MEDI-CAL DISCLOSURE STATEMENT

Every applicant or provider must complete and submit a current Medi-Cal Disclosure Statement (DHCS 6207) as part of a complete application package for enrollment, continued enrollment, or certification as a Medi-Cal provider.

Important:

- **FOR NEW APPLICANTS:** Failure to disclose complete and accurate information may result in a denial of enrollment and imposition of a three-year reapplication bar.
- **FOR CURRENTLY ENROLLED APPLICANTS:** Failure to disclose complete and accurate information may result in denial, deactivation of all business addresses and the imposition of a three-year reapplication bar. The Department is required to report the termination of your participation in the Medi-Cal Program to the Centers for Medicare & Medicaid Services and to other States' Medicaid and Children's Health Insurance Programs pursuant to United States Code, Title 42, Sections 1396a(kk)(6) and 1902(kk)(6) and the Code of Federal Regulations, Title 42, Section 1002.3(b).
- Submitting a complete and accurate Medi-Cal Disclosure Statement is required.
- Read ***all*** instructions when completing the Medi-Cal Disclosure Statement.
- Type or print clearly in ink.
- DO NOT USE staples on this form or on any attachments.
- If applicant/provider must make corrections, please line through, date, and initial in ink. Do not use correction fluid.
- Return this completed statement with the complete application package to the address listed on the application form.

Overall Authority: Code of Federal Regulations, Title 42, Part 455; California Code of Regulations, Title 22, Sections 51000–51451; Welfare and Institutions Code, Sections 14043–14043.75

TABLE OF CONTENTS

	GENERAL INSTRUCTIONS	**ii**
I.	**APPLICANT/PROVIDER INFORMATION**	**1**
II.	**UNINCORPORATED SOLE-PROPRIETOR OR INDIVIDUAL RENDERING PROVIDER ADDING TO A GROUP**	**5**
III.	**OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ENTITIES)**	**6**
IV.	**OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)**	**9**
V.	**SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS**	**13**
VI.	**INCONTINENCE SUPPLIES**	**18**
VII.	**PHARMACY APPLICANTS OR PROVIDERS**	**19**
VIII.	**DECLARATION AND SIGNATURE PAGE**	**20**

GENERAL INSTRUCTIONS FOR COMPLETING THE MEDI-CAL DISCLOSURE STATEMENT

- DO NOT USE staples on this form or on any attachments.
- Do not use a pencil, correction tape, white out, highlighter pen, etc. on this form.
- If you must correct an entry, the applicant or provider must initial and date the correction in ink.
- Do not leave any questions, boxes, lines, etc., blank. Check or write "N/A" if not applicable to you.
- To review the Title 22 provider enrollment regulations, please visit the Medi-Cal Website (www.medi-cal.ca.gov) and click the "Provider Enrollment" link. It is the responsibility of the applicant/provider to comply with all regulations pertaining to Medi-Cal.

Section I: Applicant/Provider Information

1. All applicants and providers must complete this Section unless they are eligible to use the "Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers" (DHCS 6216) or the "Medi-Cal Ordering/Referring/Prescribing Provider Application/Agreement/ Disclosure Statement for Physician and Nonphysician Practitioners" (DHCS 6219).
2. Rendering providers joining a group who are not eligible to use the "Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers" may leave parts E–H blank if part D is checked.
3. If applicant leases the location where services are being rendered or provided, please attach a copy of a current signed lease agreement.
4. In California, a domestic or foreign limited liability company is not permitted to render professional services, as defined in Corporations Code Sections 13401, subdivision (a) and 13401.3. **See California Corporations Code Section 17701.04(e).**

Section II: Unincorporated Sole-Proprietor or Individual Rendering Provider Adding to a Group

Disclosure of social security number is optional. *(See Privacy Statement on page 21)*

Section III: Ownership Interest and/or Managing Control Information (Entities)

1. To determine percentage of ownership, mortgage, deed of trust, note or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the applicant's or provider's assets, A's interest in the provider's assets equates to 6 percent and shall be reported pursuant to California Code of Regulations, Title 22, Section 51000.35. Conversely, if B owns 40 percent of a note secured by 10 percent of the applicant's or provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.
2. "Indirect ownership interest" means an ownership interest in any entity that has an ownership interest in the applicant or provider. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or provider. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the applicant or provider, A's interest equates to an 8 percent indirect ownership interest in the applicant or provider and shall be reported pursuant to California Code of Regulations, Title 22, Section 51000.35. Conversely, if B owns 80 percent of the stock of a corporation, which owns 5 percent of the stock of the applicant or provider, B's interest equates to a 4 percent indirect ownership interest in the applicant or provider and need not be reported.

