DELETED

MEDI-CAL DISCLOSURE STATEMENT

Every applicant or provider must complete and submit a current Medi-Cal Disclosure Statement (DHS 6207) as part of a complete application package for enrollment, continued enrollment, or certification as a Medi-Cal provider.

Important:

- Failure to disclose may result in a denial of enrollment and may prevent enrollment for a period of three years.
- Submitting a complete and accurate Medi-Cal Disclosure Statement is required.
- Read ***all*** instructions when completing the Medi-Cal Disclosure Statement.
- Type or print clearly in ink.
- DO NOT USE staples on this form as well as on any attachments.
- If applicant/provider must make corrections, please line through, date, and initial in ink. Do not use white out.
- Return this completed statement with the complete application package to the address listed on the application form.

Overall Authority: Code of Federal Regulations, Title 42; Section 455; California Code of Regulations, Title 22, Sections 51000–51451; Welfare and Institutions Code, Sections 14043–14043.75

TABLE OF CONTENTS

GENERAL INSTRUCTIONS FOR COMPLETING THE MEDI-CAL DISCLOSURE STATEMENT

- DO NOT USE staples on this form as well as on any attachments.
- Do not use a pencil, correction tape, white out, highlighter pen, etc. on this form.
- If you must correct an entry, the applicant or provider must initial and date the correction in ink.
- Do not leave any questions, boxes, lines, etc., blank.
- To review the Title 22 provider enrollment regulations, go to the Medi-Cal Home Page website at www.Medi-Cal.ca.gov and click on the "Provider Enrollment" link. It is the responsibility of the applicant/provider to comply with all regulations pertaining to Medi-Cal.

Section I: Applicant/Provider Information
All applicants and providers must complete this Section.
Rendering providers joining a group may leave parts E–H blank if part D is checked.

Section II: Unincorporated Sole-Proprietor or Individual Rendering Provider Adding to a Group
Disclosure of social security number is optional. *(See Privacy Statement at bottom of page 13.)*

Section III: Ownership Interest and/or Managing Control Information (Entities)

1. To determine percentage of ownership, mortgage, deed of trust, note or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation.
2. Indirect ownership interest means an ownership interest in any entity that has an ownership interest in the applicant or provider. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or provider. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity.
3. Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.
4. All entities with managing control of applicant/provider must be listed in this Section.

Section IV: Ownership Interest and/or Managing Control Information (Individuals)

1. Refer to Section III instructions.
2. Person with an ownership or control interest means a person that:
   a. Has an ownership interest of 5 percent or more in an applicant or provider;
   b. Has an indirect ownership interest equal to 5 percent;
   c. Has a combination of direct and indirect ownership interest equal to 5 percent or more in an applicant or provider;
   d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or provider if that interest equals at least 5 percent of the value of the property or assets of the applicant or provider;
   e. Is an officer or director of an applicant or provider that is organized as a corporation;
   f. Is a partner in an applicant or provider that is organized as a partnership.
3. All management employees must be included in this section.
4. Disclosure of social security number is optional. *(See Privacy Statement at bottom of page 13.)*

Section V: Subcontractor

1. "Indirect ownership interest" means an ownership interest in any entity that has an ownership interest in the applicant or provider. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or provider. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the applicant or provider, A's interest equates to an 8 percent indirect ownership interest in the applicant or provider and shall be reported pursuant to Section 51000.35. Conversely, if B owns 80 percent of the stock of a corporation, which owns 5 percent of the stock of the applicant or provider, B's interest equates to a 4 percent indirect ownership interest in the applicant or provider and need not be reported.

