DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
~~Roberts/Day~~ / FOIA	12-17-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000144	[ ] Prepare reply for the Director's signature DATE DUE
2. DATE SIGNED BY DIRECTOR cc: Brooks, Mullis See attached e-mail... these will be processed.	[ ] Prepare reply for appropriate signature DATE DUE [X] FOIA DATE DUE 1-2-15 [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Cleared 1/5/15, letter attached.			12/22/14 Lesley received will email to Cheri
2.			153 Request Forward to DHEC.
3.			
4.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Roberts/Day/FOIA	12-17-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000144	[ ] Prepare reply for the Director's signature DATE DUE
2. DATE SIGNED BY DIRECTOR cc: Brooks, Mull's See attached e-mail... these will be processed.	[ ] Prepare reply for appropriate signature DATE DUE [X] FOIA DATE DUE 1-2-15 [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Cleared 1/5/15, letter attached.			12/22/14 Lesley received will email to ~~Cheri~~
2.			193 Request Forward to DHEC.
3.			
4.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Roberts/Day/FOIA	12-17-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000144	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Brooks, Mullis	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 1-2-15 [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

South Carolina Department of Health & Human Services

Anthony E. Keck• Director
Nikki R. Haley• Governor

TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

The South Carolina Department of Health and Human Services has received and processed your FOIA request. The cost for processing this information is as follows:

Staff processing time at $10.00 per hour	_____ Hours	$_____
Pages copied at $.10 per page	_____ Pages	$_____
Pages faxed at $.20 per page	_____ Pages	$_____
Shipping and Handling Costs		$_____
Other costs associated with the FOIA request: _____		$_____
Total Amount Due SCDHHS:		$_____

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8297

Please contact _____ should you have any questions.

_____ _____
Signature Date:

Finance and Administration
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-3202 • Fax (803) 255-8235

Brenda James

From: Linda Boyer
Sent: Monday, January 05, 2015 11:35 AM
To: Brenda James; Lesley King
Cc: Byron Roberts; Constance Holloway
Subject: RE: FOIA Logs #144 & #145

Importance: High

Hi Lesley,
Per Byron, we should not send the letters to DHEC for FOIA #144 & #145.
We will process these requests and send out to the Requestor.

Thanks!

Linda Boyer
Administrative Assistant
BOYER@scdhhs.gov
803.898.2669
1801 Main Street Suite 1100
Columbia, SC - 29201
www.scdhhs.gov

From: Brenda James
Sent: Monday, January 05, 2015 10:09 AM
To: Linda Boyer; Marie Brown
Cc: Byron Roberts; Constance Holloway
Subject: RE: Logs #144 & #145

Sorry I'm just getting back to you, but the letter itself. Thanks, bj

Brenda James
Administrative Coordinator I
JAMESBR@scdhhs.gov
803.898.2580

1801 Main Street Suite 1100
Columbia, SC - 29201
www.scdhhs.gov

From: Linda Boyer
Sent: Monday, December 29, 2014 12:45 PM
To: Brenda James; Marie Brown
Cc: Byron Roberts; Constance Holloway
Subject: RE: Logs #144 & #145

Hi Brenda,
Yes, we have the FOIA's (#144 & #145).
Are you saying the FOIA request itself needs to go to DHEC or the "Final Response Letters" need to go to DHEC?

Thanks!

Linda Boyer
Administrative Assistant
BOYER@scdhhs.gov
803.898.2669
1801 Main Street Suite 1100
Columbia, SC - 29201
www.scdhhs.gov

From: Brenda James
Sent: Tuesday, December 23, 2014 11:12 AM
To: Marie Brown
Cc: Byron Roberts; Linda Hillian; Linda Boyer
Subject: Logs #144 & #145

Hi Linda, if you have picked up logs 144 & 145, Lesley King says the letter goes to DEHEC. Let me know so I can close them out. Thanks, bj

Brenda James
Administrative Coordinator I
JAMESBR@scdhhs.gov
803.898.2580
1801 Main Street Suite 1100
Columbia, SC - 29201
www.scdhhs.gov