3. "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the applicant or provider.
4. All entities with managing control of applicant/provider must be listed in this Section.
5. List the National Provider Identifier (NPI) of each listed corporation, unincorporated association, partnership, or similar entity having 5% or more (direct or indirect) ownership or control interest, or any partnership interest, in the applicant/provider identified in Section I.
6. Corporations with ownership or control interest in the applicant or provider must provide all corporate business addresses and the corporation Taxpayer Identification Number issued by the IRS. For verification, a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification) must be included.

Section IV: Ownership Interest and/or Managing Control Information (Individuals)

1. Refer to Section III instructions and definitions.
2. "Person with an ownership or control interest" means a person that:
   a. Has an ownership interest of 5 percent or more in an applicant or provider;
   b. Has an indirect ownership interest equal to 5 percent;
   c. Has a combination of direct and indirect ownership interest equal to 5 percent or more in an applicant or provider;
   d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or provider if that interest equals at least 5 percent of the value of the property or assets of the applicant or provider;
   e. Is an officer or director of an applicant or provider that is organized as a corporation;
   f. Is a partner in an applicant or provider that is organized as a partnership.
3. "Agent" means a person who has been delegated the authority to obligate or act on behalf of an applicant or provider.
4. "Managing employee" means 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 applicant or provider. **All managing employees must be included in this section.**
5. List the National Provider Identifier (NPI) of each individual with ownership or control interest or ***any*** partnership interest, in the applicant/provider identified in Section I. In addition, ***all*** officers of the corporation, directors, agents and managing employees of the applicant/provider must be reported in this section.
6. Disclosure of social security number is mandatory. *(See Privacy Statement on page 21)*

Section V: Subcontractor Information and Significant Business Transactions

1. "Subcontractor" means an individual, agency, or organization:
   a. To which an applicant or provider has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment, or supplies to its patients.
   b. With whom an applicant or provider has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Medi-Cal Program.
2. "Significant business transaction" means any business transaction or series of transactions that involve health care services, goods, supplies, or merchandise related to the provision of services to Medi-Cal beneficiaries that, during any one fiscal year, exceed the lesser of $25,000 or 5 percent of an applicant's or provider's total operating expenses.

3. "Wholly owned supplier" means a supplier whose total ownership interest is held by an applicant or provider or by a person, persons, or other entity with an ownership or control interest in an applicant or provider.

Section VI: Incontinence Supplies

1. Applicant or provider must check "Yes" or "No."
2. If "Yes," complete A–C.

Section VII: Pharmacy Applicants or Providers

All pharmacy applicants or providers must complete this Section.

Section VIII: Declaration and Signature Page

1. All applicants or providers must complete this Section.
2. Legal name of applicant/provider must match name listed on associated application package.
3. The signature must be an individual who is the sole proprietor, partner, corporate officer, or an official representative of a governmental entity or nonprofit organization who has the authority to legally bind the applicant or provider. **See Title 22, CCR Section 51000.30(a)(2)(B).**
4. An original signature is required. Stamped, faxed, and/or photocopied signatures are ***not*** acceptable.
5. Disclosure Statement must be notarized by a Notary Public except for those applicants and providers licensed pursuant to Business and Professions Code, Division 2, beginning with Section 500. For example: Physicians, Pharmacy providers, Chiropractors, Osteopaths, Certified Nurse Midwives and Nurse Practitioners do not need to notarize this form. Durable Medical Equipment (DME) providers, Prosthetics, Orthotics, Medical Transportation providers, etc., must notarize this form.

FOR MORE INFORMATION, PLEASE VISIT THE MEDI-CAL WEBSITE (WWW.MEDI-CAL.CA.GOV) AND CLICK THE "PROVIDER ENROLLMENT" LINK.

CLEAR PRINT

MEDI-CAL DISCLOSURE STATEMENT

Do not leave any questions, boxes, lines, etc., blank. Check or enter N/A if not applicable to you.