2. "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 an applicant or provider.
3. "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the applicant or provider.
4. "Person with an ownership or control interest" means a person or corporation that:
   a. Has an ownership interest totaling 5 percent or more in an applicant or provider.
   b. Has an indirect ownership interest equal to 5 percent or more in an applicant or provider.
   c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in an applicant or provider.
   d. Owns an interest of 5 percent or more in any mortgage deed of trust, note, or other obligation secured by the applicant or provider if that interest equals at least 5 percent of the value of the property or assets of the applicant or provider.
   e. Is an officer or director of an applicant or provider that is organized as a corporation.
   f. Is a partner in an applicant or provider that is organized as a partnership.
5. To determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the applicant or provider's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and shall be reported pursuant to Section 51000.35(a). Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.
6. "Significant business transaction" means any business transaction or series of transactions that involve health care services, goods, supplies, or merchandise related to the provision of services to Medi-Cal beneficiaries that, for the 12-month period immediately preceding the application, exceed the lesser of $25,000 or 5 percent of an applicant's or provider's total operating expenses.
7. "Subcontractor" means an individual, agency, or organization:
   a. To which an applicant or provider has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment, or supplies to its patients.
   b. With whom an applicant or provider has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Medi-Cal Program.
   c. ***On this form, report only those transactions as defined in line 6 above.***

Section VI: Incontinence Supplies

1. Applicant or provider must check "Yes" or "No."
2. If "Yes," complete A–C.

Section VII: Pharmacy Applicants or Providers

All pharmacy applicants or providers must complete this Section.

Section VIII: Declaration and Signature Page

1. All applicants or providers must complete this Section.
2. Legal name of applicant/provider must match name listed on associated application package.
3. The signature must be an individual who is the sole proprietor, partner, corporate officer, or an official representative of a governmental entity or nonprofit organization who has the authority to legally bind the applicant or provider.
4. An original signature is required. Stamped, faxed, and/or photocopied signatures are ***not*** acceptable.
5. Disclosure Statement must be notarized by a Notary Public except for those applicants and providers licensed pursuant to Business and Professions Code, Division 2, beginning with Section 500. For example: Physicians, Pharmacy providers, Chiropractors, Osteopaths, Certified Nurse Midwives, and Nurse Practitioners do not need to notarize this form. Durable Medical Equipment (DME) providers, Prosthetists, Orthotists, Medical Transportation providers, etc., must notarize this form.

FOR MORE INFORMATION, PLEASE VISIT THE MEDI-CAL WEBSITE AT WWW.MEDI-CAL.CA.GOV AND CLICK ON THE "PROVIDER ENROLLMENT" LINK.

DELETED

MEDI-CAL DISCLOSURE STATEMENT

Do not leave any questions, boxes, lines, etc., blank. Check or enter N/A if not applicable to you.

I. APPLICANT/PROVIDER INFORMATION

A. Legal name of applicant/provider as reported to the IRS

B. Legal name of applicant/provider as it appears on professional license *(if applicable)* ☐ N/A

C. Existing Medi-Cal Provider Number(s) *(if applicable)* ☐ N/A

D. If applying as a rendering provider to a provider group, check here ☐ and proceed to Part I below.

E. Fictitious business name *(if applicable)* ☐ N/A

F. "Doing Business As" name *(if applicable)* ☐ N/A

G. Address where services are rendered or provided (number, street) (City) (State) (ZIP code)

1. Does applicant/provider lease this location? ☐ Yes ☐ No
2. If yes, provide the following information regarding Lessor:
   a. Lessor name
   b. Lessor address (number, street) (City) (State) (ZIP code)

c. Lessor telephone number	d. Term of lease	e. Amount of lease

3. If no, does applicant/provider own this location? ☐ Yes ☐ No
4. If applicant/provider does not lease or own this location, explain below:

H. Type of Entity *(must check one)*:

☐ General Partnership *(Enclose Partnership Agreement)*
☐ Limited Partnership *(Enclose Partnership Agreement)*
☐ Limited Liability Partnership *(Enclose Partnership Agreement)*
☐ Sole Proprietor (Unincorporated)
☐ Limited Liability Company: State of formation: _____
☐ Governmental
☐ Corporation: Corporate number: _____ State incorporated: _____
☐ Nonprofit:
Check one: ☐ Corporation ☐ Unincorporated Association
Check one: ☐ Charitable ☐ Religious
☐ Other *(specify)*: _____

I. List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid and ***all*** other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). ***Submit copies of all documents*** pertaining to the arrangements including terms and conditions. See California Code of Regulations (CCR), Title 22, Section 51000.50(a)(6). ☐ N/A

FINE/DEBT	AGENCY	DATE ISSUED	DATE TO BE PAID IN FULL
$			
$			

Do not leave any questions, boxes, lines, etc., blank.

