



Ownership and Control Disclosure Form

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 CFR455.101, 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, title XX 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. 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 document with the application; retain a copy for your files. Failure to provide this form and/or incomplete information will result in a delay in the credentialing process.

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 as incomplete.

1. Name, address, date of birth and social security number of each person with an ownership or controlling interest in the entity or any subcontractors in which the entity has or had direct or indirect ownership totaling five percent (5%) or more and whether any of these person(s) named is related to another as spouse, child or sibling.

Name	DOB	SSN
Address	Phone	Relationship
Name	DOB	SSN
Address	Phone	Relationship
Name	DOB	SSN
Address	Phone	Relationship

2. Name and address of any other entity in which a person with an ownership or controlling interest in the entity also has an ownership or controlling interest.

Name	DOB	SSN
Address	Phone	Relationship

Name	DOB	SSN
Address	Phone	Relationship

3. Name of any person, agent, managing employee, or any other person who has ownership or controlling interest equal to five percent (5%) or greater in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, title XX, other federal program, or other state Medicaid program.

Name	DOB	SSN
Address	Phone	Relationship
Name	DOB	SSN
Address	Phone	Relationship

I attest that the information provided is true and accurate to the best of my knowledge. I understand it is the provider's responsibility to notify PHP/PIC if there is a change in any information provided on this form (including name/address/staffing changes; criminal convictions; status, etc.).

Signature _____ Date _____