State of Missouri

Department of Social Services

Missouri Medicaid Audit & Compliance

ENROLLMENT APPLICATION - ORGANIZATION

LIMITED ENROLLMENT FOR MANAGED CARE NETWORK PROVIDER (ORGANIZATION)

To comply with the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) and 42 CFR § 438.602(b), each State Medicaid Agency (SMA) must screen and enroll all network providers of contracted MCOs. If you execute a network provider agreement with one or more of the contracted MCOs in Missouri, you must submit this enrollment application to the Missouri Medicaid Audit & Compliance (MMAC) Provider Enrollment Unit within 120 days of the effective date of your MCO contract. You only need to submit one application to MMAC, regardless of how many MCOs you hold a contract with. If you do not complete the application process with MMAC, the MCO(s) is required to terminate your network agreement.

Organizational providers completing this application will not submit claims to MO HealthNet, nor will they be required to provide any services to Medicaid Fee for Service participants.

If you are already enrolled with MO HealthNet as a billing or performing provider, you do not need to complete this application.

Please type or print legibly using BLACK OR BLUE INK ONLY, and retain a copy of this entire document for your records.

Fax or email this application to: MMAC Provider Enrollment
205 Jefferson Street, 2nd Floor
P.O. Box 6500
Jefferson City, MO 65102
Fax: 573-634-3105
Email: mmac.providerenrollment@dss.mo.gov

Provider Enrollment Application Instructions for MCO Network Provider (Organization)

This application is to be used by organizational providers and only if you are enrolling for the sole purpose of meeting the federally mandated requirements of the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) and 42 CFR § 438.602(b). All questions must be completed. Attach additional sheets if necessary to answer each question completely and each additional sheet must display the relevant question number from the application.

If your organization is already enrolled with MO HealthNet and you only need to update information, please complete and submit a Provider Update Form. If you want to terminate your MO HealthNet enrollment, please complete a Provider Update Form.

Requirements:

42 CFR § 438.602(b) states: **(1) The State must screen and enroll, and periodically revalidate, all network providers of MCOs**, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E of this chapter. This requirement extends to PCCMs and PCCM entities to the extent the primary care case manager is not otherwise enrolled with the State to provide services to Fee-For-Services (FFS) beneficiaries. This provision does not require the network provider to render services to FFS beneficiaries. **(2) MCOs**, PIHPs, and PAHPs **may execute network provider agreements pending the outcome of the process in paragraph (b)(1) of this section up to 120 days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider**, and notify affected enrollees.

This requirement will apply to Ordering, Prescribing, and Referring (OPR) providers in a managed care setting as well.

- **If you are already enrolled with MO HealthNet , you do not need to complete this application.**
- This application is solely for MCO Network providers not participating with the MO HealthNet Fee for Service program. If at any time you would like to become a fully participating MO HealthNet provider, you must submit a new enrollment application form for your specific provider type.
- You must have a ten digit National Provider Identifier (NPI). The NPI is the standard, unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES).
    - The NPI must be for an organization (not an individual physician or non-physician practitioner NPI).
    - Applying for the NPI is a separate process from MO HealthNet enrollment.
    - To obtain an NPI, apply online at https://nppes.cms.hhs.gov.
    - For more information about NPI enumeration, visit www.cms.gov/NationalProvIdentStand.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE

MO HEALTHNET PROVIDER ENROLLMENT APPLICATION – ORGANIZATION LIMITED ENROLLMENT FOR MANAGED CARE NETWORK PROVIDER

THIS FORM IS MANDATORY FOR ALL PROVIDERS; READ AND ANSWER ALL QUESTIONS CAREFULLY.

Failure to provide this information is grounds for denial of this application and/or termination of provider participation. A SEPARATE form MUST be completed for each provider identifier. EACH form MUST contain an ORIGINAL SIGNATURE. Answer all questions. Attach an additional sheet to provide complete information for any question. Enrollment inquiries may be directed to Provider Enrollment via e-mail at MMAC.ProviderEnrollment@dss.mo.gov

Provider Agency Legal Name, as registered with the IRS and MO Secretary of State	
Provider Agency Doing Business As (DBA) Name, as registered with MO Secretary of State - (If applicable)	
Provider Agency Full Physical Address	**County**
Provider Agency Full Mailing Address	**County**