I. APPLICANT/PROVIDER INFORMATION *(Continued)*

J. List the name and address of all health care providers, participating or not participating in Medi-Cal, in which applicant/provider also has an ownership or control interest. If none, check N/A. If additional space is needed, attach additional page (label "Additional Section I, Part J"). See CCR, Title 22, Section 51051(b) for provider types. ☐ N/A

1. Full legal name of health care provider

2. Address (number, street) (City) (State) (ZIP code)

K. Respond to the following questions:

1. ***Within ten years of the date of this statement***, have you, the applicant/provider, been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No

   If yes, provide the date of the conviction (mm/dd/yyyy): _____

2. ***Within ten years of the date of this statement,*** have you, the applicant/provider, been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No

   If yes, provide the date of final judgment (mm/dd/yyyy): _____

3. ***Within ten years of the date of this statement,*** have you, the applicant/provider, entered into a settlement in lieu of conviction for fraud or abuse involving a government program? ☐ Yes ☐ No

   If yes, provide the date of the settlement (mm/dd/yyyy): _____

4. Do you, the applicant/provider, currently participate or have you ever participated as a provider in the Medi-Cal program or in another state's Medicaid program? ☐ Yes ☐ No

   If yes, provide the following information:

STATE	NAME(S) (LEGAL AND DBA)	PROVIDER NUMBER(S)

5. Have you, the applicant/provider, ***ever*** been suspended from a Medicare, Medicaid, or Medi-Cal program? ☐ Yes ☐ No

   If yes, attach verification of reinstatement and provide the following information:

CHECK APPLICABLE PROGRAM	PROVIDER NUMBER(S)	EFFECTIVE DATE(S) OF SUSPENSION	DATE(S) OF REINSTATEMENT(S), AS APPLICABLE
☐ Medi-Cal ☐ Medicaid ☐ Medicare			
☐ Medi-Cal ☐ Medicaid ☐ Medicare			

6. Has the individual license, certificate, or other approval to provide health care of the applicant/provider ***ever*** been suspended or revoked? ☐ Yes ☐ No

   If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

Do not leave any questions, boxes, lines, etc., blank.

I. APPLICANT/PROVIDER INFORMATION *(Continued)*

7. Have you, the applicant/provider, ***ever*** lost or surrendered your license, certificate, or other approval to provide health care ***while a disciplinary hearing was pending***? ☐ Yes ☐ No

   If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

8. Has the license, certificate, or other approval to provide health care of the applicant/provider ***ever*** been disciplined by any licensing authority? ☐ Yes ☐ No

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

- If you, the applicant/provider, are an unincorporated sole-proprietor or an individual rendering provider adding to a group, proceed to Section II.

OR

- If you, the applicant/provider, are a partnership, corporation, governmental entity, or nonprofit organization, proceed to Section III.

Do not leave any questions, boxes, lines, etc., blank.

II. UNINCORPORATED SOLE-PROPRIETOR OR INDIVIDUAL RENDERING PROVIDER ADDING TO A GROUP

A. Full legal name (Last) (Jr., Sr., etc.) (First) (Middle)

B. Residence address (number, street) (City) (State) (ZIP code)

C. Social security number

D. Date of birth

E. Driver's license number or state-issued identification number *(Attach a current and legible copy.)*

- If you, the applicant/provider, are an unincorporated sole-proprietor, proceed to Section V.

OR

- If you, the applicant/provider, are a rendering provider adding to a group, proceed to Section VIII.

Do not leave any questions, boxes, lines, etc., blank.

III. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ENTITIES)

A. In the table below, list all corporations, unincorporated associations, partnerships, or similar entities having 5% or more (direct or indirect) ownership or control interest, or ***any*** partnership interest, in the applicant/provider identified in Section I. Attach a separate Section III, Part B and C for each entity listed below. Number of pages attached: _____

☐ Check here if this section does not apply and proceed to Section IV.

	ENTITY LEGAL BUSINESS NAME	PERCENT (%) OF OWNERSHIP OR CONTROL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Do not leave any questions, boxes, lines, etc., blank.

III. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ENTITIES) *(Continued)*

B. Entity with (Direct or Indirect) Ownership Interest and/or Managing Control—Identification Information.

1. Legal business name

2. Doing Business As (DBA) name *(if applicable)* ☐ N/A

3. Address (number, street) (City) (State) (ZIP code)

4. Check all that apply:

☐ 5% or more ownership interest ☐ Managing control ☐ Partner ☐ Other (specify): _____

5. Effective date of ***ownership*** (mm/dd/yyyy)

6. Effective date of ***control*** (mm/dd/yyyy)

C. Respond to the following questions:

1. ***Within ten years from the date of this statement,*** has this entity been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No

   If yes, provide the date of the conviction (mm/dd/yyyy): _____

2. ***Within ten years from the date of this statement,*** has this entity been found liable for fraud or abuse involving any government program in any civil proceeding? ☐ Yes ☐ No

   If yes, provide the date of final judgment (mm/dd/yyyy): _____

3. ***Within ten years from the date of this statement,*** has this entity entered into a settlement in lieu of conviction for fraud or abuse involving any government program? ☐ Yes ☐ No

   If yes, provide the date of the settlement (mm/dd/yyyy): _____

4. Does this entity currently participate, or has this entity ever participated, as a provider in the Medi-Cal program or in another state's Medicaid program? ☐ Yes ☐ No

   If yes, provide the following information:

STATE	NAME(S) (LEGAL AND DBA)	PROVIDER NUMBER(S)

5. Has this entity ever been suspended from a Medicare, Medicaid, or Medi-Cal program? ☐ Yes ☐ No

   If yes, attach verification of reinstatement and provide the following information:

CHECK APPLICABLE PROGRAM	PROVIDER NUMBER(S)	EFFECTIVE DATE(S) OF SUSPENSION	DATE(S) OF REINSTATEMENT(S), AS APPLICABLE
☐ Medi-Cal ☐ Medicaid ☐ Medicare			
☐ Medi-Cal ☐ Medicaid ☐ Medicare			

6. List the name and address of all health care providers, participating or not participating in Medi-Cal, in which this entity also has an ownership or control interest. See CCR, Title 22, Section 51051(b) for provider types. **If none, check here.** ☐

   If additional space is needed, attach additional page (label "Additional Section III, Part C, Item 6"). Number of pages attached:____

   a. Full legal name of health care provider (include any fictitious business names)

   b. Address (number, street) (City) (State) (ZIP code)

- Proceed to Section IV.

Do not leave any questions, boxes, lines, etc., blank.

IV. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

A. In the table below, list any individual that has 5% or greater (direct or indirect) ownership or control interest or ***any*** partnership interest, in the applicant/provider identified in Section I. In addition, ***all*** officers, directors, and managing employees of the applicant/provider must be reported in this section. Attach a separate Section IV, Part B and C, for each individual listed below. Number of pages attached:_____

	INDIVIDUAL NAME	PERCENT (%) OF OWNERSHIP OR CONTROL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Do not leave any questions, boxes, lines, etc., blank.

IV. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

B. Individual with Ownership Interest and/or Managing Control—Identification Information

1. Full legal name (Last) (Jr., Sr., etc.) (First) (Middle)

2. Residence address (number, street) (City) (State) (ZIP code)

3. Social security number	4. Date of birth	5. Driver's license number or state-issued identification number *(Attach a current and legible copy.)*

6. Is the above individual related to any individual listed in Table A? ☐ Yes ☐ No
   If yes, check the appropriate box and list name of individual:
   ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other (explain): _____
   Name of individual: _____

7. If the above individual is ***directly*** associated with the entity identified in Section I, what is this individual's relationship with the applicant/provider? Check all that apply.
   ☐ 5% or greater owner ☐ Partner ☐ Managing employee
   ☐ Director/officer, title: _____ ☐ Other (specify): _____

