CHPW PROVIDER OWNERSHIP AND CONTROL INTEREST DISCLOSURE FORM

The federal regulations set forth in 42 CFR §455.100 - §455.106 require providers to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to Managed Care Organizations that contract with a State Medicaid Agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR §455.105 and 3) the identity of any excluded individual with an ownership or control interest in the provider entity or who is an agent or managing employee of the provider entity. Please attach a separate sheet, if necessary.

Completion and submission of this form is a condition of participation, and full and accurate disclosure of ownership and financial interest is required. A failure to submit the requested information will result in a refusal by Community Health Plan of Washington (CHPW) to enter into an agreement or contract with the individual and/or entity or in the termination of any existing agreements.

Please answer all questions as of the current date. If additional space is needed please use an attached sheet. Federal statutes and regulations clearly prohibit CHPW from paying for items or services furnished, ordered or prescribed by excluded persons. CHPW is required to search the exclusions database not only by the name of an entity seeking to participate in the program, but also by the name of any owner or managing employee.

This form can also be completed online at www.chpw.org/-oac/. This link will also provide you with access to FAQs and instructions.

I. Identifying Information	
OWNER TYPE (check one) *(as shown on your W-9)* ☐ Individual/sole proprietor ☐ Corporation ☐ Partnership ☐ Trust/estate	FEDERAL TAX ID/SSN *(as shown on your W-9)*
ORGANIZATION NAME *(as shown on your W-9)*	MINORITY WOMEN OWNED BUSINESS ENTERPRISE (MWOBE):
BUSINESS NAME – If different from above *(as shown on your W-9)*	CHPW CONTRACT NUMBER

II. Ownership and Control Information

List each individual (e.g. members of the board of directors or officer), organization, corporation, or entity that has direct or indirect ownership or controlling interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. Attach additional pages as necessary. If there are no individuals or entities with 5% of more ownership/control interest, complete for managing employee(s). ***All fields must be completed – please type or print legibly.***

FIRST NAME	MIDDLE NAME	LAST NAME	SSN *(personal, not business TIN)*	DOB
ADDRESS				
FIRST NAME	MIDDLE NAME	LAST NAME	SSN *(personal, not business TIN)*	DOB
ADDRESS				
FIRST NAME	MIDDLE NAME	LAST NAME	SSN *(personal, not business TIN)*	DOB
ADDRESS				

List those persons with ownership or control interest that are related to each other (spouse, parent, child, or sibling)

NAME	RELATIONSHIP	DOB

Does any owner of the disclosing entity also have an ownership or controlling interest of 5% or more in any other entity?

NAME AND TITLE	SSN *(personal, not business TIN)*	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN *(personal, not business TIN)*	DOB
ADDRESS		PERCENTAGE

III. Subcontractor Information		
List each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. Attach additional pages as necessary.		
NAME AND TITLE	SSN ***(personal, not business TIN)***	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN ***(personal, not business TIN)***	DOB
ADDRESS		PERCENTAGE

IV. Criminal Offenses		
List each individual (e.g. members of the board of directors or officer) 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 Title XVIII, XIX, or XX since the inception of those programs. Attach additional pages as necessary.		
NAME AND TITLE	SSN ***(personal, not business TIN)***	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN ***(personal, not business TIN)***	DOB
ADDRESS		PERCENTAGE

V. Suspension or Debarment		
Have you, any of your employees, or any individual who has an ownership or controlling interest in the disclosing entity ever been placed on the federal Office of the Inspector General, Health and Human Services (OIG/HHS) exclusions list or otherwise been suspended or debarred from participation in Medicare, Medicaid, or Title XVIII, XIX, or XX services programs? If yes, list each person below. Attach additional pages as necessary. The current lists of excluded individuals can be found at: http://exclusions.oig.hhs.gov/search.aspx and https://www.sam.gov/.		
NAME AND TITLE	SSN ***(personal, not business TIN)***	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN ***(personal, not business TIN)***	DOB
ADDRESS		PERCENTAGE
Whoever knowingly and willfully makes or causes to be made a false statement or representation of this 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 termination of an existing agreement or contract with the Plan/Network. By my signature, I certify that the information provided within is true and correct, and I acknowledge that I fully understand the consequences as explained above.		
PRINT NAME	TITLE OF INDIVIDUAL COMPLETING FORM	
SIGNATURE	DATE	

Submission Information: Option 1: Secure Online Submission at www.chpw.org/-oac/ **Option 2:** Fax 206 613-5018, Attn: Provider Relations, Email to PR.Team@chpw.org or **USPS**: Community Health Plan of Washington, C/O Provider Relations, 720 Olive Way, Ste. 300, Seattle, WA 98101