Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR §455.100-106 require providers to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to Managed Care Organizations that contract with a State Medicaid Agency or CHIP managed care network: 1) the identity of all owners with a control interest of 5% or greater; 2) certain business transactions as described in 42 CFR §455.105 and 3) the identity of any excluded individual with an ownership or control interest in the provider entity or who is an agent or managing employee of the provider entity. **Please attach a separate sheet** if **necessary.**

Completion and submission of this statement is a condition of participation in Medicaid programs. This statement will be renewed every three (3) years and/or at any time there is a revision to the information or upon a request for updated information.

Practice Group/Organization Name **Tax ID**

Does any person who has ownership or control interest in the provider, or is an agent or managing employee of the provider ever 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 these programs? ___ No ____Yes, if yes please list:

	Name
1.	
2.	
3.	

Managing Employee Section

Please provide the name, Social Security Number, & home addresses for any employee who meets the definition of Managing Employee*.

	Name	Social Security Number	Home Addresses
1.			
2.			
3.			

Ownership Section

Please provide the name, Social Security Number, & home addresses for **all** owners with 5% or more ownership or control interest in the entity. (See **42 CFR §455.104)**

	Name	Social Security Number	Home Addresses
1.			
2.			
3.			

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Managing employee is defined in **42 CFR §455.101** as 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.

I certify that the information provided herein is true, accurate and complete. Additions to or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate or incomplete data may result in denial of participation. Individuals and Sole Proprietors must sign their own form. An authorized representative may sign for Partnership, Corporation, LLC or Other disclosing entities.

_____ MD/DO

Provider Name

_____

Signature

Title

_____ _____

Name (Please print)

Date