



How-To: Disclosure Statement of Information to be Completed by Providers and Fiscal Agents

Please Note: This training material may contain fictitious information and does not contain protected health information (PHI) or personally identifiable information (PII) data.

PURPOSE: Sections 6401 and 6501 of the [Affordable Care Act](#) require states to incorporate additional program integrity provisions within Medicaid and the Children’s Health Insurance Program to prevent fraud, waste, and abuse. In compliance with [Title 42 CFR §455, Subpart B](#), providers must complete the online DMAP Disclosure Statement of Information by Providers and Fiscal Agents upon enrollment, revalidation, re-enrollment, reactivation, and within 30 days of any change contained in the enrollment application.

For any questions about DMAP enrollment applications on the Provider Portal,

Call Us: Provider Relations at **1-800-999-3371**; Option **0**, then Option **4**. Or

Email* Us: delawarepret@gainwelltechnologies.com – *Reminder: Do not send any correspondence that has protected health information (PHI) to this mailbox.

Click on the following [Appendix A](#) link to move to [Appendix A – Disclosure Statement Definitions](#).

Login and Navigation Steps

1.	Go to the Delaware Medical Assistance Portal: https://medicaid.dhss.delaware.gov/ .
2.	Click on the Click here link to enter the Provider Portal.

Login and Navigation Steps


State of Delaware
The Official Website of the First State


DELaware HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance


Home


Home Thursday 01/04/2024 02:53 PM EST

Welcome to the Delaware Medical Assistance Portal

 **MEMBERS** - [Click here](#) to enter the **Member Portal**

 **PROVIDERS** - [Click here](#) to enter the **Provider Portal**

 **PHARMACY** - [Click here](#) to enter the **Pharmacy Corner**

 **DENTAL** - [Click here](#) to enter the **Dental Corner**

Delaware.gov | Privacy | Contact | Phone Directory

Login and Navigation Steps

3. Log in by entering your User ID, Challenge Question, and Password.

The screenshot shows the State of Delaware Medical Assistance Portal for Providers. At the top, there is a search bar and a 'State Services & Information' dropdown menu. Below the header, the page title is 'DELAWARE HEALTH AND SOCIAL SERVICES Division of Medicaid & Medical Assistance'. A 'Home' button is visible. The main content area features a 'Login' section on the left with a 'Log In' button and links for 'Forgot User ID?', 'Register Now', and 'Where do I enter my password?'. The 'User ID' field is highlighted with a red box. To the right of the login section, there is a welcome message and a banner for 'Adult Dental Copays Started December 1, 2023'.

4. From the **My Home** tab, click the *Update Disclosure* link in the **Provider** panel.

The screenshot shows the 'My Home' page of the State of Delaware Medical Assistance Portal for Providers. At the top, there is a navigation bar with tabs for 'My Home', 'Eligibility', 'Claims', 'Care Management', 'Patient Health History', 'Files Exchange', and 'Resources'. Below the navigation bar, there is a 'My Home' section with a search bar for 'Provider Name', 'Role IDs', and 'Location Taxonomy'. The main content area features a 'Welcome Health Care Professional!' message and a 'Provider' panel. The 'Update Disclosure' link in the 'Provider' panel is highlighted with a red box.

Login and Navigation Steps

5.

On the **Provider Enrollment** panel, click the *Enrollment Application* link.

My Home | **Eligibility** | **Claims** | **Care Management** | **Patient Health History** | **Files Exchange** | **Resources**

[My Home](#) > Provider Enrollment Thursday 01/23/2020 10:34 AM EST

Provider Name Role IDs Location
Taxonomy

Provider Enrollment

[Enrollment Application](#)
Initiate a disclosure provider enrollment application.

[Resume Enrollment](#)
Resume an existing enrollment application that has not been submitted.

[Enrollment Status](#)
Check the current status of an enrollment application.

6.

On the **Provider Enrollment Welcome** panel, click **Continue** at the bottom of the page.