SOUTH CAROLINA Healthy Connections MEDICAID

Log #1467

Healthy Connections MEDICAID

Nikki Haley
Christian L. Soura
P.O. Box 8206 Columbia, SC 29202
www.scdhhs.gov

January 5, 2015

VIA EMAIL ONLY: jhutchins@christiananddavis.com

Mr. Matthew W. Christian, Attorney at Law
Christian & Davis, LLC
1007 E. Washington Street
Greenville, South Carolina 29601

Dear Mr. Christian:

This is in response to your request for information from the South Carolina Department of Health and Human Services (DHHS) pursuant to the South Carolina Freedom of Information Act (FOIA) dated December 15, 2014 and received by DHHS on December 17, 2014. Enclosed are copies of all documents regarding ownership, control interests and related entities in reference to Amedisys Home Health.

Thank you for your request. If you have any questions, please feel free to contact me at (803)898-0062.

Sincerely,

Constance Holloway
Attorney II
General Counsel

Enclosures

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT
PART 2

General Instructions

Federal Medicaid regulations (42 CFR 455.100 – .106) require that all Medicaid providers disclose the name, address, and other identifying information for each person with an ownership or control interest in the provider and any subcontractor in which the provider has a 5% or more interest. All applicants, except an individual practitioner or group of practitioners as defined in 42 CFR 455.101, must complete this form in order to enroll as a provider in the Medicaid program. The provider must also screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) and/or all federal health care programs. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.

Please answer all questions as of the **current date**. If the "**Yes**" block for an item is checked, list the requested additional information in the area provided; attach additional pages and/or documentation as needed, referencing the item number to which the information corresponds. Return the original to the South Carolina Department of Health and Human Services (SCDHHS); retain a copy for your files. Failure to provide this form and/or incomplete information will result in a refusal by SCDHHS to enter into an agreement or contract with any such provider or institution or in termination of existing agreements.

This form is to be completed for all programs established by Title XIX and Title XXI and **must be submitted within 35 days of any changes to provider information.** Completion and submission of this form is a condition of approval or renewal of a contract or agreement between the disclosing entity and SCDHHS. Any substantial delay in completing the form should be reported to SCDHHS.

Disclosure of Social Security Number (SSN): Disclosure of a SSN is used for the purpose of determining whether persons and entities named in an application are federally excluded parties and to verify licensure. **Refusal to provide a SSN will result in rejection of the provider's application to participate in the Medicaid program or termination of any existing provider agreement or contract.**

I. Instructions / Definitions: Providers that must have a National Provider Identifier (NPI) must include the NPI. If currently enrolled in South Carolina Medicaid with multiple NPI numbers, a separate Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514) must be completed for each NPI number.

I. Identifying Information

[a] Name of Provider (Disclosing Entity): Amedisys SC, L.L.C			
Doing Business As (trade or company name): Amedisys Home Health of Beaufort			
Street Address 2121 Boundary Street, Suite 200		City, State, Zip + 4 Beaufort, SC 29902-6812	
County Beaufort	Provider Number(If Known) HHA189	NPI 1043278542	Telephone Number 843-379-2320
[b] Federal Employer Identification Number (FEIN): 20-1968800			

[c] Type of Entity (Applies to either For Profit or Non-Profit)

- ☒ Limited Liability Corporation (LLC)
- ☐ Partnership
- ☐ Corporation
- ☐ Business Proprietorship or Company
- ☐ Sole Proprietor
- ☐ Governmental Unit
- ☐ Other (Please specify)_____

II. Instructions / Definitions:

Providers must disclose ownership and control information as required by 42 CFR 455.101 - 104.
Ownership interest is defined as the possession of equity in the capital, the stock or the profits of the disclosing entity. ***A disclosing entity*** is a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership interest means 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. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: If A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Control interest is defined as the direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Therefore, ***a person with an ownership or control interest*** is a ***person*** or ***corporation*** that –

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest totaling 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interest 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) Is 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.

Subcontractor means (a) an individual, agency, or organization 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) an individual, agency, or organization 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.

