What is the Federally Required Disclosure Form (FRDF) for Entities?

As required by 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).

How do I submit the FRDF?

Upload a completed/signed FRDF to the attachments panel on the POSC for enrollments initiated on the POSC.

Mailed to: MassHealth Provider Enrollment
P.O. Box 121205
Boston, MA 02112-1205

PE-FRD-E INSTRUCTIONS (09.19)
• **Tip:** All fields must be completed. Nothing should be left unanswered. If the section does not apply, check the box above the name field for the section.

• **Tip:** Each service location must have a separate FRDF, even if they are listed on one application as it is expected that each location will have a different Managing Employee.

• **Tip:** If additional space is needed, you must make a copy the appropriate page and attach each such copy to the signed form. All entries must be submitted using this form.

**How to complete the FRDF**

**Review FRDF: Page 1**
Enter the contact information for the person completing the form. We will contact this person with any questions.

![CONTACT INFORMATION FORM](image)

**Review FRDF: Page 3, Section 1**
Enter the disclosing entity DBA name and address, FEIN and NPI.

![SECTION 1](image)

**Review FRDF: Page 3, Section 2**
Indicate which ownership or control interest describes your entity.

![SECTION 2](image)

For individuals, you must enter the name, answer if the individual is on the board of directors, their DOB, home address, SSN % ownership (if applicable) and NPI (if applicable).
For corporations you must enter the name, primary address, FEIN, % ownership (if applicable) and NPI (if applicable).

Review FRDF: Page 3, Section 2
If the individual above is related as noted, you must list the individual and indicate their relationship.

If a corporation was listed above, you must list all other business locations, corporate addresses and PO Boxes.

There is another section to enter ownership or control interest information.

If additional space is needed, you must make a copy this page and include with the submitted form.
Review the FRDF: Page 4, Section 3
Enter ownership information as requested in other disclosing entities. If none, check the box above the name field.

Review the FRDF: Page 4, Section 4
Enter ownership information in subcontractors. If none, check the box above the name field.

Review the FRDF: Page 4, Section 5
Enter familial relationship in subcontractors. If none, check the box above the name field.
Review the FRDF: Page 4
If additional space is needed, you must make a copy this page and include with the submitted form.

Review the FRDF: Page 5, Section 6
Enter the agents and managing employees. It is expected that an organization will have at least one agent or managing employee per service location.
If additional space is needed, you must make a copy this page and include with the submitted form.

Review the FRDF: Page 6, Section 7
Answer each question with regard to disclosure of criminal convictions and relationships to excluded individuals.
Each question must be answered yes or no.
Review the FRDF: Page 7, Section 8

Enter any additional explanation for questions answered in Section 7

**SECTION 8: Additional Explanation**

If “Yes” is answered to any of the questions in Section 7, a detailed explanation is required below, including the name, Social Security Number/Tax Identification Number (SSN/TIN) and address of the individual/ entity, nature, date, and forum of the action, and any case or record number.

Attach additional pages if necessary.

If additional space is needed, you must make a copy this page and include with the submitted form.

Review the FRDF: Page 8, Section 9

The form must be signed by an authorized representative. Their name, title and the date must be printed as well.

**SECTION 9: Attestation, Signature, and Date**

All disclosing entities must complete this section.

I certify that the information on this form, and any attached statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge.

I understand that I sign under the pains and penalties of perjury, and may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

I agree to abide by all applicable federal and state laws and regulations, as well as the rules and regulations of particular to the type of program covered by this enrollment application.

Note: Signature or date stamps, electronically generated signatures or dates, or the signature of anyone other than the disclosing entity or person legally authorized to sign on behalf of the entity are not acceptable.

In accordance with 130 CMR 450.223(B), I agree to notify the MassHealth agency in writing within 14 days of any change to any of the information submitted upon enrollment.

In accordance with 2 CFR § 455.105, I agree to disclose full and complete information regarding the following business transactions within 35 days following a request of the MassHealth agency or the Secretary of Health and Human Services:

1. Information about the ownership of any subcontractor with whom the provider, MCE, or disclosing entity 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.

Signature: ............................................................................................................................

Printed Name

Title

Date (MM/DD/YYYY)