I. APPLICANT/PROVIDER INFORMATION

A. Legal name of applicant/provider as reported to the IRS

B. Legal name of applicant/provider as it appears on professional license
IF NOT APPLICABLE, CHECK THE BOX ☐ **N/A**

C. Existing provider number(s) (NPI) used at the address indicated in Item G below. ☐ **N/A**

D. If applying as a rendering provider to a provider group, check here ☐ and proceed to Part I. (marked with *asterisk on page 2)

E. Fictitious business name ☐ **N/A**

F. "Doing Business As" name ☐ **N/A**

G. Address where services are rendered or provided (number, street)	City	State	ZIP code (9-digit)

1. Does applicant/provider lease this location? ☐ Yes ☐ No
2. If YES, complete the following information regarding the Lessor and **enclose a copy of the current signed Lease Agreement**, including any sublease agreements entered into by the applicant provider at the business address on the Application.

a. Lessor name

b. Lessor address (number, street)	City	State	ZIP code (9-digit)

c. Lessor telephone number	d. Term of lease	e. Amount of lease

3. If no, does applicant/provider own this location? ☐ Yes ☐ No
4. If applicant/provider does not lease or own this location, explain below:

I. APPLICANT/PROVIDER INFORMATION *(Continued)*

H. Type of Entity *(must check one)*:

- ☐ General Partnership *(Enclose Partnership Agreement)*
- ☐ Limited Partnership *(Enclose Partnership Agreement)*
- ☐ Limited Liability Partnership *(Enclose Partnership Agreement)*
- ☐ Sole Proprietor (Unincorporated)
- ☐ Limited Liability Company State of formation: _____
- ☐ Governmental
- ☐ Corporation *(Enclose Articles of Incorporation and Statement of Information)* Corporate number: _____ State incorporated: _____
- ☐ Nonprofit:
  Check one:
  - ☐ Corporation
  - ☐ Unincorporated Association

  Check one:
  - ☐ Charitable
  - ☐ Religious
  - ☐ Other *(specify)*: _____

*I. List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid and ***all*** other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). ***Submit copies of all documents*** pertaining to the arrangements including terms and conditions. See California Code of Regulations, Title 22, Section 51000.50(a)(6). ☐ **N/A**

Fine/Debt	Agency	Date Issued	Date to be Paid in Full
$			
$			

J. List the name and address of all health care providers, participating or not participating in Medi-Cal, in which the applicant/provider, listed in Part A, also has an ownership or control interest. If none, check N/A. If additional space is needed, attach additional page (label "Additional Section I, Part J").
☐ **N/A**

1. Full legal name of health care provider

2. Address (number, street)	City	State	ZIP code (9-digit)

K. Respond to the following questions:

1. ***Within ten years of the date of this statement*****,** have you, the applicant/provider, been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No
   If yes, provide the date of the conviction (mm/dd/yyyy): _____
2. ***Within ten years of the date of this statement*****,** have you, the applicant/provider, been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No
   If yes, provide the date of the final judgment (mm/dd/yyyy): _____

Do not leave any questions, boxes, lines, etc., blank.

I. APPLICANT/PROVIDER INFORMATION *(Continued)*

3. ***Within ten years of the date of this statement*,** have you, the applicant/provider, entered into a settlement in lieu of conviction for fraud or abuse involving a government program? ☐ Yes ☐ No
   If yes, provide the date of the settlement (mm/dd/yyyy): _____
4. Do you, the applicant/provider, currently participate or have you ever participated as a provider in the Medi-Cal program or in another state's Medicaid program? ☐ Yes ☐ No
   If yes, provide the following information:

State	Name(s) (Legal and DBA)	NPI and/or Provider Number(s)

5. Have you, the applicant/provider, ***ever*** been suspended from a Medicare, Medicaid, or Medi-Cal program? ☐ Yes ☐ No
   If yes, attach verification of reinstatement and provide the following information:

Check Applicable Program	NPI and/or Provider Number(s)	Effective Date(s) of Suspension	Date(s) of Reinstatement(s), as applicable
☐ Medi-Cal ☐ Medicaid ☐ Medicare			
☐ Medi-Cal ☐ Medicaid ☐ Medicare			

6. Has the individual license, certificate, or other approval to provide health care of the applicant/provider ***ever*** been suspended or revoked? ☐ Yes ☐ No
   If yes, include copies of licensing authority's decision(s) and written confirmation(s) from them that your professional privileges have been restored and provide the following information:

Where Action(s) was Taken	Action(s) Taken	Effective Date(s) of Licensing Authority's Action(s)

Do not leave any questions, boxes, lines, etc., blank.