II. Individuals and Organizations with Ownership or Control Interest

[a] List names, addresses, date of birth and SSN for individuals, or list names, addresses and the FEIN for organizations, having direct or indirect ownership or control interest, **as defined on pg. 2,** in the entity listed in Section I. Attach additional pages, if needed, for any additional names and addresses. **If Sole Proprietor or Business Proprietorship or company is checked in Section I, skip this section.**

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN
Amedisys SC, L.L.C.	5959 South Sherwood Forest Boulevard Baton Rouge, LA 70816-8038			20-1968800

[b] Are any persons / entities with ownership or control interest in the provider also owners of other Medicare / Medicaid providers? If yes, list name of the owner from Section II [a] and the name and NPI and/or FEIN for each facility or SSN if an individual provider.

☒ Yes ☐ No

Name of Owner from Section II [a]	Name of Other Provider or Entity	NPI/SSN	FEIN
See Attachment III.(d)			

III. Subcontractors

[a] Please list any subcontractors of the disclosing entity (provider), **as defined on pg. 2,** in which the disclosing entity has a direct or indirect ownership of 5% or more.

☒ Not Applicable

Name of Subcontractor	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] List the following information for individuals or organizations having direct or indirect ownership or a control interest, **as defined on pg. 2,** in any subcontractor in which the disclosing entity (provider) has a direct or indirect ownership of 5% or more. Attach additional pages, if needed, for additional names.

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

IV. Relationships

Are any of the individuals identified in Sections I, II or III related to each other? ☐ Yes ☒ No

If yes, list the individuals identified and the relationship to each other (spouse, sibling, parent, child, etc).

Name of Person 1	Name of Person 2	Relationship

Attachment III.(d)

Amedisys, Inc. - Active Locations

9/6/201

5507	State	Tax ID #	Status	Parent #	Origin	Legal Entity Name d/b/a Agency Name Agency Address	Phone Fax Toll Free	Home Care or Hospice License #	NPI (Login)	Medicare # & Branch ID	Medicaid # & Other Provider #'s	FI / Prior FI	Care Center Type	Legal Entity Lineage with Tax ID #
2205	SC	20-1968800	*Parent	2205	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Georgetown 1105 Church Street Georgetown, SC 29440-3201	P: 843-546-1730 F: 843-545-9260 TF:800-946-0244	HHA-192	1760430334 (2205SC)	42-7085	Medicaid: HHA192	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2206	SC	20-1968800	*Parent	2206	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Myrtle Beach 1705 North Oak Street, Suite 2 Myrtle Beach, SC 29577-3580	P: 843-916-0931 F: 843-916-0985 TF:866-604-1172	HHA-187	1811955085 (2206SC)	42-7087	Medicaid: HHA187	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2207	SC	20-1968800	*Parent	2207	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Charleston East 1027 Physicians Drive, Suite 210 Charleston, SC 29414-5352	P: 843-556-0200 F: 843-556-0020 TF:800-951-6877	HHA-0191	1447218748 (2207SC)	42-7027	Medicaid: HHA191	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2209	SC	20-1968800	Branch	2207	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Mount Pleasant 950 Houston Northcutt Blvd, Suite 105 Mt. Pleasant, SC 29464-5648	P: 843-972-0416 F: 843-972-0421	HHA-0191	1447218748 (2207SC)	42-7027 Branch ID: 42Q7027002	Medicaid: HHA191	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2208	SC	20-1968800	Branch	2207	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Walterboro 402 Robertson Blvd. Walterboro, SC 29488-2756	P: 843-542-9020 F: 843-549-3236 TF:888-962-6877	HHA-0191	1447218748 (2207SC)	42-7027 Branch ID: 42Q7027001	Medicaid: HHA191	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2210	SC	20-1968800	*Parent	2210	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Beaufort 2121 Boundary Street, Suite 200 Beaufort, SC 29902-6812	P: 843 379-2320 F: 843-379-2321 TF:800-300-9559	HHA-0189	1043278542 (2210SC)	42-7304	Medicaid: HHA189	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2211	SC	20-1968800	*Parent	2211	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Lexington 714 South Lake Drive, Suite 250 Lexington, SC 29072-3462 *Relocated from West Columbia 3/11/2008	P: 803-359-2253 F: 803-356-7135 TF:866-318-7323	HHA-0190	1760430375 (2211SC)	42-7039	Medicaid: HHA190	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2212	SC	20-1968800	Branch	2211	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Newberry 184 Commerce Dr. Newberry, SC 29108-2954	P: 803-276-9359 F: 803-276-9560 TF:866-276-9359	HHA-0190	1760430375 (2211SC)	42-7039 Branch ID: 42Q7039004	Medicaid: HHA190	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2213	SC	20-1968800	Branch	2211	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Orangeburg 1704 Village Park Drive Orangeburg, SC 29118-2401	P: 803-534-2022 F: 803-534-3731 TF:888-534-2022	HHA-0190	1760430375 (2211SC)	42-7039 Branch ID: 42Q7039005	Medicaid: HHA190	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2214	SC	20-1968800	Branch	2211	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Sumter 3461 Declaration Blvd Sumter, SC 29154-6140	P: 803-905-5240 F: 803-905-5244 TF:877-284-6630	HHA-0190	1760430375 (2211SC)	42-7039 Branch ID: 42Q7039001	Medicaid: HHA190	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2216	SC	20-1968800	*Parent	2216	Acquired 02/01/08	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Camden 1110 Broad Street, Suite B Camden, SC 29020-3624 *Relocated from West Columbia, SC 05/29/2008	P: 803-713-9774 F: 803-713-9264 TF:888-318-7323	HHA-0194	1699733246 (2216SC)	42-7036	Medicaid: HHA194	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2225	SC	20-1968800	Branch	2216	Opened 11/03/08	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Columbia 3227 Sunset Boulevard, Suite F101 West Columbia, SC 29169-3201	P: 803-739-6881 F: 803-739-5886	HHA-0194	1699733246 (2216SC)	42-7036 42Q7036002	HHA194	PGBA/ N/A	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2221	SC	20-1968800	*Parent	2221	Acquired 02/01/05	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Georgetown East 1105-C Church Street Georgetown, SC 29440-3201	P: 843-546-2009 F: 843-546-1509 TF:800-946-9244	HHA-0188	1255399747 (2221SC)	42-7068	Medicaid: HHA188	PGBA / PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.