State of Delaware
The Official Website of the First State

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

Home > Provider Enrollment > Enrollment Application

Thursday 01/04/2024 03:36 PM EST

Provider Enrollment: Welcome

Welcome

Request Information
Taxonomies
Addresses
Provider Identification
Languages
EFT Enrollment
ERA Enrollment
Other Information
Disclosures
Attachments and Fees
Agreement
Summary

Provider Enrollment

Thank you for your interest in becoming a provider in the Delaware Medical Assistance Program (DMAP) and welcome to the DMAP provider enrollment portal. This portal contains information for fee-for-service (FFS) healthcare providers that submit claims and ordering, referring and prescribing (ORP) providers that do not submit claims.

Did you know?
The Centers for Medicare and Medicaid Services (CMS) requires States to deny claims from providers who are not enrolled in the States Medicaid or CHIP programs. These claims include reimbursement for services rendered, prescriptions, referrals, and orders for lab work and tests. Enroll in the Delaware Medical Assistance Program (DMAP) today!

Ordering, Referring, & Prescribing (ORP) Providers
Ordering and Referring Providers are physicians or other professionals that only order or refer items or services for Medicaid beneficiaries. These providers do not submit claims for reimbursement for any services provided but are required to enroll solely for the purposes of ordering and referring services for Medicaid beneficiaries. Ordering and referring providers are required to complete a limited-capacity enrollment form so that DMAP may identify the providers who write only orders, referrals, and prescriptions. Enrollment is required so that payments can be made for claims related to client services. This requirement does not apply to providers who are enrolled with the Delaware managed care organizations.

Managed Care Only Providers (MCOPs)
In compliance with 42 CFR 438.602 and 42 CFR Part 455, subparts B and E and the 21st Century Cures Act states must screen, enroll, and revalidate MCO network providers according to Program Integrity enhanced screening provisions. MCOPs are required to complete a streamlined provider enrollment application to conduct federally mandated screening activities. This provider enrollment application is mandatory for all MCO providers at initial enrollment, reenrollment, revalidation and for continual participation (registration) with the Managed Care Organization (MCO) under Delaware's Medicaid Program. In accordance with federal guidelines, the MCO application process will standardize screening processes for DMAP/fee for service (FFS) providers and MCOPs alike, overall enhancing member services. MCOPs are not required to provide services to DMAP/FFS members, however the DMAP / FFS enrollment application is available on the Delaware Medical Assistance Portal for providers that chose to participate in both the DMAP/FFS Program and Delaware Managed Care Organization Networks.

High risk providers must successfully enroll in Medicare prior to enrolling with (DMAP).

NPI is only needed if applicable.

When a nurse has an APN license, the RN license is also required.

Please complete each step in the enrollment process. When you have completed all steps of the application, "submit" and "confirm" the application for further processing by the HealthCare system.

You will need the following information to complete your enrollment request:

- Application (this enrollment)
- Tax ID Card/Assignment Letter (include as attachment)
- Provider Contract (noted on Agreement page)
- Business, Professional License, and/or Board Certification (include as attachment)
- Collaborative Agreement (Nurse Practitioner) (include as attachment)
- Drug Enforcement Administration (DEA) License, if applicable (include as attachment)
- Disclosure of Ownership and Control Interest Statement (entered on Disclosure page)
- Electronic Funds Transfer (EFT) Form (entered on EFT page)
- Electronic Remittance Advice (RA) Agreement (entered on ERA page)
- Delaware Title XIX Electronic Claim Submission Form (include as attachment)
- Institutional Fee or Hardship Payment Letter (include as attachment)
- Medicare Certification or Enrollment in another Medicaid State (include as attachment)
- Home Health Agency providers must successfully enroll in Medicare prior to enrolling with DMAP
- DME providers must successfully enroll in Medicare prior to submitting this DMAP enrollment application.
- Verification of enrollment and or certification with Medicare or another State's Medicaid Program (or) CHIP.
- NPPES denial notification if provider does not qualify for NPI (include as attachment).

