DISCLOSURE OF OWNERSHIP AND CONTROL—Completion is required by 42 CFR Part 455.104. MVP will follow applicable regulatory requirements associated with the disclosure of this information, up to and including termination of any contracts with entities found not to be in compliance with this requirement. Failure to fully respond or to provide accurate and detailed information can result in a delay in the processing of your application. {If additional space is needed, copy form; all entries must be on the form.}

SECTION 1:
Disclosing Entity / Applicant

Entity Name	
FEIN	**NPI (if exempt, leave blank)**

Ownership in Applicant (per 42 CFR, Part 455.104(b)(1)(i) – (Entities and/or Individuals)

Copy this page to report additional owners.

Name of Individual or Entity		Title (if individual)	Date of Birth (if individual) (MM/DD/YYYY)
Address (Home Address if Individual; Primary Address if Corporation) - Street			**City, State & Zip Code (9 digit)**
SSN (if individual)	**FEIN (if entity)**	**% of Ownership (if none, put 0%)**	**NPI or NY Medicaid ID (if none, write None)**

For Individuals Only: If you are related* to another person with an ownership or control interest in the Applicant, complete the following:

Name of other Owner: ____________________ **Relationship to other Owner (parent, child, sibling, spouse):** ____________________

____________________ ____________________

____________________ ____________________

For Corporations Only: Use the space below to report other business addresses (per 42CFR, Part 455.104(b)(1)(i)):

1)____________________ 2)____________________ 3)____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Name of Individual or Entity		Title (if individual)	Date of Birth (if individual) (MM/DD/YYYY)
Address (Home Address if Individual; Primary Address if Corporation) - Street			**City, State & Zip Code (9 digit)**
SSN (if individual)	**FEIN (if entity)**	**% of Ownership (if none, put 0%)**	**NPI or NY Medicaid ID (if none, write None)**

For Individuals Only: If you are related* to another person with an ownership or control interest in the Applicant, complete the following:

Name of other Owner: ____________________ **Relationship to other Owner (parent, child, sibling, spouse):** ____________________

____________________ ____________________

____________________ ____________________

For Corporations Only: Use the space below to report other business addresses (per 42CFR, Part 455.104(b)(1)(i)):

1)____________________ 2)____________________ 3)____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

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SECTION 2:

Ownership in Other Disclosing Entities (ODE) (per 42 CFR, Part 455.104(b)(3)) - (Complete if any identified in Section 1 has an ownership or control interest in ODE)

Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE

SECTION 3:

Ownership in Subcontractors If the Applicant has an ownership or control interest of 5% or more in a subcontractor and an Owner of the Applicant also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or control interest in one of these subcontractors, complete Section 4).

Owner's Name (from Section 1)	Subcontractor Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor Name	Tax Identification Number

SECTION 4:

Familial Relationship in Subcontractors (Complete if those identified in Section 3 have a *familial relationship with a person with ownership or control interest in one of the subcontractors identified in Section 3).
*parent, child, sibling, spouse

Owner's Name	Subcontractor's Name	Name & Familial Relationship
Owner's Name	Subcontractor's Name	Name & Familial Relationship

SECTION 5:

Managing Employees & Those with a Control Interest – Including, but not necessarily limited to, the following: Facility Administrator, all Members of the Board of Directors, Managing Employees, Compliance Officer, Laboratory Director, Supervising Pharmacist. Include familial relationship to the Applicant (spouse, parent, child, sibling), if any.

Name		Association Type (see instructions)
Home Address	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship
Name		Association Type (see instructions)
Home Address	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship
Name		Association Type (see instructions)
Home Address	City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship

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{If additional space is needed, copy form; all entries must be on the form}

Managing Employees & Those with a Control Interest – (continued)

Name		**Association Type (see instructions)**	
Home Address	**City & State**		**Zip Code (9 digit)**
SSN	**Date of Birth (MM/DD/YYYY)**	**Familial Relationship**	
Name		**Association Type (see instructions)**	
Home Address	**City & State**		**Zip Code (9 digit)**
SSN	**Date of Birth (MM/DD/YYYY)**	**Familial Relationship**	
Name		**Association Type (see instructions)**	
Home Address	**City & State**		**Zip Code (9 digit)**
SSN	**Date of Birth (MM/DD/YYYY)**	**Familial Relationship**	
Name		**Association Type (see instructions)**	
Home Address	**City & State**		**Zip Code (9 digit)**
SSN	**Date of Birth (MM/DD/YYYY)**	**Familial Relationship**	
Name		**Association Type (see instructions)**	
Home Address	**City & State**		**Zip Code (9 digit)**
SSN	**Date of Birth (MM/DD/YYYY)**	**Familial Relationship**	
Name		**Association Type (see instructions)**	
Home Address	**City & State**		**Zip Code (9 digit)**
SSN	**Date of Birth (MM/DD/YYYY)**	**Familial Relationship**	
Name		**Association Type (see instructions)**	
Home Address	**City & State**		**Zip Code (9 digit)**
SSN	**Date of Birth (MM/DD/YYYY)**	**Familial Relationship**	
Name		**Association Type (see instructions)**	
Home Address	**City & State**		**Zip Code (9 digit)**
SSN	**Date of Birth (MM/DD/YYYY)**	**Familial Relationship**	