National Provider Identifier (NPI) Number	**Business E-mail Address**
Federal Employer Identification Number (EIN) from IRS	**Business Telephone Number**
Medicare Number (If applicable)	**Business Fax Number**
License Number and Issuing State (If applicable)	**Contact Person's Name**
DEA Number (If applicable)	**CLIA Number (If applicable)**

National Council for Prescription Drug Programs (NCPDP) Identification Number (If applicable)

Type of Practice:

Partnership ☐ **Corporation (INC, LLC)** ☐ **Charitable** ☐ **Privately Owned** ☐
City, Municipal, County, District, or State Owned ☐

All applying providers must submit the attached **Business Organizational Structure (BOS)** form to comply with federal and state Medicaid regulations requiring disclosure of all individuals and/or business organizations that have direct or indirect ownership, management and/or control interests.

In addition to submitting the Business Organizational Structure (BOS) form, providers may utilize separate documents (i.e. organizational chart, spreadsheet, etc.) to identify individuals and businesses with ownership or control interests and all "managing employees" as defined in 13 CSR 65-2.010(21). Those documents must contain the full name (First, middle, last and suffix Jr., Sr., etc.), date of birth, and social security number of each individual who has 5% or greater direct/indirect ownership, controlling interest, partnership interest; any contractor or subcontractor; managing employees; officers or directors; or the legal business name and federal EIN of any organization(s) having direct or indirect ownership or controlling interest. A current copy of the provider's Ownership & Disclosure documents submitted to a Managed Care Organization (MCO) or the portion of a Medicare CMS-855 that includes the required information may be submitted, if one has been completed.

Indicate Your Provider Type:

- ___ Adult Day Health Care 29
- ___ Aged & Disabled Waiver 28
- ___ Alcohol and Drug Rehabilitation 86
- ___ Ambulance 80
- ___ Audiologist 33
- ___ Birthing Centers 61
- ___ Care Coordinator 44
- ___ Case Management 18
- ___ Chiropractor 95
- ___ Community Mental Health Dept Ctr 56
- ___ Comprehensive Rehab 76
- ___ CRNA/AA Services 91
- ___ Dental Hygienist 74
- ___ Dentist 40
- ___ Disease Mgmt (Diabetes care) 35
- ___ DME Supplier 62
- ___ Full Service PHP 92
- ___ General Hospital 01
- ___ Hearing Aid Specialist 34
- ___ Home Health Agency 58
- ___ Hospice 82
- ___ Indep or Portable X-ray/IDTF 71
- ___ Independent Clinic - Includes FQHC
- ___ Independent Laboratory 70
- ___ Psych Hospital 02
- ___ NEMT 65
- ___ Nurse Midwife 25
- ___ Nurse Practitioner (Advanced) 42
- ___ Nursing Home 10
- ___ Nutrition Consultant 43
- ___ Occupational Therapist 47
- ___ Optician 32
- ___ Optometrist 31
- ___ Personal Care 26
- ___ Pharmacy 60
- ___ Physical Therapist 48
- ___ Physician, DO 24
- ___ Physician, MD 20
- ___ Podiatrist 30
- ___ Podiatry Clinic 36
- ___ Private Duty Nurse 94
- ___ Private Home - ICF/MR Home 11
- ___ Professional Clinic – Optometry 53
- ___ Psychiatric Rehabilitation 87
- ___ Psychologist 49
- ___ Public Health Dept Clinic 51
- ___ Rehabilitation Center 57
- ___ Rural Health Clinic (RHC) 59
- ___ School Services 96
- ___ Speech Therapist 46
- ___ Other Specialties not listed:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Indicate Your Specialty:

Physician Specialties: If you are a physician, designate your specialties. Check all that apply. A physician must meet all federal and state requirements for specialties checked.