Attachment III.(d)

Amedisys, Inc. - Active Locations

9/6/201

5507	State	Tax ID #	Status	Parent #	Origin	Legal Entity Name d/b/a Agency Name Agency Address	Phone Fax Toll Free	Home Care or Hospice License #	NPI (Login)	Medicare # & Branch ID	Medicaid # & Other Provider #'s	FI / Prior FI	Care Center Type	Legal Entity Lineage with Tax ID #
2224	SC	20-1968800	*Parent	2224	Acquired 12/31/07	Amedisys SC, L.L.C d/b/a Amedisys Home Health of Bluffton 23 Plantation Park Drive, Suite 503 Bluffton, SC 29910-6080	P: 843-815-8068 F: 843-815-8090 TF:800-697-5235	HHA -0203	1215110226 (2224SC)	42-7048	Medicaid: HHA203	PGBA/ PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.
2226	SC	20-1968800	*Parent	2226	Acquired 06/01/08	Amedisys SC, L.L.C. d/b/a Neighbors Care Home Health Agency, an Amedisys Company 1645 JA Cochran Bypass, Suite I Chester, SC 29706-3101	P: 803-581-6775 F: 803-581-8915	HHA-0198	1629245808 (2226SC)	42-7063 Branch ID: N/A	Medicaid: HHA301	PGBA/ PGBA	Home Health	Amedisys, Inc. owns (100%) Amedisys Holding, L.L.C.#36-4576454 owns (100%) Amedisys SC, L.L.C.#20-1968800 which owns (100%) this agency.

V. Managing Employees

[a] List current managing employees as indicated below. "Managing employee" means general manager, office or business manager, administrator, director, or other individual who exercises operational or managerial control over the institution, agency, or organization, or who directly or indirectly conducts the day-to-day operations. Attach additional pages, if needed, for additional names.

