B.7.35 **Disclosure Statement Of Ownership And Control Interest, Related Business Transactions and Persons Convicted of a Crime**

This form shall be submitted to the DMAHS annually and upon request. For definitions, procedures and requirements refer to 42 CFR 455.100-106 (copy attached).

Attach Separate Sheets

I. Identifying Information of Disclosing Entity (HMO)

Name of Disclosing Entity (HMO) and D/B/A:				
Street Address:	City:	County:	State:	Zip Code:
Telephone No:		Medicaid Provider No:		

II. Ownership and Control Interest

A. Please list the information required by subsections 7.35.A.1 and 2 of the Contract:

1.

Name:	Relationship:	
	Percent of Ownership:	
Primary Address:	Date of Birth: *(For Individuals)*	
	SSN: *(For Individuals)*	
PO Box Address: *(For Corporations)*		
IRS ID/Other Tax ID: *(For Corporations)*		
All business location addresses: *(For Corporations)*		
Relationship to other persons with ownership or control interest as required by 7.35.A.2. List all.		

2.

Name:	Relationship:	
	Percent of Ownership:	
Primary Address:	Date of Birth: *(For Individuals)*	
	SSN: *(For Individuals)*	
PO Box Address: *(For Corporations)*		
IRS ID/Other Tax ID: *(For Corporations)*		

All business location addresses: *(For Corporations)*
Relationship to other persons with ownership or control interest as required by 7.35.A.2. List all.

3.

Name:	Relationship:	
	Percent of Ownership:	
Primary Address:	Date of Birth: *(For Individuals)*	
	SSN: *(For Individuals)*	

PO Box Address: *(For Corporations)*
IRS ID/Other Tax ID: *(For Corporations)*
All business location addresses: *(For Corporations)*
Relationship to other persons with ownership or control interest as required by 7.35.A.2. List all.

III. Disclosure by Contractor: Information related to business transactions.

Provide ownership information of

(1) Any subcontractor with whom the Contractor 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 Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

Name	Address	Ownership

Disclose information on types of transactions with a "party in interest" as defined in Section 1318(b) of the Public Health Service Act (Section 1903(m)(4)(A) of the Social Security Act).

Name of party in interest	Description of Transaction	Accrued $ Value	Justification

IV. Disclosure of Information on persons convicted of crimes.

Identity of any person who has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs.

Are there any directors, officers, agents, or managing employees of the Contractor who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, XX or XXI?

☐ **If Yes, list names and addresses of individuals or corporations.**

Name	Address	DOB and SSN, or TIN

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this Disclosure Statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the state agency or the secretary, as appropriate.

Name of Authorized Representative (Typed), Title and HMO

Signature **Date**

If applicable, provide your Office Roster.

Office Name	Address

Submit Form