BHRS FORM 700- Provider or Fiscal Agent
Disclosure of Ownership and Control Statement

PRIVACY ACT STATEMENT: THIS PROVIDES INFORMATION AS REQUIRED BY THE PRIVACY ACT OF 1974.
The primary use of the Disclosure of Ownership and Controlling Interest Form is to meet federal requirements for the screening of entities wishing to participate in the Medicaid program. Accurate completion of this form is a requirement of receiving or renewing a San Mateo County Behavioral Health & Recovery Services (BHRS) provider agreement and receiving reimbursement from any BHRS program.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date. If additional space is needed, please attach additional sheets and reference the item number that you're continuing on another sheet.

Please read the definitions in each section carefully to ensure correct completion of this form. More detailed information can be found in the Code of Federal Regulations, Title 42, Subpart B – Disclosure of Information by Providers and Fiscal Agents, Sections 455.100 through 455.106.

Throughout this document, "**Entity**" means the organization, institution, business, or agency that is requesting a BHRS provider agreement in the application of which this Disclosure is a part. The "**Entity**" may also be a fiscal agent or managed care organization.

Government-Owned Entities: If the Entity is owned by a unit of government, for example, a state agency or university or college, county health department, or public school, only Part 1 of this disclosure must be completed.

All other entities, non-profit or for-profit, must complete all parts of this form.

SOCIAL SECURITY NUMBERS

BHRS understands that individuals and entities may have concerns about supplying Social Security numbers (SSNs). Collection of SSNs is required by federal regulations as a critical part of the Medicaid provider screening process to prevent fraud and misuse of taxpayer funds. SSNs are handled by a limited number of enrollment staff who are trained to keep the information confidential. Our treatment of SSNs is akin to our treatment of member and provider identification numbers which are not disclosed to the public. BHRS's computer system is highly secure and meets HIPAA requirements for the handling of personal health information. BHRS conducts regular security tests and audits of the system. In addition, only a limited number of BHRS staff can view SSNs in the system.

Failure to submit Social Security numbers means that BHRS must decline to contract with the Entity and/or terminate existing contracts.

PART 1: ENTITY INFORMATION

(a) Name of Entity: _____

(b) DBA Name if any:
_____

(c) Federal Tax Identification Number (TIN) OR: _____

(d) Check the type that best describes the structure of the Entity. Check **only one** box.

☐ For-Profit Corporation ☐ Non-Profit Corporation ☐ Partnership ☐ Government Owned ☐ LLC

PART 2: PERSONS WITH AN OWNERSHIP OR CONTROL INTEREST

"Person with an ownership or control interest" means a person or corporation that:

(a) Owns 5% or more of the Entity
(b) Indirectly owns 5% of more of the Entity (for example, a person who owns 10% of a corporation that owns 50% of the Entity)
(c) Has a combination of direct and indirect ownership interests totaling 5% or more in the Entity
(d) Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Entity if that interest equals at least 5 % of the value of the property or assets of the Entity
(e) If the Entity is organized as a corporation, is an officer or director of that corporation
(f) If the Entity is organized as a partnership, is a general or limited partner in the Entity.

If this Entity has corporate owners, be sure to list the owning corporation below, as well as any individuals whose ownership in the owning corporation would give them an indirect ownership in the Entity of more than 5%. (For example, if the Entity is "Good Hospital" and it's 50% owned by "Great Corporation", list "Great Corporation" in Part 2, and also list any individual or corporation that owns 10% or more of "Great Corporation" because that person would have a 5% or greater indirect ownership of Good Hospital.

If you list any corporations below, you must include as applicable: the primary business address; the address of every business location and any P.O. Box addresses.

If you need more information about direct and indirect ownership or calculating percentage interests, please see the Code of Federal Regulations site above.

You must list ALL direct and indirect owners that meet the 5% test in in (a),(b), (c) or (d) above.

You must list ALL corporate officers and directors and all general and limited partners regardless of whether they meet the 5% test.

Attach additional sheets of paper as necessary and note on the sheet that it's a continuation of Part 2.

PERSONS WITH AN OWNERSHIP OR CONTROL INTEREST, INCLUDING ALL GENERAL AND LIMITED PARTNERS, AND ALL CORPORATE OFFICERS AND DIRECTORS

Name	Address	SSN/TIN	Date of Birth	Type of Interest (a-f above)

PART 3: OWNER/CONTROL RELATIONSHIPS

List those persons named in Part 2 that are related to each other (spouse, parent, child, or sibling). You only have to list each relationship pair once. For example, if you've listed John Smith and Mary Smith as owners, just list John Smith related to Mary Smith as husband. You don't need to also list Mary Smith related to John Smith as wife.

Name	Related to:	Relationship

PART 4: SUBCONTRACTORS

"Subcontractor" means an individual, agency, or organization to which the Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients;

For fiscal agents only: A "subcontractor" also means an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

If the Entity has a 5% or more interest in any Subcontractor, list the information below for each Person with an ownership or controlling interest" (see definition in Part 2) in the Subcontractor

Name	Address	SSN/TIN	Date of Birth	Type of Interest (a-f above)

PART 5: SUBCONTRACTOR RELATIONSHIPS

List any persons named in Part 2 that is related to a person listed in Part 4 as spouse, parent, child or sibling. You only have to list each relationship pair once. For example, if you've listed John Smith in Part 2 and Mary Smith in Part 4, just list John Smith related to Mary Smith as husband. You don't need to also list Mary Smith related to John Smith as wife.

Name	Related to:	Relationship

PART 6: OTHER DISCLOSING ENTITIES

"**Other Disclosing Entity**" means:

(a) an organization, agency or business that is a Medicaid provider or a Medicaid fiscal agent, OR
(b) any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare, OR
(c) any Medicare intermediary or carrier, OR
(d) any other entity (other than an individual practitioner or group or practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Social Security Act.

List the information below for any person listed in Part 2 who is also a "Person With an Ownership or Control Interest" (as defined in Part 2) for any Other Disclosing Entity.

Person or Corp. Name (from Part 2)	Other Disclosing Entity Name and Address

PART 7: MANAGING EMPLOYEES

"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 the Entity.

List the information below for all Managing Employees of the Entity.

Name	Address	SSN/TIN	Date of Birth

PART 8: CRIMINAL CONVICTIONS

"**Agent**" means any person who has been delegated the authority to obligate or act on behalf of the Entity.

List the information below for anyone who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of the program AND is listed in Parts 2 or 7 or is an Agent of the Entity.

Name	Address	SSN/TIN	Date of Birth

PART 9: VERIFICATION

I have used all resaonable diligence in preparing this statement. I have reviewed this statement and to the best of my knowledge the information contained herein and in any attached pages is true and complete. I acknowledge this is a public document.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date Signed:_____ Signature:_____

(month/day/year) *(Print and sign form, submit to BHRS)*