Name/Title	Address	SSN	Date of Birth
See Attachment III.(c)			

[b] Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
☐ Yes ☒ No
If Yes, give date for change: Date / / . List names, titles, and SSN of the prior Administrator, Director of Nursing, or Medical Director.

Name	Title	SSN

VI. Management Company

A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility. If the answer is yes, list the name of the management firm as well as the managing employees of the firm (i.e., CEO, CFO, etc). Attach additional pages, if needed, for additional names.

Is the provider/entity/facility operated by a management company?
☐ Yes ☒ No
If Yes, what is the term of the agreement?
Beginning Date / / to Ending Date / /

Name of Management Co.	Address	FEIN

Name(s) of Managing Employee(s)	SSN	Date of Birth

VII. Instructions / Definitions: Criminal Offenses related to the delivery of services or items under Medicare or Medicaid programs include convictions relating to patient neglect or abuse in connection with the delivery of a health care item or service; felony and/or misdemeanor convictions related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; and felony and/or misdemeanor convictions related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

VII. Criminal Offenses

If any of the questions are answered "Yes", list names, addresses, and SSNs for individuals and names, addresses, and FEINs for organizations, or attach documentation or additional pages if needed.

[a] As listed in **Sections II or III**, have any individuals and organizations with a direct or indirect ownership of 5% or more in the disclosing entity (provider), or any subcontractor(s) in which the provider has a direct or indirect ownership of 5% or more, been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)?

☐ Yes ☒ No

Attachment: III.(c)

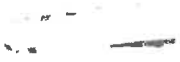
Officers/Managers for Amedisys SC, L.L.C.
d/b/a Amedisys Home Health of Georgetown

William F. Borne
President
5959 South Sherwood Forest Boulevard
Baton Rouge, LA 70816-6038

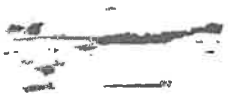
Ronald A. LaBorde
Vice-President
5959 South Sherwood Forest Boulevard
Baton Rouge, LA 70816-6038

Celeste R. Peiffer
Secretary
5959 South Sherwood Forest Boulevard
Baton Rouge, LA 70816-6038

Thomas J. Dolan
Treasurer
5959 South Sherwood Forest Boulevard
Baton Rouge, LA 70816-6038



Gusti McGee
Director, Regulatory
5959 South Sherwood Forest Boulevard
Baton Rouge, LA 70816-6038



Robin L. Kinard
Administrator
2121 Boundary Street, Suite 200
Beaufort, SC 29902-6812

[b] As listed in **Sections V or VI**, have any directors, officers, agents, or managing employees of the disclosing entity (provider) ever been convicted of a criminal offense related to their involvement in such program established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)? ☐ Yes ☒ No

Name	Address	SSN/FEIN

VIII. Instructions / Definitions: Sanctions and other adverse actions include any revocation or suspension of a license to provide health care by any State licensing authority; any revocation or suspension of accreditation; and/or any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

VIII. Sanctions and Other Adverse Actions

Has your organization, under any current or former name or business identity, or any individuals and organizations listed in **Sections II, III, V, or VI,** ever had a final adverse action imposed against it? If yes, report the individual(s) or organization(s) involved, each final adverse action, when it occurred, and the Federal or State agency or the court/administrative body that imposed the action. ☐ Yes ☒ No

Individual/Organization	Adverse Action	Date	Taken by

IX. Instructions/ Definitions: Changes in provider status are defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership, including changes in any partnership arrangement, or any changes of ownership.

IX. Changes in Provider Status

If there has been a change in ownership /partnership within the last year or if you anticipate a change, indicate the date in the appropriate space. If there are no owners (i.e., the provider is a sole proprietorship), check Not Applicable.