__ Addiction Medicine
__ Allergy/Immunology
__ Anesthesiology
__ Cardiac electrophysiology
__ Cardiac surgery
__ Cardiovascular disease (Cardiology)
__ Colorectal surgery (Proctology)
__ Critical Care (Intensivists)
__ Dermatology
__ Diagnostic Radiology
__ Emergency Medicine
__ Endocrinology
__ Family practice
__ Gastroenterology
__ General practice
__ General surgery
__ Geriatric medicine
__ Geriatric psychiatry
__ Gynecological oncology
__ Hand surgery
__ Hematology
__ Hematology/Oncology
__ Hospice
__ Infectious disease
__ Internal medicine
__ Interventional pain management
__ Interventional radiology
__ Medical oncology
__ Nephrology
__ Neurology
__ Neuropsychiatry
__ Neurosurgery
__ Nuclear Medicine
__ Obstetrics/Gynecology
__ Ophthalmology
__ Optometry
__ Oral Surgery (Dentist Only)
__ Orthopedic surgery
__ Osteopathic manipulative medicine
__ Otolaryngology
__ Pain Management
__ Palliative care peripheral vascular disease
__ Physical medicine and rehabilitation
__ Plastic and reconstructive surgery
__ Podiatry
__ Preventative medicine
__ Psychiatry
__ Pulmonary disease
__ Radiation oncology
__ Rheumatology
__ Sports Medicine
__ Surgical oncology
__ Thoracic surgery
__ Urology
__ Vascular surgery
__ Unlisted physician type
Specify: _____

Non-Physician Specialties: If you are a non-physician practitioner, check the appropriate box to indicate your specialty. Check only one. All non-physician practitioners must meet specific licensing, educational, and work experience requirements.

__ Certified Nurse Midwife
__ Certified Registered Nurse Anesthetist
__ Nurse Practitioner
__ Clinical Psychologist
__ Clinical Social Worker
__ Dentist
__ Physician Assistant
__ Unlisted non-physician practitioner type
Specify: _____

NUMBERS 1 THROUGH 13 – IF YOU ARE AN AUTHORIZED REPRESENTATIVE COMPLETING THIS APPLICATION FOR A HEALTH CARE ORGANIZATION, YOU SHOULD ANSWER EACH QUESTION ON BEHALF OF ALL INDIVIDUALS WHO HAVE BEEN IDENTIFIED AS HAVING AN OWNERSHIP OR CONTROLLING INTEREST, AND THOSE IDENTIFIED AS MANAGING EMPLOYEES. IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, AN EXPLANATION, DATE, STATE, CITY AND COUNTY, MUST BE COMPLETED. INCLUDE ADDITIONAL SHEETS AND/OR ATTACHMENTS IF NECESSARY.

1. Has the applying provider, any managing employee, or any person having an ownership or control interest; ever been personally terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare, Medicaid, MO HealthNet, or ANY state or federal programs in ANY state? Yes ☐ No ☐
Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

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

3. Has the license of the applying provider, any managing employee, or any person having an ownership or control interest; ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by ANY licensing authority in ANY state? Yes ☐ No ☐

4. Is there any proceeding currently pending to revoke, suspend, censure or restrict by probation or agreement, the license of the applying provider, any managing employee, or any person having an ownership or control interest; in Missouri or in ANY state? Yes ☐ No ☐

5. Does the applying provider, any managing employee, or any person having an ownership or control interest; have any outstanding criminal fines, restitution orders, or overpayments pertaining to health care in Missouri or ANY other state? Yes ☐ No ☐

6. Has the applying provider, any managing employee, or any person having an ownership or control interest; ever been convicted of a crime, excluding minor traffic citations? Yes ☐ No ☐
If yes, list conviction(s), when, and where:

7. Are there any criminal proceedings currently pending for the applying provider, any managing employee, or any person having an ownership or control interest; or any individual involved with the applying provider's practice, clinic, group, corporation or any other association? Yes ☐ No ☐
If yes, list pending changes and location:

8. Is the applying provider, any managing employee, or any person having an ownership or control interest; related, including but not limited to, a 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?
Yes ☐ No ☐
If yes, list conviction, date and location:

9. Does the applying provider now hold a certificate to dispense controlled substances from the federal Drug Enforcement Agency (DEA), the Missouri Bureau of Narcotics and Dangerous Drugs (BNDD), or any other state?
Yes ☐ No ☐ If yes, list all states, certificate numbers, AND #12 MUST BE COMPLETED.

DEA Number: BNDD Number:
DEA Number: BNDD Number:

10. Has the DEA or BNDD certificate ever been suspended, revoked, surrendered, or in any way restricted by probation or agreement? Yes ☐ No ☐ If yes, explain with date, state, city, county, and included attachments.

