

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If reporting a change to existing information, check "**Change**," provide the effective date of the change, and complete the appropriate fields in this section.

Change      Effective Date:

Has the organization reported in above, under any current or former name or business identity, ever had a final adverse legal action imposed against it?

YES (continue below)      NO

If **YES**, report each final adverse legal action, when it occurred, the Federal or State Agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

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In Affirmation thereof, the facts stated above are true and correct: (The undersigned understands that false statements made in this filing are subject to the penalties provided under Section 575.040, RSMo)

\_\_\_\_\_  
*Authorized signature*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Date*