Please click the "Continue" button to start the enrollment application.

Continue **Cancel**

7.

In order to reach the **Disclosures** panel, click **Continue** at the bottom of each page prior to the **Disclosures** panel.

****Note:** On the **Request Information** panel, you must complete the fields containing an asterisk before continuing.

Provider Identification	Enrollment in the Delaware Medical Assistance Program follows guidelines from section 6401 of the Affordable Care Act, referring to provider screening and enrollment requirements under the Medicare, Medicaid and CHIP Program Integrity Provisions.
Languages	
EFT Enrollment	This application is to be used for the enrollment or revalidation of Hospital, Nursing/Assisted Living and Adult/Community Mental Health Clinic/Center providers Home Health Agencies.
ERA Enrollment	
Other Information	All required attachments must be uploaded directly to this application.
Disclosures	Per ACA guidelines, providers are required to revalidate their enrollment data at set intervals. Providers that are due for revalidation will be required to review and update application information. All required attachments will need to be uploaded and submitted with a revalidation application. Failure to complete this requirement will result in termination from the Delaware Medical Assistance Program.
Attachments and Fees	
Agreement	Please retain the Application Tracking Number (ATN) provided by saving your application for reference when contacting Provider Enrollment and to quickly access a saved draft of your application in the future.
Summary	Selecting Crossover Taxonomies (Portable X-Ray Equipment, Audiology, Hearing Aid Dealer, Nurse Anesthetist) will only pay if Medicare is listed as Primary (will pay after Medicare). Please email the enrollment team with any questions at delawarepret@gainwelltechnologies.com. Providers may also reach a representative by phone, Monday - Friday, 8:00am - 4:30pm at (800) 999-3371 ext. 0 then 4. Enrollment Type Other Taxonomy Requesting Enrollment Effective Date 06/28/2023
Provider Information	
The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required. Individual Providers are to enroll with their SSN only.	
NPI ..	NPI Zip + 4
Tax ID Number *****	Tax ID Type
Effective Date . .	End Date Fiscal End Date
Are you currently enrolled as a Provider? Yes	Current Medicaid ID
Were you previously enrolled as a Provider? No	
Do you have hospital admitting privileges? No	
Contact Information	
*Last Name	<input type="text"/>
*First Name	<input type="text"/>
Title	<input type="text"/>
*Phone @	<input type="text"/> Ext <input type="text"/>
Fax Number @	<input type="text"/>
*Work Email @	<input type="text"/>
*Confirm Email @	<input type="text"/>
Preferred Method of Communication	Email <input checked="" type="checkbox"/>
Subscribe for Notify Me	
We will send DMAP notifications to the e-mail address provided below.	
* Indicates a required field.	
E-mail Address	<input type="text"/>
	Change existing subscription email address
	<input type="button" value="Verify Me"/>
	Select All Deselect All
	<input checked="" type="checkbox"/> Special Bulletins / Alerts
	<input checked="" type="checkbox"/> Manual Updates
	<input type="checkbox"/> Dental
	<input type="checkbox"/> Pharmacy
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>

Login and Navigation Steps

8.

For Individual and ORP providers, the **Disclosures** panel opens with '-' as the default to the 4 disclosure questions. Select the type of disclosure from the drop-down menu.

Provider Name EDWIN JOHNSON	Role IDs Provider - In Network - 1598732224 (NPI) ▼	Location 200104703 - EDWIN JOHNSON
		Taxonomy 207RC0000X-Internal Medicine - Cardiovascular Disease