11. Does the applying provider have any pending enrollment applications with any other state or federal program, other than this application? Yes ☐ No ☐ If yes, list state and program:

12. Does the applying provider, any managing employee, or any person having an ownership or control interest; have any pending complaint investigations being reviewed by any professional boards?
Yes ☐ No ☐ If yes, explain:

13. Does the applying provider, any managing employee, or any person having ownership or control interest; or any individual involved with the applying provider's practice, clinic, group, corporation or any other association, have any outstanding overpayments to Medicare, Medicaid, or any other federal/state health care programs?
Yes ☐ No ☐ If yes, explain:

☐ By checking this block, I certify that I have reviewed the federal and state disclosure regulations for all applying Medicaid providers which are attached to this enrollment application. I also certify that all individuals and/or business organizations with direct or indirect ownership, management and/or control interests have been fully disclosed.

To the best of my knowledge, the information supplied on this application is accurate, complete and is hereby released to the Missouri Department of Social Services. I also understand that pursuant to 13 CSR 70-3.020(7), I must advise the Department, in writing, of any changes affecting the provider's enrollment record.

ORIGINAL Signature of Applicant or Authorized Representative: (Stamp or other facsimile is not acceptable)

Type or print name and title of person signing this application:	**Date Signed**:

Submit this enrollment application and all attachments to:

Missouri Medicaid Audit & Compliance
Attn: Provider Enrollment Unit
205 Jefferson Street, 2nd Floor
P.O. Box 6500
Jefferson City, MO 65102

Fax: 573-634-3105

Email submissions and questions: MMAC.ProviderEnrollment@dss.mo.gov

Federal and State Disclosure Requirements for Medicaid Providers

42 CFR § 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

(a) Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(1)(i) 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.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) When the disclosures must be provided—

(1) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

(2) Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:

(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

(ii) Upon the fiscal agent executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the fiscal agent.

(3) Disclosures from managed care entities. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:

(i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.

(ii) Upon the managed care entity executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the managed care entity.

(4) Disclosures from PCCMs. PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section.

(d) To whom must the disclosures be provided. All disclosures must be provided to the Medicaid agency.

(e) Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

[76 FR 5967, Feb. 2, 2011]

42 CFR § 455.105 Disclosure by providers: Information related to business transactions.

(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—

(1) 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; and
(2) 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.

(c) Denial of Federal financial participation (FFP)

(1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).
(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

42 CFR § 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(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 those programs.

(b) Notification to Inspector General.

(1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) Denial or termination of provider participation.

(1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

Missouri Regulation - 13 CSR 65-2.020(3) - Provider Enrollment and Application

(3) All providers, fiscal agents, and managed care entities are required to disclose as follows:

(A) The following disclosures are mandatory:

1. The name and address of any person with an ownership or control interest in the applying provider. The address for corporate entities must include as applicable primary business address, every business location, and PO Box address;

2. Date of birth and Social Security number (in the case of a corporeal person);

3. Other tax identification number of any person with an ownership or control interest in the applying provider or in any subcontractor in which the applying provider has a five percent (5%) or more interest;

4. Whether any person with an ownership or control interest in the applying provider is related to another person with ownership or control interest in the applying provider as a spouse, parent, child, or sibling;

5. Whether any person with an ownership or control interest in any subcontractor in which the applying provider has a five percent (5%) or more interest is related to another person with ownership or control interest in the applying provider as a spouse, parent, child, or sibling;

6. The name of any other provider or applying provider in which an owner of the applying provider has an ownership or control interest; and

7. The name, address, date of birth, and Social Security number of any managing employee of the applying provider;

(B) Disclosures from any provider or applying provider are due at the following times, and must be updated within thirty-five (35) days of any changes in information required to be disclosed:

1. Upon the provider or applying provider submitting an application; and

2. Upon request of MMAC;

(C) Disclosures from fiscal agents are due at the following times:

1. Upon the fiscal agent submitting the proposal;

2. Upon request of MMAC;

3. Ninety (90) days prior to renewal or extension of the contract; and

4. Within thirty-five (35) days after any change in ownership of the fiscal agent;

(D) Disclosures from managed care entities (managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and health insuring organizations), except primary care case management programs, are due at the following times:

1. Upon the managed care entity submitting the proposal;

2. Upon request of MMAC; and

3. Ninety (90) days prior to renewal or extension of the contract;

(E) Disclosures from Primary Care Case Management Programs (PCCM). PCCMs will comply with disclosure requirements under subsection (B) of this section;

(F) All Disclosures must be provided to MMAC. Disclosures not made to MMAC will be deemed non-disclosed and not in compliance with this section; and

(G) Consequences for Failure to Provide Required Disclosures.