I. APPLICANT/PROVIDER INFORMATION *(Continued)*

7. Have you, the applicant/provider, ***ever*** lost or surrendered your license, certificate, or other approval to provide health care ***while a disciplinary hearing was pending***? ☐ Yes ☐ No
   If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

Where Action(s) was Taken	Action(s) Taken	Effective Date(s) of Licensing Authority's Action(s)

8. Has the license, certificate, or other approval to provide health care of the applicant/provider ***ever*** been disciplined by any licensing authority? ☐ Yes ☐ No
   If yes, include copies of licensing authority decision(s) including any terms and conditions for each decision and provide the following information:

Where Action(s) was Taken	Action(s) Taken	Effective Date(s) of Licensing Authority's Action(s)

- If you, the applicant/provider, are an unincorporated sole-proprietor or an individual rendering provider adding to a group, proceed to Section II.

OR

- If you, the applicant/provider, are a partnership, corporation, governmental entity, or nonprofit organization, proceed to Section III.

II. UNINCORPORATED SOLE-PROPRIETOR OR INDIVIDUAL RENDERING PROVIDER ADDING

A. Full legal name (Last) (Jr., Sr., etc.) (First) (Middle)

B. Residence address (number, street)	City	State	ZIP code (9-digit)

C. Social security number (*required*)

D. Date of birth

E. Driver's license number or state-issued identification number (*Attach a current and legible copy)*

- If you, the applicant/provider, are an unincorporated sole-proprietor, proceed to Section V.

OR

- If you, the applicant/provider, are a rendering provider adding to a group, proceed to Section VIII.

Do not leave any questions, boxes, lines, etc., blank.

III. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ENTITIES)

A. In the table below, list all corporations, unincorporated associations, partnerships, or similar entities having 5% or more (direct or indirect) ownership or control interest, or ***any*** partnership interest, in the applicant/provider identified in Section I. **Attach a separate Section III, Part B and C for each entity listed below.** Number of pages attached: ____

☐ Check here if this section does not apply and proceed to Section IV.

	Entity Legal Business Name	Percent (%) of Ownership or Control	NPI Number (If Applicable)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Do not leave any questions, boxes, lines, etc., blank.

III. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ENTITIES) *(Cont.)*

B. Entity with (Direct or Indirect) Ownership Interest and/or Managing Control – Identification Information.

1. Legal business name

2. Doing Business As (DBA) name *(if applicable)* ☐ N/A

3. Primary Business Address (number, street)	City	State	ZIP code (9-digit)

* If this entity is a corporation, attach a list of **ALL** business location addresses and P. O. Box addresses of the corporation.

4. If this entity is a corporation, list the Taxpayer Identification Number issued by the IRS and attach a legible copy of the IRS form.

5. Check all that apply:
   ☐ 5% or more ownership interest ☐ Managing control
   ☐ Partner ☐ Other (specify): _____

6. Effective date of ***ownership*** (mm/dd/yyyy)	7. Effective date of ***control*** (mm/dd/yyyy)

C. Respond to the following questions:

1. ***Within ten years from the date of this statement***, has this entity been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No
   If yes, provide the date of the conviction (mm/dd/yyyy): _____
2. ***Within ten years from the date of this statement***, has this entity been found liable for fraud or abuse involving any government program in any civil proceeding? ☐ Yes ☐ No
   If yes, provide the date of the final judgment (mm/dd/yyyy): _____
3. ***Within ten years from the date of this statement***, has this entity entered into a settlement in lieu of a conviction for fraud or abuse involving any government program? ☐ Yes ☐ No
   If yes, provide the date of the settlement (mm/dd/yyyy): _____

Do not leave any questions, boxes, lines, etc., blank.

III. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ENTITIES) *(Cont.)*

Name of entity listed in Section III, Part B, Item 1

4. Does this entity currently participate, or has this entity ever participated, as a provider in the Medi-Cal program or in another state's Medicaid program? If yes, provide the following information: ☐ Yes ☐ No

State	Name(s) (Legal and DBA)	NPI and/or Provider Number(s)

5. Has this entity ***ever*** been suspended from a Medicare, Medicaid, or Medi-Cal program? ☐ Yes ☐ No
If yes, attach verification of reinstatement and provide the following information:

Check Applicable Program	NPI and/or Provider Number(s)	Effective Date(s) of Suspension	Date(s) of Reinstatement(s), as applicable
☐ Medi-Cal ☐ Medicaid ☐ Medicare			
☐ Medi-Cal ☐ Medicaid ☐ Medicare			

6. List the name and address of all health care providers, participating or not participating in Medi-Cal, in which this entity also has an ownership or control interest. **If none, check here** ☐
If additional space is needed, attach additional page (label "Additional Section III, Part C, Item 6"). Number of pages attached: ____

a. Full legal name of health care provider (include any fictitious business names)

b. Address (number, street)	City	State	ZIP code (9-digit)

Do not leave any questions, boxes, lines, etc., blank.

IV. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

A. In the table below, list any individual that has 5% or more (direct or indirect) ownership or control interest or ***any*** partnership interest, in the applicant/provider identified in Section I. In addition, ***all*** officers of the corporation, directors, agents and managing employees of the applicant/provider must be reported in this section. **Attach a separate Section IV, Part B and C for each individual listed below.** Number of pages attached: ____

	Individual Name	Percent (%) of Ownership or Control	NPI Number (If Applicable)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Do not leave any questions, boxes, lines, etc., blank.

IV. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIV.) *(Continued)*

B. Identification Information – for Individuals with Ownership or Control Interest, Officers, Directors, Managing Employees, Partners and/or Agents of the Partnership, Group Association, Corporation, Institution or Entity.

1. Full legal name (Last) (Jr., Sr., etc.) (First) (Middle)

2. Residence address (number, street	City	State	ZIP code (9-digit)

3. Social security number (required)	4. Date of birth	5. Driver's license number or state-issued identification number (Attach a current and legible copy)

6. Is the above individual related to any individual listed in Section IV, Table A (Page 9)? If yes, check the appropriate box and list name of individual: ☐ Yes ☐ No

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other (explain): _____

Name of individual:

7. If the above individual is ***directly*** associated with the entity identified in Section I, what is the individual's relationship with the applicant/provider? Check all that apply.

☐ 5% or greater owner ☐ Partner ☐ Managing employee ☐ Agent

☐ Director/officer, title: ☐ Other (specify):

8. If the above individual is ***directly*** associated with an entity identified in Section III, indicate the name of that entity in the space below:

a. Legal business name of entity as listed in Section III, Part A

b. What is this individual's role with the entity reported in Section III? Check all that apply.

☐ 5% or greater owner ☐ Partner ☐ Managing employee ☐ Agent

☐ Director/officer, title: ☐ Other (specify):

C. Respond to the following questions:

1. ***Within ten years from the date of this statement***, has the above individual been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No
   If yes, provide the date of the conviction (mm/dd/yyyy): _____

2. ***Within ten years from the date of this statement***, has the above individual been found liable for fraud or abuse involving any government program in any civil proceeding? ☐ Yes ☐ No
   If yes, provide the date of the final judgment (mm/dd/yyyy): _____

Do not leave any questions, boxes, lines, etc., blank.

IV. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIV.) *(Continued)*

Name of individual listed in Section IV, Part B, Item 1: _____

3. ***Within ten years from the date of this statement***, has the above individual entered into a settlement in lieu of a conviction for fraud or abuse involving any government program? ☐ Yes ☐ No
   If yes, provide the date of the settlement (mm/dd/yyyy): _____

4. Does the above individual currently participate, or has he or she ever participated, as a provider in the Medi-Cal program or in another state's Medicaid program? If yes, provide the following information: ☐ Yes ☐ No

State	Name(s) (Legal and DBA)	NPI and/or Provider Number(s)

5. Has the above individual ***ever*** been suspended from a Medicare, Medicaid, or Medi-Cal program? If yes, attach verification of reinstatement and provide the following information: ☐ Yes ☐ No

Check Applicable Program	NPI and/or Provider Number(s)	Effective Date(s) of Suspension	Date(s) of Reinstatement(s), as applicable
☐ Medi-Cal ☐ Medicaid ☐ Medicare			
☐ Medi-Cal ☐ Medicaid ☐ Medicare			

6. Has the above individual's license, certificate, or other approval to provide health care ***ever*** been suspended or revoked? ☐ Yes ☐ No
   If yes, include copies of licensing authority's decision(s) and written confirmation from them that his or her professional privileges have been restored and provide the following information:

Where Action(s) was Taken	Action(s) Taken	Effective Date(s) of Licensing Authority's Action(s)

Do not leave any questions, boxes, lines, etc., blank.