Provider Enrollment: Disclosures ?	
Welcome	<p>Answer all questions. If you do not believe that a question is applicable, you should select a response of "No". For any "Yes" response, please provide an explanation in the text box provided for each link.</p> <p>This Disclosure Statement will apply to all enrolled providers with this NPI/Tax Id combination. A separate Disclosure Statement must be completed for each unique NPI/Tax Id combination.</p> <p>*Do you have any of the following to disclose? - ▼</p> <ol style="list-style-type: none">1. Has the provider, or any person who has ownership or control interest in the provider, or any person who is an agent or managing employee of the provider 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?2. Has the provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding 12-month period?3. Has the provider had any significant transactions with any wholly owned supplier or with any subcontractor during the preceding five-year period?4. Are there any other entities to report for this NPI/Tax ID combination?
Request Information	
Taxonomies	
Addresses	
Provider Identification	
Languages	
EFT Enrollment	
ERA Enrollment	
Other Information	
▶ Disclosures	
Attachments and Fees	
Agreement	
Summary	

[Continue](#) [Finish Later](#) [Cancel](#)

9.

On the **Disclosures** panel, if the Individual or ORP provider selects “No” and then **Continue**, the **Attachment and Fees** panel will display. The provider will not be required to complete the *Provider Disclosure Statement* section.

****Note:** Only Individual and ORP providers are able to bypass the *Provider Disclosure Statement*.

Provider Name EDWIN JOHNSON	Role IDs Provider - In Network - 1598732224 (NPI) ▼	Location 330114703 - EDWIN JOHNSON
		Taxonomy 207R0000X Internal Medicine - Cardiovascular Disease

Provider Enrollment: Disclosures	
Welcome	<p>Answer all questions. If you do not believe that a question is applicable, you should select a response of "No". For any "Yes" response, please provide an explanation in the text box provided for each link.</p> <p>This Disclosure Statement will apply to all enrolled providers with this NPI/Tax Id combination. A separate Disclosure Statement must be completed for each unique NPI/Tax Id combination.</p> <p>*Do you have any of the following to disclose? <input type="text" value="No"/></p> <ol style="list-style-type: none">1. Has the provider, or any person who has ownership or control interest in the provider, or any person who is an agent or managing employee of the provider 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?2. Has the provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding 12-month period?3. Has the provider had any significant transactions with any wholly owned supplier or with any subcontractor during the preceding five-year period?4. Are there any other entities to report for this NPI/Tax ID combination?
Request Information	
Taxonomies	
Addresses	
Provider Identification	
Languages	
EFT Enrollment	
ERA Enrollment	
Other Information	
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Summary	

[Continue](#) [Finish Later](#) [Cancel](#)

Provider Name	Role IDs Provider - In Network - 1598732224 (NPI) ▼	Location
		Taxonomy

Provider Enrollment: Attachments And Fees	
Welcome	<p>Supporting Documentation</p> <p>The following actions need to be taken to complete the enrollment process. If you need to submit attachments, please follow the instructions in the Attachments panel below.</p> <p>High risk providers must successfully enroll in Medicare prior to enrolling with DMAP. NPI is only needed if applicable. When a nurse has an APN license, the RN license is also required.</p> <p>Review Privacy Notice before adding attachments: Privacy Notice</p> <p>Checklist of General Provider Information Needed</p> <ul style="list-style-type: none">▪ Application (this enrollment)▪ Tax ID Card/Assignment Letter (W-9) or Social Security Card (include as attachment)▪ Provider Contract (noted on Agreement page)▪ Business, Professional License, and/or Board Certification (include as attachment)▪ Disclosure of Ownership and Control Interest Statement (entered on Disclosure page)▪ Electronic Funds Transfer (EFT) Form (entered on EFT page)
Request Information	
Taxonomies	
Addresses	
Provider Identification	
Languages	
EFT Enrollment	
ERA Enrollment	
Other Information	
Disclosures	
Attachments and Fees	
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On the **Disclosures** panel, if the provider selects “Yes”, the **Answer Enrollment Disclosure Questions** panel displays. Complete the *Provider Disclosure Statement* form. When form is completed, click **Submit**.