[a] Has there been a change in ownership or controlling interest within the last year? If Yes, give date.
☐ Yes - Date: / / ☒ No ☐ Not Applicable

X. Instructions / Definitions: A chain affiliate is any free-standing health care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other devices, control and direction of a private, charitable or propriety. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

X. Chain Affiliation

[a]. Is this facility chain-affiliated? If Yes, list name, address and FEIN of parent Corporation below.
☒ Yes ☐ No

Name	Address	FEIN
Amedisys, Inc.	5959 South Sherwood Forest Boulevard Baton Rouge, LA 70816-6038	11-3131700

[b]. If the answer to part [a] of this item was "No", was the facility ever affiliated with a chain? If Yes, list name, address and FEIN of parent Corporation.
☐ Yes ☐ No

Name	Address	FEIN

Certification Statement

You MUST sign and date the certification statement below in order to be enrolled in the Medicaid program. In doing so, you are attesting to meeting and maintaining the Medicaid requirements stated below.

I, the undersigned, certify to the following:

1. I have read the contents of this form, and the information contained herein is true, correct, and complete. If I become aware that any information listed on this form is not true, correct, or complete, I agree to notify Medicaid of this fact within thirty-five (35) days of discovery.

2. I authorize Medicaid to verify the information contained herein. I agree to notify Medicaid of a change in ownership, practice location and/or Final Adverse Action within 35 days of the reportable event. In addition, I agree to notify Medicaid of any other changes to the information on this form within 35 days of the effective date of change. I understand that any change in business structure of this provider may require the submission of a new application.

3. I understand that any deliberate omission, misrepresentation, or falsification of any information contained on this form or contained in any communication supplying information to Medicaid, or any deliberate alteration of any text on this form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicaid billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.

4. I agree to abide by the Medicaid laws, regulations and program instructions that apply to me or to the organization. The Medicaid laws, regulations, and program instructions are available through SCDHHS. I understand that payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, and on the provider's compliance with all applicable conditions of participation in Medicaid.

5. Neither I, nor any managing employee listed on this form, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicaid or other Federal program beneficiaries.

6. I agree that any existing or future overpayment made to me or to the organization(s) listed on this form, by the Medicaid program, may be recouped by Medicaid through the withholding of future payments.

7. I understand that the Medicaid identification number issued to me can only be used by me or by a provider to whom I have reassigned my benefits under current Medicaid regulations, when billing for services rendered by me.

8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

Name of Authorized Representative (Printed or Typed):	Title:
Gusti McGee	Director, Regulatory
Signature: Gusti McGee	Date: 9/6/12

INSTRUCTIONS TO APPLICANTS FOR MEDICAID PROVIDER ENROLLMENT REGARDING REQUIRED DISCLOSURES
Part 1

1. If you are an individual practitioner or in a group of practitioners that is not organized as a business proprietorship, limited liability corporation, partnership, or corporation, whether it be for profit or not for profit, you are not required to complete Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please indicate if you are enrolling only as an individual practitioner and are exempt from these disclosure requirements.

☐ **Yes** ☒ **No**

By answering "Yes", you are enrolling as an individual only and therefore exempt from disclosure requirements as required by Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please complete all of Part 1. If "No" is checked, proceed to Part 2.

2. Provide the following information about yourself (individual practitioner only).
PLEASE NOTE: If you are not required to have a National Provider Identifier (NPI), please indicate "NA" in the NPI Field below.

*Full Name: First	M.I.	Last	Suffix	Title (MD, etc.)
*SSN:	*Date of Birth (mm/dd/ccyy): / /		*Gender:	
Provider Number: (If Known)	*NPI:	Email address:		
*Primary Practice Location Name and Address:		*Telephone Number:		
Name	Street Address	City	State	Zip + 4

Fields marked with an * must be completed.

3. Have you ever been convicted of a criminal offense in relation to Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP)? ☐ **Yes** ☐ **No**

If "Yes", list the charge(s), where convicted, the date, and disposition status of the conviction. (Attach additional page(s) if necessary.)

Charge(s)	City/State of Conviction	Conviction Date	Disposition Status
		/ /	
		/ /	

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE IN MEDICAID, OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF THE AGREEMENT OR CONTRACT WITH the SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (SCDHHS).

*Print or Type Full Name: _____

*Signature: _____ *Date: _____

Please send this page (Part 1) with your completed Medicaid enrollment application. Do not send Part 2 of the Disclosure form if you are exempt from Disclosure requirements. All other applicants for Medicaid enrollment must complete and submit only Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).