IV. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIV.) *(Continued)*

Name of individual listed in Section IV, Part B, Item 1: _____

7. Has the above individual otherwise lost or surrendered his or her license, certificate, or other approval to provide health care while a disciplinary hearing was pending? ☐ Yes ☐ No
   If yes, attach a copy of the written confirmation from the licensing authority that his or her professional privileges have been restored and provide the following information:

Where Action(s) was Taken	Action(s) Taken	Effective Date(s) of Licensing Authority's Action(s)

8. Has the above individual's license, certificate, or other approval to provide health care ***ever*** been disciplined by any licensing authority? ☐ Yes ☐ No
   If yes, include copies of licensing authority decision(s) including any terms and conditions for each decision and provide the following information:

Where Action(s) was Taken	Action(s) Taken	Effective Date(s) of Licensing Authority's Action(s)

9. List the name and address of all health care providers, participating or not participating in Medi-Cal, in which the above individual also has an ownership or control interest.
   If none, check here ☐
   If additional space is needed, attach additional page (label "Additional Section IV, Part C, Item 9"). Number of pages attached: ____

a. Full legal name of health care provider (include any fictitious business names)

b. Address (number, street)	City	State	ZIP code (9-digit)

- Proceed to Section V.

Do not leave any questions, boxes, lines, etc., blank.

V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS

A. Does the applicant/provider (as named in Section I, Part A on Page One of this form) have direct or indirect ownership of 5 percent or more in any of its subcontractors that provide healthcare services or goods? ☐ Yes ☐ No

Do any of the entities named in Section III, Part A on Page Six of this form have direct or indirect ownership of 5 percent or more in any of the applicant provider's subcontractors that provide healthcare services or goods? ☐ Yes ☐ No

Do any of the individuals named in Section IV, Part A on Page Nine of this form have direct or indirect ownership of 5 percent or more in any of the applicant provider's subcontractors that provide healthcare services or goods? ☐ Yes ☐ No

If you answered NO to ALL of the above, please proceed to Section V, Part C on Page 15.

If you answered YES to ANY of the above, please complete the following information about the subcontractor and attach a copy of any written agreement(s) that you have with the subcontractor that relate to its functions/responsibilities.

1. Subcontractor's full legal name			2. Subcontractor's phone number
3. Subcontractor's address (number, street)	City	State	ZIP code (9-digit)
4. Subcontractor's federal employer identification number (if applicable)		5. Subcontractor's corporation number (if applicable)	

5. If there is more than one subcontractor, provide a separate sheet with all required information (label "Additional Section V, Part A").
☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

Do not leave any questions, boxes, lines, etc., blank.

V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS *(Cont.)*

B. List the following information for any person or entity, other than the applicant/provider, with 5 percent or more ownership and/or control interest in any **subcontractor** listed in Part A. If there is more than one subcontractor, provide a separate sheet with all required information (label "Additional Section V, Part B").

☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

Name of Subcontractor in Part A

1. Full legal name of person or entity with ownership or control interest in the Subcontractor			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

What is this individual's role with the subcontractor reported in Part A? Check all that apply.

☐ 5% or greater owner – Percent of ownership: ____ ☐ Partner ☐ Managing employee

☐ Director/officer, title: _____ ☐ Other (specify): _____

Is the above individual related to any individual listed in Section IV, Table A (Page 9)? ☐ Yes ☐ No

If yes, check the appropriate box and list the name of the related individual.

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other (explain): _____

Name of related individual:

2. Full legal name of person or entity with ownership or control interest in the Subcontractor			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

What is this individual's role with the subcontractor reported in Part A? Check all that apply.