****Note:** For help understanding the Disclosure Statement, click [HERE](#) to view the definitions used in the form.



Home

Home > Provider Enrollment > Enrollment Disclosures > Enrollment Disclosure View

Thursday 01/29/2026 12:22 PM EST

Answer Enrollment Disclosure Questions



This Disclosure Statement will apply to all enrolled providers with this NPI/Tax Id combination. A separate Disclosure Statement must be completed for each unique NPI/Tax Id combination.

[Please click here for instructions, terms, and definitions used in the form](#)

Provider Disclosure Statement

Total # of Questions: 10

*Doing Business As

*Phone (9999999999)

Questions 1 - 3 must be answered by all providers.

- *Has the provider, or any person who has ownership or control interest in the provider, or any person who is an agent or managing employee of the provider 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?
 Yes No
- *Has the provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding 12-month period?
 Yes No
- *Has the provider had any significant transactions with any wholly owned supplier or with any subcontractor during the preceding five-year period?
 Yes No

Questions 4 - 6 must be answered by fiscal agents/managed care entities and by all providers.

4. Provide the name, address, social security number (SSN), and date of birth of each person, or Tax Identification Number of each corporation with an ownership or control interest in the provider/fiscal agent/managed care entity or in any subcontractor in which the provider/fiscal agent/managed care entity has direct or indirect ownership of five percent or more. Also, provide the name, address, date of birth and social security number of any managing employee of the provider/fiscal agent/managed care entity.

*Last Name/ Company Name	*First Name	*SSN/EIN (999999999)	Birth Date (MM/DD/YYYY)	*Street	*City	*State	*Zip
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Add Row](#)

- *Is any person named in question #4 related to another as spouse, parent, child, or sibling?
 Yes No
- *Does any person named in question #4 have an ownership or control interest in any other Medicaid provider or in any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act?
 Yes No

Optional Remarks

Enter optional comments here (500 characters max.)

Whoever knowingly and willfully makes or causes to be made a false statement, may be prosecuted under applicable federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with the State agency.

*Name of Provider or Authorized Representative *Date (MM/DD/YYYY) Title

Submit

Cancel

Login and Navigation Steps

10.

Click **Continue** at the bottom of each page to get to the **Agreement** panel.

State of Delaware
The Official Website of the First State

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

My Home **Eligibility** Claims Care Management Patient Health History Files Exchange Resources

My Home > [Provider Enrollment](#) > Enrollment Disclosures Thursday 01/23/2020 01:20 PM EST

Provider Name Role IDs Location Taxonomy

Provider Enrollment: Disclosures

Welcome
Request Information
Taxonomies
Addresses
Provider Identification
Languages
EFT Enrollment
IRA Enrollment
Other Information
Disclosures
Attachments and Fees
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Summary

Answer all questions. If you do not believe that a question is applicable, you should select a response of "No". For any "Yes" response, please provide an explanation in the text box provided for each link.
This Disclosure Statement will apply to all enrolled providers with this NPI/Tax Id combination. A separate Disclosure Statement must be completed for each unique NPI/Tax Id combination.

Available Enrollment Disclosures

Click the disclosure name to open the disclosure for editing. After completing the disclosure, select **Submit** to return to this page.
All Disclosures must be completed to **Continue**.

Disclosure Name	Description	Status
Provider Disclosure Statement	All providers enrolling with the DMES program must complete a Provider Disclosure Statement.	Completed

Continue **Finish Later** **Cancel**

11.

On the **Agreement** panel, do **NOT** check the box at the bottom of the page next to "I accept". Click **Submit**.

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

I accept I understand that my electronic signature is equivalent to written signature.