1. Any person's failure to provide, or timely provide, disclosures pursuant to this section may result in deactivation, denial, rejection, suspension, or termination. If the failure is inadvertent or merely technical, MMAC may choose not to impose consequences if, after notice, the person promptly corrects the failure.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT

BUSINESS ORGANIZATIONAL STRUCTURE

PLEASE TYPE OR PRINT CLEARLY

LEGAL PROVIDER NAME AS FILED WITH THE SECRETARY OF STATE, INCLUDING DBA NAME (Sole Proprietors: Include Name and DBA name)

Legal Name including DBA:

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

☐**NEW** ☐**UPDATE** ☐**CHANGE OF OWNERSHIP (CHOW)**

- **Complete ONLY ONE of the following sections (I, II, III, IV or V)**
- **Attach the documents as indicated for the completed section**
- **Attach additional sheets, if necessary**
- **Signature required on page 3**

SECTION I: SOLE PROPRIETOR

↳ Attach the following:
- Registration of Fictitious Name (if applicable)

The legal business name must match the IRS Employee Identification Number letter, the same person can be listed as both owner and managing employee.

PART I – OWNER

OWNER'S NAME		
DATE OF BIRTH	SOCIAL SECURITY NUMBER	EIN
ADDRESS		
CITY, STATE, ZIP		

PART 2 – MANAGING EMPLOYEE(S)

NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	
CITY, STATE, ZIP	

SECTION II: PARTNERSHIP

↳ Attach Registration of Fictitious Name (if applicable) and Partnership Agreement

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN	DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
GENERAL INTEREST IN PARTNERSHIP %		GENERAL INTEREST IN PARTNERSHIP %	
NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN	DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
GENERAL INTEREST IN PARTNERSHIP %		GENERAL INTEREST IN PARTNERSHIP %	

SECTION III: CORPORATION

☐ For Profit ☐ Not For Profit

↳ Attach the following:

- Articles of Incorporation;
- Current Certificate of Good Standing; and
- Registration of Fictitious Name (if applicable)

PART I – OFFICERS (Attach additional sheets, if necessary)

PRESIDENT		VICE PRESIDENT	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
SECRETARY		TREASURER	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	

PART II – DIRECTORS (Attach additional sheets, if necessary)

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	

PART III – MANAGING EMPLOYEES (Attach additional sheets, if necessary)

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	

PART IV – STOCKHOLDERS **(N/A FOR NON-PROFIT)** (Attach additional sheets, if necessary)

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN	DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
PERCENTAGE OF STOCK HELD %		PERCENTAGE OF STOCK HELD %	
NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN	DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
PERCENTAGE OF STOCK HELD %		PERCENTAGE OF STOCK HELD %	

SECTION IV: LIMITED LIABILITY COMPANY

Check the LLC's federal income tax reporting status: ☐SOLE MEMBER ☐MULTIPLE MEMBERS

↳ Attach the following:

- Current Certificate of Good Standing;
  Articles of Organization;
- LLC Operating Agreement;
- LLC Management Agreement (if applicable); and
- Registration of Fictitious Name (if applicable)

The managers and members listed must agree with the IRS Employee Identification Number letter, the operating agreement and the Management Agreement (if applicable). The same person/people can be listed as both manager(s) and member(s).

PART I – MANAGERS AND EXECUTIVE OFFICERS (Attach additional sheets, if necessary)

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	

PART II – MEMBERS (Attach additional sheets, if necessary)

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN	DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
PERCENTAGE OF OWNERSHIP %		PERCENTAGE OF OWNERSHIP %	

SECTION V: OTHER

Type:

↳ Attach an explanation and verification

SECTION VI: LEGAL DISCLOSURE

Has the enrolling entity above, under any current or former name or business identity, ever had a final adverse legal action imposed against it? ☐YES ☐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

SIGNATURE

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 (form will not be accepted without signature)	DATE