☐ 5% or greater owner – Percent of ownership: ____ ☐ Partner ☐ Managing employee

☐ Director/officer, title: _____ ☐ Other (specify): _____

Is the above individual related to any individual listed in Section IV, Table A (Page 9)? ☐ Yes ☐ No

If yes, check the appropriate box and list the name of the related individual.

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other (explain): _____

Name of related individual:

Do not leave any questions, boxes, lines, etc., blank.

V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS *(Cont.)*

Name of Subcontractor in Part A

3. Full legal name of person or entity with ownership or control interest in the Subcontractor			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

What is this individual's role with the subcontractor reported in Part A? Check all that apply.
☐ 5% or greater owner – Percent of ownership: ____ ☐ Partner ☐ Managing employee
☐ Director/officer, title: _____ ☐ Other (specify): _____

Is the above individual related to any individual listed in Section IV, Table A (Page 9)? ☐ Yes ☐ No
If yes, check the appropriate box and list the name of the related individual.

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other (explain): _____

Name of related individual:

4. Full legal name of person or entity with ownership or control interest in the Subcontractor			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

What is this individual's role with the subcontractor reported in Part A? Check all that apply.
☐ 5% or greater owner – Percent of ownership: ____ ☐ Partner ☐ Managing employee
☐ Director/officer, title: _____ ☐ Other (specify): _____

Is the above individual related to any individual listed in Section IV, Table A (Page 9)? ☐ Yes ☐ No
If yes, check the appropriate box and list the name of the related individual.

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other (explain): _____

Name of related individual:

C. Has the applicant/provider had any significant business transactions with any wholly owned supplier or with any subcontractor (not listed on Part A) during the 5-year period immediately preceding the date of this Application? ☐ Yes ☐ No

"Significant business transaction" means any business transaction or series of transactions that involve health care services, goods, supplies, or merchandise related to the provision of services to Medi-Cal beneficiaries that, during any one fiscal year, exceed the lesser of $25,000 or 5 percent of an applicant's or provider's total operating expenses.

"Wholly owned supplier" means a supplier whose total ownership interest is held by an applicant or provider or by a person, persons, or other entity with an ownership or control interest in an applicant or provider.

Do not leave any questions, boxes, lines, etc., blank.

V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS *(Cont.)*

"Subcontractor" means an individual, agency, or organization: (a) To which an applicant or provider has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment or supplies to its patients. (b) With whom an applicant or provider has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Medi-Cal Program.

If **No**, please proceed to Section V, Part D.

If **Yes**, complete the following information about the supplier or subcontractor:

1. Subcontractor's or supplier's full legal name			2. Subcontractor's or supplier's phone number
3. Subcontractor's or supplier's address (number, street)	City	State	ZIP code (9-digit)

4. Describe the transaction(s):

If there is more than one subcontractor or supplier, provide a separate sheet with all required information (label "Additional Section V, Part C").

☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

D. List the name and address of each person(s) with an **ownership or control interest** in any subcontractor (listed in Part C) with whom the applicant or provider has had business transaction involving health care services, goods, supplies or merchandise related to the provision of services to a Medi-Cal beneficiary that total more than $25,000 during the 12-month period immediately preceding the date of the Application, or immediately preceding the date on the Department's request for such information. If there is more than one subcontractor, provide a separate sheet with all required information. (label "Additional Section V, Part D").

☐ Check here if no subcontractors listed in Part C or applicant/provider has had no business transactions with subcontractors involving health care services, goods, supplies or merchandise related to the provision of services to a Medi-Cal beneficiary that total more than $25,000 during the 12-month period immediately preceding the date of the Application, or immediately preceding the date on the Department's request for such information. **Proceed to Section VI**.

☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

Name of Subcontractor in Part C

1. Full legal name of person or entity with ownership or control interest			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS *(Cont.)*

Name of Subcontractor in Part C

2. Full legal name of person or entity with ownership or control interest			Phone number
Address (number, street)	City	State	ZIP code (9-digit)
3. Full legal name of person or entity with ownership or control interest			Phone number
Address (number, street)	City	State	ZIP code (9-digit)
4. Full legal name of person or entity with ownership or control interest			Phone number
Address (number, street)	City	State	ZIP code (9-digit)

- Proceed to Section VI.

