CalOptima Health
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OWNERSHIP AND DISCLOSURE FORM

Completing and submitting the Ownership and Disclosure Form is a condition of participating in the CalOptima Health network. Failure to submit the requested information may result in the denial of entering into a provider contract or the termination of a current one.

Purpose:

Pursuant to Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006, Medi-Cal managed care plans, such as CalOptima Health, must comply with the ownership and control disclosure requirements as set forth in 42 Code of Federal Regulations (CFR) § 455.104 by collecting information on whether their subcontractors are persons with ownership or control controlling interests or managing employees. The provider will complete and return this form in accordance with CalOptima Health's instructions prior to the contract effective date. The provider will also submit updates to this form to CalOptima Health within 30 days of any change.

Types of providers required to complete the Ownership and Disclosure Form:
Providers that apply as a partnership, corporation, governmental entity or nonprofit organization must disclose ownership or control information as required by Title 42 of the CFR, Section 455.104. Examples include, but are not limited to, hospitals, nursing homes, community mental health centers, managed care organizations and fiscal agents.

Types of providers exempt from completing the Ownership and Disclosure Form:
Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information described in Title 42 of the CFR Section 455.104. Examples include solo practitioners, a group of individual practitioners, or those entirely state or federally funded.

Definitions as outlined in 42 CFR 455.101:

1. **Control Interest** (person with an ownership or control interest): A person or corporation that has an ownership interest totaling 5 percent or more in a disclosing entity.
2. **Disclosing Entity:** A provider (other than an unincorporated solo proprietor, group of individual practitioners, or those entirely state or federally funded) or fiscal agent.
3. **Fiscal Agent:** A contractor who processes or pays vendor claims on behalf of the agency.
4. **Group of Practitioners:** Two or more health care practitioners who practice their profession at a common location (whether they share common facilities, supporting staff or equipment).
5. **Managing Employee:** An individual who makes day-to-day decisions on behalf of the provider entity.
6. **Ownership Interest:** The possession of equity in the capital, stock or profits of the disclosing entity.
7. **Provider Entity:** A health care provider or supplier who bills Medi-Cal or Medicare for services rendered and has a National Provider Identifier (NPI) number.
8. **Subcontractor:** An individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients.
9. **Solo Proprietor:** One person owns and operates the business, with no legal distinction between the owner and the business.

Instructions:

1. Read each section throughout the form and enter the requested information.
2. Answer all questions as of the current date, i.e., request date.
3. If there is no information to include, indicate “none” or “Not Applicable” (N/A) in the space provided. Do not leave blank spaces.
4. If more space is needed, please attach additional sheets as necessary.

The Ownership and Disclosure Form must be submitted at the following times:

1. At the initial request to contract with CalOptima Health.
2. Within 30 days after any change in ownership of the disclosing entity.
3. Upon request by CalOptima Health during the recredentialing process or as specified in regulation 455.414, as requested by CalOptima Health.

Please enter the entity information below:

1. Provider Entity Information	
Name of Entity:	
Doing Business As (DBA): *(If applicable)*	**NPI Number:**
Federal Tax ID (TIN):	**Social Security Number (SSN):** *(If applicable)*
Practice Address:	**City, State, Zip**
Please select the option that best describes the provider entity	
☐ **Unincorporated solo proprietor/group of individual practitioners, entirely state or federally funded** Check if your provider type is exempt from completing the disclosure form. i.e., solo practitioner, solo group of individuals ***If this box is checked, sections 2 through 4 do not apply.*** **Please sign and date the document.**	☐ **Organization ownership** Check if your provider type is required to complete the disclosure form, i.e., disclosing entity, hospitals, nursing homes ***If this box is checked, sections 2 through 4 apply.*** **Please sign and date the document.**

2. List the Names of Board of Directors, Directors, General Partners, Managing Employee, Officers

Name	Title	Name	Title

3. Ownership and Control Information

Individuals with ownership or control interest owning more than 5 percent of the provider's stock:
List all individuals with an ownership or control interest. Include each person's name, address, date of birth (DOB) and SSN. Also, indicate the title (e.g., Chief Executive Officer, owner) and, if an owner, the percent of ownership.

Name	Title	% of Ownership	DOB	SSN	Address (Street/City/State/Zip)

Is any person listed above related to another as a spouse, parent, child or sibling? Yes ☐ No ☐
If yes, list the names of individuals listed above who are related to each other.

Name	Relationship	Name of Person Related to

Organizations with an ownership or control interest holding more than 5 percent of the provider's debt:
List all organizations with an ownership or control interest. Include the TIN, percent of ownership, primary business address, every business location and P.O. Box address(es).

Name	% of Ownership	TIN	Address or P.O. Box (Street/City/State/Zip)

4. Suspension and Debarment

Have you, any of your employees or any individuals who have ownership and/or controlling interest in the disclosing entity ever been placed on the Federal Office of Inspector General Health and Human Services (OIG/HHS) exclusions list or otherwise been suspended or debarred from participation in Medi-Cal or Medicare programs? No ☐ Yes ☐ If yes, list below.

Please check the OIG for excluded individuals: exclusions.oig.hhs.gov.

Name	Exclusion Date	Exclusion Reason

Any designated representative of the organization may complete and sign this form on behalf of the organization.

The undersigned hereby certifies that the following information regarding PROVIDER (the "Provider") is true and correct as of the date set forth below:

Print Name of Authorized Representative (First, Last)	Signature
Title	**Date**