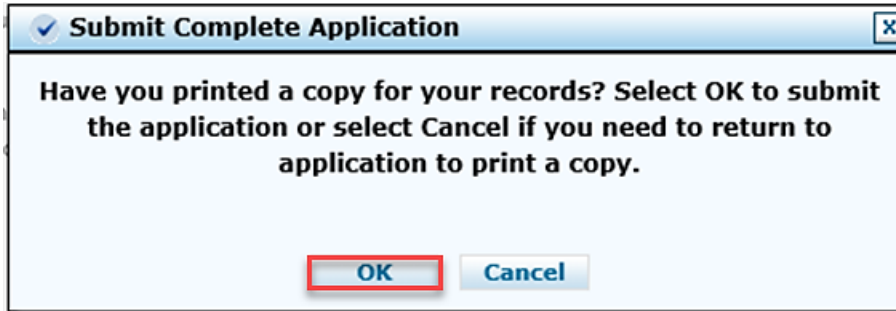
Your Signature _____
(Entering your name in the box to the right will constitute your electronic signature.)
Title _____
Submission Date 01/23/2020

Submit **Finish Later** **Cancel**

Login and Navigation Steps

12.

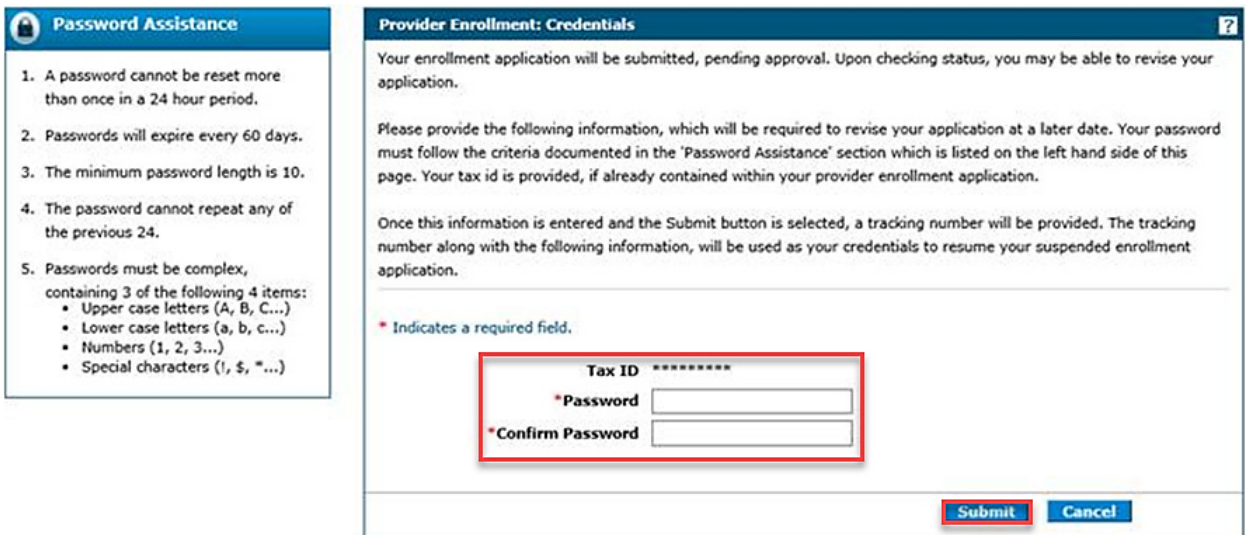
At the bottom of the **Summary** panel, do **NOT** check the box at the bottom of the page next to “I accept”. Click **Confirm**. The **Submit Complete Application** dialogue box will appear – click **OK**.



The dialog box has a title bar with a checkmark icon and the text "Submit Complete Application" and a close button (X). The main text reads: "Have you printed a copy for your records? Select OK to submit the application or select Cancel if you need to return to application to print a copy." At the bottom, there are two buttons: "OK" (highlighted with a red box) and "Cancel".

13.