VI. INCONTINENCE SUPPLIES

Does the applicant/provider intend to sell or currently sell incontinence medical supplies? ☐ Yes ☐ No

If No, Pharmacy applicants/providers proceed to Section VII. All other applicants/providers proceed to Section VIII.

If Yes, provide the following information:

A. List the names and addresses of all current sources of capital, as defined in CCR, Title 22, Section 51000.5.

If there is more than one source of capital, provide a separate sheet with all required information (label "Additional Section VI, Part A").

☐ N/A

☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

Full legal name of person or entity with ownership or control interest

Address (number, street)	City	State	ZIP code (9-digit)

B. List all manufacturers, suppliers, and other providers with whom the applicant/provider has any type of business relationship relative to the goods and services provided to Medi-Cal beneficiaries.

If there is more than one, provide a separate sheet with all required information (label "Additional Section VI, Part B").

☐ N/A

☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

Full legal name of person or entity with ownership or control interest

Address (number, street)	City	State	ZIP code (9-digit)

C. List all persons or entities to which the applicant/provider has extended a line of credit, as defined in CCR, Title 22, Section 51000.10, of $5,000 or more.

If there is more than one, provide a separate sheet with all required information (label "Additional Section VI, Part C").

☐ N/A

☐ Check here if additional sheet(s) is attached. Number of pages attached: ____

Full legal name of person or entity

Address (number, street)	City	State	ZIP code (9-digit)

- Pharmacy applicants/providers proceed to Section VII.
- All other applicants/providers proceed to Section VIII.

Do not leave any questions, boxes, lines, etc., blank.

VII. PHARMACY APPLICANTS OR PROVIDERS

A. Has the individual license, certificate, or other approval to provide health care, of the ***Pharmacist-in-Charge***, ever been suspended or revoked? ☐ Yes ☐ No

If yes, include copies of licensing authority decision(s) and written confirmation from them that his or her professional privileges have been restored and provide the following information:

Where Action(s) was Taken	Action(s) Taken	Effective Date(s) of Licensing Authority's Action(s)

B. Has the individual license, certificate, or other approval to provide health care, of the ***Pharmacist-in-Charge***, ever been lost, or surrendered while a disciplinary hearing on his or her license was pending? ☐ Yes ☐ No

If yes, attach a copy of the written confirmation from the licensing authority that professional privileges have been restored and provide the following information:

Where Action(s) was Taken	Action(s) Taken	Effective Date(s) of Licensing Authority's Action(s)

C. Has any licensing authority ever disciplined the Board of Pharmacy License of the ***Pharmacist-in-Charge***? ☐ Yes ☐ No

If yes, include copies of licensing authority decision(s) including any terms and conditions and provide the following information:

Where Action(s) was Taken	Action(s) Taken	Effective Date(s) of Licensing Authority's Action(s)

- Proceed to Section VIII.

Do not leave any questions, boxes, lines, etc., blank.

VIII. DECLARATION AND SIGNATURE PAGE

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.

I declare that I have the authority to legally bind the applicant or provider pursuant to Title 22, CCR Section 51000.30(a)(2)(B).

1. Printed legal name of applicant/provider

2. Printed name of person signing this declaration with authority to legally bind the applicant or provider (if an entity or business name is listed in Item above)

3. Original signature of the applicant, provider or the person with authority to legally bind the applicant or provider (in ink)

4. Title of person signing this declaration

5. Executed at: _____, _____ on _____
   (City) (State) (Date)

6. Notary Public:

   Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ***ARE NOT REQUIRED*** to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

Do not leave any questions, boxes, lines, etc., blank.

PRIVACY STATEMENT
(Civil Code Section 1798 et seq.)

All information requested on the Application, the disclosure statement, and the provider agreement is mandatory. This information is required by the California Department of Health Care Services and any other California State Departments that are delegated responsibility to administer the Medi-Cal program, by the authority of the Welfare and Institutions Code, Sections 14043 - 14043.75, the California Code of Regulations,Title 22, Sections 51000 – 51451 and the Code of Federal Regulations, Title 42, Part 455. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Some or all of this information may also be provided to the California State Controller's Office, the California Department of Justice, the California Department of Consumer Affairs, the California Department of Corporations, the California Franchise Tax Board or other California state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or as required or permitted by law. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945.

Do not leave any questions, boxes, lines, etc., blank.