Los Angeles County Department of Mental Health

OWNERSHIP/CONTROLLING INTEREST DISCLOSURE

Completion of this form is mandated by the Centers for Medicare and Medicaid Services, Department of Health and Human Services and applicable regulation as found at 42 CFR 455.101 and 42. CFR 455.104. Disclosure must be made at the time of enrollment or contracting with Los Angeles County Department of Mental Health, at the time of survey, or within 35 days of a written request from Los Angeles County Department of Mental Health. It is the provider's responsibility to ensure all information is accurate and to report any changes as required by law by completing a new Ownership/Controlling Interest Disclosure form. Please add additional disclosures on the back of form.

Part 1. Applicant/Vendor Information

Name of Entity (Legal name as it appears on tax identification form)	Provider # (if currently enrolled in CA Medicaid	NPI Number

Doing Business As	Street Address	City	State	Zip Code

Telephone Number	Fax Number	E-mail Address

Part 2. Ownership, indirect ownership, and managing employee interests

☐ **If Non-Profit Organization, Please check this Box**

Does any person have an ownership or controlling interest of 5% or more in the entity?

☐ **NO (If No, please sign below)** ☐ **YES (If yes, please completed A, B, C, D and sign below)**

A. Lists the name, address, Federal Employer Identification Number (FEIN) or Social Security Number (SSN), Date of Birth (DOB) and percentage of interest of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. Add additional disclosures on back of form.

Name Add Name Delete Name	Street Address	City	State	Zip Code	FEIN/SSN	DOB	% Interest

B. Are any of the above mentioned persons related to one another as a spouse, parent, child, or sibling? Add additional disclosures on back of form.

☐ **No** ☐ **Yes (If yes, please complete below)**

Name Add Name Delete Name	FEIN/SSN	DOB	Name of Person Related To	Relationship

C. List any person who holds a position of managing employee within the disclosing entity. Add additional disclosures on back of form.

Name	FEIN/SSN	DOB	Position Title

D. Does any person, business, organization or corporation with an ownership or control interest (identified in A and/or B) have an ownership or controlling interest of 5% or more in any other California Medicaid Provider? Add additional disclosures on back of form.

☐ **No** (if No, please sign below) ☐ **Yes** (If yes, please name and show information)

Name	Other Provider Name	FEIN/SSN	DOB	% Interest

Provider Statement

I certify that information provided on this form is true, accurate and complete. I will notify Los Angeles County Department of Mental Health in writing within 35 days of any additions/changes to the information.

_____ _____ _____

Signature of Provider/Authorized Representative/Agent **Title** **Date**

(Stamped signatures NOT accepted)

_____ _____

Print Name **Telephone Number**

ADDENDUM

Los Angeles County Department of Mental Health

OWNERSHIP/CONTROLLING INTEREST DISCLOSURE

ADDENDUM INFORMATION FOR ADDITIONAL OWNERSHIP/CONTROLLING DISCLOSURE

OWNERSHIP, INDIRECT OWNERSHIP, AND MANAGING EMPLOYEE INTEREST

PLEASE COMPLETE A, B, C, D AND SIGN BELOW **Continued from Page 1.**

A. Lists the name, address, Federal Employer Identification Number (FEIN) or Social Security Number (SSN), Date of Birth (DOB) and percentage of interest of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.

Name Add Name Delete Name	Street Address	City	State	Zip Code	FEIN/SSN	DOB	% Interest

B. Are any of the above mentioned persons related to one another as a spouse, parent, child, or sibling? **Continued from Page 1.**

☐ **No** ☐ **Yes (If yes, please complete below)**

Name Add Name Delete Name	FEIN/SSN	DOB	Name of Person Related To	Relationship

C. List any person who holds a position of managing employee within the disclosing entity. **Continued from Page 1.**

Name	FEIN/SSN	DOB	Position Title

D. Does any person, business, organization or corporation with an ownership or control interest (identified in A and/or B) have an ownership or controlling interest of 5% or more in any other California Medicaid Provider? **Continued from Page 1.**

☐ **No** (if No, please sign below) ☐ **Yes** (If yes, please name and show information)

Name	Other Provider Name	FEIN/SSN	DOB	% Interest

Provider Statement

I certify that information provided on this form is true, accurate and complete. I will notify Los Angeles County Department of Mental Health in writing within 35 days of any additions/changes to the information.

_____ _____ _____

Signature of Provider/Authorized Representative/Agent **Title** **Date**

(Stamped signatures NOT accepted)

_____ _____

Print Name **Telephone Number**