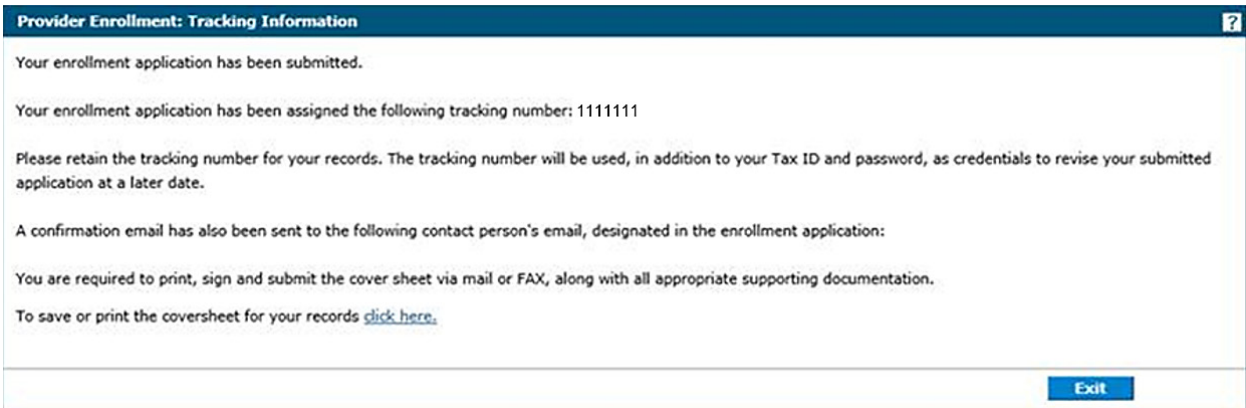
In the **Provider Enrollment: Credentials** box, enter your password and click **Submit**.



The form is titled "Provider Enrollment: Credentials" and includes a "Password Assistance" section on the left. The main form area contains instructions and a legend: "* Indicates a required field." Below this, there are input fields for "Tax ID *****", "* Password", and "* Confirm Password". The "Submit" button is highlighted with a red box. The "Cancel" button is also visible.

14.

If the Disclosure application was submitted successfully, tracking information will be provided. Save the tracking number for your records.



The form is titled "Provider Enrollment: Tracking Information" and contains the following text: "Your enrollment application has been submitted." "Your enrollment application has been assigned the following tracking number: 1111111" "Please retain the tracking number for your records. The tracking number will be used, in addition to your Tax ID and password, as credentials to revise your submitted application at a later date." "A confirmation email has also been sent to the following contact person's email, designated in the enrollment application:" "You are required to print, sign and submit the cover sheet via mail or FAX, along with all appropriate supporting documentation." "To save or print the coversheet for your records [click here](#)." At the bottom right, there is an "Exit" button.

Appendix A – Disclosure Statement Definitions

<u>Term</u>	<u>Definition</u>
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing Entity	A Medicaid provider (other than an individual practitioner), or a fiscal agent.
Any Entity	Any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act, includes: <ul style="list-style-type: none"> a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); b. Any Medicare intermediary or carrier; and c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.
Fiscal Agent	A contractor that processes or pays vendor claims on behalf of the Medicaid agency.
Group of Practitioners	Two or more healthcare practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
Indirect Ownership Interest	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
Individual Practitioner	A physician or other person licensed or certified under State law to practice his or her profession
Managing Employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership Interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an Ownership or Control	A person or corporation that: <ul style="list-style-type: none"> a. Has an ownership interest totaling 5 percent or more in a disclosing entity; b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; e. An officer or director of a disclosing entity that is organized as a corporation; or f. Is a partner in a disclosing entity that is organized as a partnership.
Significant Business Transaction	Any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 or 5 percent of a provider's total operating expenses.

Subcontractor	An individual, agency, or organization: a. To which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or b. With which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Supplier	An individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).
Wholly Owned Supplier	A supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.
Click HERE to view regulations, terms, and definitions for completing the Disclosure Statement of Information by Providers and Fiscal Agents.	

Need Assistance?

Call Us: Provider Relations at **1-800-999-3371**; Option **0**, then Option **4**.

Email* Us: delawarepret@gainwelltechnologies.com – *Reminder: Do not send any correspondence that has protected health information (PHI) to this mailbox.