8. If the above individual is ***directly*** associated with an entity identified in Section III, indicate the name of that entity in the space below:
   a. Legal business name of entity as listed in Section III, Part A:
   _____
   b. What is this individual's role with the entity reported in Section III? Check all that apply.
   ☐ 5% or greater owner ☐ Partner ☐ Managing employee
   ☐ Director/officer, title: _____ ☐ Other (specify): _____

C. Respond to the following questions:

1. ***Within ten years from the date of this statement,*** have you been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No
   If yes, provide the date of the conviction (mm/dd/yyyy): _____

2. ***Within ten years from the date of this statement,*** have you been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No
   If yes, provide the date of final judgment (mm/dd/yyyy): _____

3. ***Within ten years from the date of this statement,*** have you entered into a settlement in lieu of conviction for fraud or abuse involving any government program? ☐ Yes ☐ No
   If yes, provide the date of the settlement (mm/dd/yyyy): _____

4. Do you currently participate, or have you ever participated, as a provider in the Medi-Cal program or in another state's Medicaid program? ☐ Yes ☐ No
   If yes, provide the following information:

STATE	NAME(S) (LEGAL AND DBA)	PROVIDER NUMBER(S)

Do not leave any questions, boxes, lines, etc., blank.

IV. OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

Name of individual listed in Section IV, Part B, Item 1: _____

5. Have you ever been suspended from a Medicare, Medicaid, or Medi-Cal program? ☐ Yes ☐ No

   If yes, attach verification of reinstatement and provide the following information:

CHECK APPLICABLE PROGRAM	PROVIDER NUMBER(S)	EFFECTIVE DATE(S) OF SUSPENSION	DATE(S) OF REINSTATEMENT(S), AS APPLICABLE
☐ Medi-Cal ☐ Medicaid ☐ Medicare			
☐ Medi-Cal ☐ Medicaid ☐ Medicare			

6. Has your individual license, certificate, or other approval to provide health care ever been suspended or revoked? ☐ Yes ☐ No

   If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

7. Have you otherwise lost or surrendered your license, certificate, or other approval to provide health care while a disciplinary hearing was pending? ☐ Yes ☐ No

   If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

8. Has your license, certificate, or other approval to provide health care ***ever*** been disciplined by any licensing authority? ☐ Yes ☐ No

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

9. List the name and address of all health care providers, participating or not participating in Medi-Cal, in which you also have an ownership or control interest. See CCR, Title 22, Section 51051(b) for provider types.

   If none, check here. ☐

   If additional space is needed, attach additional page (label "Additional Section IV, Part C, Item 9"). Number of pages attached: _____

   a. Full legal name of health care provider *(include any fictitious business names)*

   b. Address (number, street) (City) (State) (ZIP code)

- Proceed to Section V.

Do not leave any questions, boxes, lines, etc., blank.

V. SUBCONTRACTOR

A. Does the applicant/provider contract or delegate any management functions or responsibilities for providing the following to Medi-Cal beneficiaries:

Health Care Services ☐ Yes ☐ No
Equipment ☐ Yes ☐ No
Supplies ☐ Yes ☐ No

If yes to any of the above, complete the following information:

1. Subcontractor's full legal name | 2. Subcontractor's phone number

3. Subcontractor's address (number, street) (City) (State) (ZIP code)

4. Does applicant/provider have any ownership and/or control interest in this subcontractor? ☐ Yes ☐ No

If there is more than one subcontractor, provide a separate sheet with all required information (label "Additional Section V, Part A").

☐ Check here if additional sheet(s) is attached. Number of additional pages: _____

B. Has the applicant/provider entered into any of the following to obtain space, supplies, equipment, or services used to provide services to Medi-Cal beneficiaries:

Contract ☐ Yes ☐ No
Agreement ☐ Yes ☐ No
Purchase Order ☐ Yes ☐ No
Lease(s) of Real Property ☐ Yes ☐ No

If yes to any of the above, complete the following information:

1. Subcontractor's full legal name | 2. Subcontractor's phone number

3. Subcontractor's address (number, street) (City) (State) (ZIP code)

4. Does applicant/provider have any ownership and/or control interest in this subcontractor? ☐ Yes ☐ No

If there is more than one subcontractor, provide a separate sheet with all required information (label "Additional Section V, Part B").

