



DISCLOSURE OF OWNERSHIP/CONTROL AND CRIMINAL OFFENSES STATEMENTS

Item I. Identifying Information					
(a) Name of Individual, Facility or Organization: _____					
(b) DBA Name: _____					
(c) Federal Tax Identification Number (TIN) or Social Security Number (SSN): _____					
(d) Check the entity type that best describes the structure of the enrolling provider entity. Check only one box.					
<input type="checkbox"/> For-Profit Corporation <input type="checkbox"/> Non-Profit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Government Owned <input type="checkbox"/> Sole Proprietorship					
(e) Is this entity chain affiliated? <input type="checkbox"/> No <input type="checkbox"/> Yes					
<p>As required by 42 CFR Part 455, Subpart B which implements Section 1124, 1126, 1902(a) (38), 1903(l) (2) and 1903(n) of the Social Security Act and sets forth State Plan requirements regarding Full Disclosure of Ownership and Control and Related Party Transactions, the following information must be submitted to AHCCCS prior to registration and upon each renewal of certification or licensure in order to participate as an AHCCCS provider.</p> <p>AHCCCS may refuse to enter into or renew an agreement with a provider if the provider fails to disclose ownership and control interest information, information related to business transactions and information on persons convicted of crimes, or if the provider did not fully and accurately make the disclosures as required.</p>					
Item II. Ownership and Control Interest Information <i>(Reference-42CFR, Part 455.104 and SSA 1124)</i>					
(a) List the name, title, address, and SSN for each officer and/or individual who has direct or indirect ownership or control interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. List the name, TIN, and address of any organization, corporation, or entity having direct or indirect ownership or control interest, separately or in combination, amounting to an ownership interest of 5% or more in the provider entity. Attach additional pages as necessary to list all officers, owners, management and ownership entities.					
Name	Title	Address	SSN/TIN	Date of Birth	Percentage
(b) List the name, title, address and SSN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more.					
Name	Title	Address	SSN	Percentage	
(c) List those persons named in Item II (a),(b) that are related to each other (spouse, parent, child, or sibling).					
Name	Relationship	SSN	Date of Birth		
(d) List the name, address and TIN of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has ownership or control interest of at least 5% or more.					
Name	Address	TIN	Percentage		



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Item III. Criminal Offenses <i>(Reference-42CFR, Part 455.106 and SSA 1124)</i>			
(a) List the name, title, SSN and address of each officer and/or individual who has ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XXI services program since the inception of those programs.			
Name	Title	Address	SSN (or TIN in organization)
(b) List the name, title, SSN and address of any individual who has an ownership or control interest in the disclosing entity and has been suspended or debarred from participation in Medicare, Medicaid or Title XXI program at any time since the inception of those programs.			
Name	Title	Address	SSN
Item IV. Board of Directors			
List the name, title and address of each member of the Board of Directors of the disclosing entity.			
Name	Title	Address	
I affirm under penalty of law that the information I have provided for this form is true, accurate and complete to the best of my knowledge.			
_____		_____	
Print Name of Authorized Representative		Title	
_____		_____	
Signature of Authorized Representative		Date	

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