SECTION 6:

Respond to these questions on behalf of:
1. the Applicant
2. all individuals and entities identified in Sections 1 & 5
3. any entity in which the Applicant has a 5% or more ownership

1. Have any of the individuals/entities (1, 2 and 3) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in New York or in any other State, Medicare, or any other governmental or private medical insurance program?

   ○ Yes ☐ No

2. Have any of the individuals/entities (1, 2 and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?

   ○ Yes ☐ No

3. Have any of the individuals/entities (1, 2 and 3) ever had their business or professional license or certification, or the license of an entity in which they had an ownership interest over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State?

   ○ Yes ☐ No

4. Is there currently pending any proceedings that could result in the above stated sanctions for the individuals/ entities (1, 2 and 3)?

   ○ Yes ☐ No

5. Has there been a change of ownership or control within the last 12 months to any of the entities (1, 2 and 3)?

   ○ Yes ☐ No

   If "Yes", provide:

   NY Medicaid ID or NPI ____________

   Date of Ownership Change _______________(MM/DD/YYYY)

6. Do you anticipate a change of ownership within the next 12 months to any of the above entities (1, 2 and 3)?

   ○ Yes ☐ No

   If "Yes", when do you anticipate the ownership change will occur:___________ (MM/DD/YYYY)

7. Is the Applicant operated by a management company, or leased in whole or part by another organization?

   ○ Yes ☐ No If Yes, give date of Change of Operations __________

8. Has there been a change in your lab director or supervising pharmacist within the past year?

   ○ Yes ☐ No ☐ Not Applicable

MVP Health Plan, Inc. is collecting this information per the New York State Department of Health Standard Clauses effective March 1, 2011, Section B, #9, which are part of your contract with MVP Health Plan, Inc.

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SECTION 7: SIGNATURE AND AFFIRMATION

By signing this form, the Applicant/Provider understands and agrees to the following with respect to Medicaid Managed Care/Family Health Plus/Child Health Plus participants:

- You agree to comply with the rules, regulations and official directives of the NYS DOH including, but not limited to, Part 504 of 18NYCRR which can be found on the Department of Health website at **www.health.ny.gov**
- Pursuant to 42 CFR, Part 455.105, you agree to disclose the following regarding business transactions within 35 days upon request of the NYS DOH or the Secretary of Health and Human Services.

  (1) Information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, and

  (2) Any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the 5-year period ending on the date of the request.
- You agree to abide by all applicable Federal and State laws as well as the rules and regulations of other New York State agencies.
- For those providers for whom the Mandatory Compliance Law applies (see **www.OMIG.ny.gov**) , the Provider has certified via the Office of the Medicaid Inspector General's website referenced above that the Provider and its affiliates have adopted, implemented and maintains an effective compliance program that meets the requirements of Social Services Law Section 363-D and 18NYCRR, Part 521.
- Unannounced site visits by Medicaid, CMS or their agents/designated contractors may be a condition of initial and continued enrollment. In addition, the provider and/or owners may be required to consent to criminal background checks, including fingerprinting.
- You agree to notify MVP immediately of any changes to information supplied on this form.

KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR, WHERE THE PROVIDER ALREADY PARTICIPATES, A TERMINATION OF ITS MVP PARTICIPATION AGREEMENT.

______________________________	______________________________
Print or Type the Name of the Person Signing Below	Title

If Applicant/Provider is a legal entity other than a person, the person signing this document on behalf of the Applicant/Provider warrants that he/she has legal authority to bind the Applicant/Provider. (Note: for Changes of Ownership, New Owner or Representative may sign.)

______________________________	______________________________
Signature of Applicant/Provider or Authorized Representative	Date (MM/DD/YYYY)

____

Name and Phone Number of Person Who Prepared Application

PLEASE RETURN COMPLETED FORM TO YOUR MVP CONTACT MANAGER.

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