☐ Check here if additional sheet(s) is attached. Number of additional pages: _____

C. List the following information for any other person or entity with 5 percent or more ownership and/or control interest in any subcontractor listed in Part A or B. If there is more than one subcontractor, provide a separate sheet with all required information (label "Additional Section V, Part C").

☐ Check here if no subcontractors listed in Part A or B.

☐ Check here if additional sheet(s) is attached. Number of additional pages: _____

Name of Subcontractor in Part A or B

1. Full legal name of person or entity with ownership or control interest | Phone number

Address (number, street) (City) (State) (ZIP code)

2. Full legal name of person or entity with ownership or control interest | Phone number

Address (number, street) (City) (State) (ZIP code)

3. Full legal name of person or entity with ownership or control interest | Phone number

Address (number, street) (City) (State) (ZIP code)

4. Full legal name of person or entity with ownership or control interest | Phone number

Address (number, street) (City) (State) (ZIP code)

- Proceed to Section VI.

Do not leave any questions, boxes, lines, etc., blank.

VI. INCONTINENCE SUPPLIES

Does the applicant/provider intend to sell or currently sell incontinence medical supplies? ☐ Yes ☐ No

If no, Pharmacy applicant/providers proceed to Section VII. All other applicant/providers proceed to Section VIII.

If yes, provide the following information:

A. List the names and addresses of all current sources of capital, as defined in CCR, Title 22, Section 51000.5.

If there is more than one source of capital, provide a separate sheet with all required information (label "Additional Section VI, Part A").

☐ N/A

☐ Check here if additional sheet(s) is attached. Number of additional pages: _____

Full legal name of person or entity with ownership or control interest

Address (number, street) (City) (State) (ZIP code)

B. List all manufacturers, suppliers, and other providers with whom the applicant/provider has any type of business relationship relative to the goods and services provided to Medi-Cal beneficiaries.

If there is more than one, provide a separate sheet with all required information (label "Additional Section VI, Part B").

☐ N/A

☐ Check here if additional sheet(s) is attached. Number of additional pages: _____

Full legal name of person or entity with ownership or control interest

Address (number, street) (City) (State) (ZIP code)

C. List all entities to which the applicant/provider has extended a line of credit, as defined in CCR, Title 22, Section 51000.10, of $5,000 or more.

If there is more than one, provide a separate sheet with all required information (label "Additional Section VI, Part C").

☐ N/A

☐ Check here if additional sheet(s) is attached. Number of additional pages: _____

Full legal name of person or entity with ownership or control interest

Address (number, street) (City) (State) (ZIP code)

- Pharmacy applicant/providers proceed to Section VII.

OR

- All other applicant/providers proceed to Section VIII.

Do not leave any questions, boxes, lines, etc., blank.

VII. PHARMACY APPLICANTS OR PROVIDERS

A. Has the individual license, certificate, or other approval to provide health care, of the ***Pharmacist-in-Charge***, ever been suspended or revoked? ☐ Yes ☐ No

If yes, attach a copy of the written confirmation from the licensing authority that professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

B. Has the individual license, certificate, or other approval to provide health care, of the ***Pharmacist-in-Charge***, ever been lost or surrendered? ☐ Yes ☐ No

If yes, attach a copy of the written confirmation from the licensing authority that professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

C. Has any licensing authority ever disciplined the Board of Pharmacy License of the ***Pharmacist-in-Charge***? ☐ Yes ☐ No

If yes, provide the following information:

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)

- Proceed to Section VIII.

VIII. DECLARATION AND SIGNATURE PAGE

I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document and any attachments is true, accurate, and complete to the best of my knowledge and belief.

I declare that I have the authority to legally bind the applicant or provider.

1. Printed legal name of applicant/provider

2. Printed name of person signing this declaration (if an entity or business name is listed in Item 1 above)

3. Original signature

4. Title of person signing this declaration

5. Executed at: _____ (City), _____ (State) on _____ (Date)

6. Notary Public:

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ***ARE NOT REQUIRED*** to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

PRIVACY STATEMENT
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, Sacramento, CA, (916) 323-1945.

Do not leave any questions, boxes, lines, etc., blank.