PROVIDER OWNERSHIP INTEREST AND/OR MANAGING CONTROL DISCLOSURE STATEMENT

SECTION I:

1. Agency Legal Business Name_____
2. Doing Business As (DBA) name if applicable_____
3. Address _____
4. Does any health care provider, participating or not participating in Medi-Cal, have an ownership or control interest in the entity?
    a. If none, check here ☐
    b. If yes, proceed with section II for EACH provider.

SECTION II:

5. Full name of Individual with Ownership Interest and/or Managing Control
    _____
6. Address_____
    a. For corporate entities, the address shall include a primary business address, every business location, and/or a P.O. Box address, as applicable.
7. Social Security Number_____
8. Date of birth_____
9. Driver license number or state-issued identification number (Attach a current and legible copy)_____
10. Tax identification number _____
11. What is the individual's relationship with the Entity
    a. ☐ 5% or greater owners
    b. ☐ Partner
    c. ☐ Managing employee
    d. ☐ Director/officer, title_____
    e. ☐ Other (specify)

12. Does the individual of any sub Contractor with whom Contractor's transactions totaling more than $25,000 during the 12-month period ending on the date of the request? Select
13. Does the individual have any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any subcontractor, during the 5-year period ending on the date of the request? Select
14. Has the individual been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs? Select

I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document and any attachments is true, accurate, and complete to the best of my knowledge and belief.

Printed legal name of individual_____

Signature of the individual_____ Date _____

Title of the individual_____