INSTRUCTIONS:

Please submit this completed form and the required attachments. Incomplete forms will be returned for completion prior to processing. Please return this form and all attachments to the location specified on your cover letter.

The following facility types can submit one form to cover all locations and a roster of all locations must be included:

- Atypical Providers
- Durable Medical Equipment Suppliers
- Federally Qualified Health Centers (FQHC)
- Indian Health Clinics
- Laboratories
- Physical Therapy/Occupational Therapy/Speech Therapy
- Radiology
- Rural Health Centers (RHC)
- Transportation Services
- Urgent Care

Facilities with multiple locations that share one license only need to complete one form.

All other facility types must complete a separate form for each location.

The information listed below should accompany the completed form:

- ☐ *Copies of current organizational or facility licenses/certifications/registrations*
- ☐ *A copy of your current (not expired) professional liability insurance face sheet*
- ☐ *A copy of the letter verifying approval of CMS participation (if applicable)*
- ☐ *If your organization is not accredited by a body listed in Section 4 of this form and your organization is required to be certified by CMS or the State, we also request a copy of the most recent CMS or State on-site survey results.*
- ☐ *W9 form(s) showing all federal Tax Identification Numbers (TINs) used by the organization/facility (Only Page 1 of this form is needed: http://www.irs.gov/pub/irs-pdf/fw9.pdf)*

1. ORGANIZATION INFORMATION: *(Provide physical location information on the following page)*	
Legal Name of Organization (Legal name listed with the IRS)	
DBA Name of Organization (if applicable)	
Historic Name(s) of Organization (if under same ownership)	
Organization Medicare # *(primary)*:	Organization Medicaid # *(primary)*:
Organization TIN *(primary)*:	Organization NPI *(primary)*:
Credentialing Contact Street Address: _____ Address Line 2: _____ City: State: Zip:	**Billing Address** *(if different than Credentialing)* Street Address: _____ Address Line 2: _____ City: State: Zip:
Contact Name: _____ Email: _____ Phone: _____ Fax: _____	Contact Name: _____ Email: _____ Phone: _____ Fax: _____

2. CURRENT PROFESSIONAL LIABILTY INSURANCE:	
☐ Please check here if your facility is not required to carry professional liability insurance.	
Current Carrier Name:	Policy Number:
Policy Start Date:	Policy End Date:
Coverage Amount Per Occurrence:	Coverage Amount Aggregate:

COMPLETE THE BELOW INFORMATION FOR EACH PRACTICE LOCATION

Only include information for locations that you wish to be listed with Molina Healthcare. Complete a copy of sections 3 and 4 of this form for every location where information differs between locations.

<table>
<tr><th colspan="2">3. PHYSICAL LOCATION INFORMATION:
(Include any additional information relevant to this location on a separate sheet)</th></tr>
<tr><td colspan="2"><u>Location DBA</u>
(if different than the Organization DBA)</td></tr>
<tr><td colspan="2"><u>Other DBAs Previously Used</u>
(if under same ownership)</td></tr>
<tr><td>Is this location Medicare Certified?
☐ Yes ☐ No</td><td>Is this the primary address?
☐ Yes ☐ No</td></tr>
<tr><td>Site-specific Medicare #:</td><td>Site-specific Medicaid #:</td></tr>
<tr><td>Site-specific TIN:</td><td>Site-specific NPI:</td></tr>
<tr><td rowspan="3"><u>Physical Practice Location</u>

Street Address: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____</td><td>State provider # (if applicable, LTC, etc.):</td></tr>
<tr><td>Is this location handicap accessible?
☐ Yes ☐ No</td></tr>
<tr><td></td></tr>
<tr><td colspan="2">Please list any languages spoken by office personnel:</td></tr>
<tr><td colspan="2">Practice Limitations (e.g., age, gender, etc.):</td></tr>
</table>

3. PHYSICAL LOCATION INFORMATION:

(Include any additional information relevant to this location on a separate sheet)

Location State License(s) and/or State Registration(s) – *(Attach a copy of all)*

☐ *Please check here if this location is not required to be licensed, certified, or registered by a State agency.*

Type of Credential	State	Number	Expiration Date	Most Recent Survey Date
State License				
State Registration				
State Certification				
Other:				

Additional Location Credentials – *(Attach a copy of all)*

☐ *Please check here if this location holds no additional licenses, certificates, registrations, etc.*

Type of Credential	State	Number	Expiration Date	Additional Notes/Info
DEA				
CLIA				
State CSR/CDS/DPS				
Other:				

Specialty & Federal Taxonomy Code

Specialty & Federal Taxonomy Code

4. ACCREDITATION / CERTIFICATION *(check all that apply)*:		
☐ *Please check here if the State conducts routine surveys of your organization for license, registration, or clinical oversight.*		
☐ *Please check here if your organization is NOT accredited and NOT required to be surveyed by ANY organization.*		
Accreditation Organization		**Date of Last Survey**
☐ (CMS)	Medicare Certification *(attach most recent survey and acceptance letter)*	
☐ (AAAHC)	Accreditation Association for Ambulatory Health Care	
☐ (ACHC)	Accreditation Commission for Health Care	
☐ (AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities	
☐ (AADE)	American Association of Diabetes Educators	
☐ (AAHHS)	Accreditation Association for Hospitals & Health Systems (AOA)	
☐ (ACR)	American College of Radiologists	
☐ (CABC)	Commission for the Accreditation of Birth Centers	
☐ (CARF)	Commission on Accreditation of Rehabilitation Facilities	
☐ (CCAC)	Continuing Care Accreditation Co	
☐ (CLIA)	Clinical Laboratory Improvement Amendments	
☐ (COLA)	Committee of Laboratory Accreditation	

4. ACCREDITATION / CERTIFICATION *(check all that apply):*		
Accreditation Organization		**Date of Last Survey**
☐ (CHAP)	Community Health Accreditation Program	
☐ (COA)	Council on Accreditation	
☐ (DNV)	Det Norske Veritas – National Integrated Accreditation for Healthcare Organizations	
☐ (IAC)	The Intersocietal Accreditation Commission	
☐ (HIS)	Indian Health Services	
☐ (OSHA)	Occupational Safety and Health Administration	
☐ (SAMHSA)	Substance Abuse and Mental Health Services Administration	
☐ (TJC)	The Joint Commission	

MolinaHealthcare, Inc.

OWNERSHIP AND CONTROL DISCLOSURE FORM

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 may result in a refusal by Plan/Network to enter into an agreement or contract with individual and/or entity or intermination 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 Plan/Network from paying for items or services furnished, ordered or prescribed by excluded persons. Plan/Network is required to search the exclusions database not only by the name of the entity seeking to participate in the program, but also by the name of any owner or managing employee.

Under 42 CFR 455: Identifying information must be supplied as described in the below sub-sections. For additional detail, please see the federal CFR database. A link to this specific section is supplied below (relevant portions are subsections 455. 100 through 455. 106): https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr455_main_02.tpl

Complete this form for all locations contracted or being contracted with Molina Healthcare, Inc. (Molina) where Molina members will be seen. Only one form is needed if multiple locations are owned by the same parent company.

I. Identifying Information	
Owner Type (checkone) ☐ Organization Ownership - If checking this box, sections2-6 are required to be completed. ☐ Individual Ownership - Check this box if: If the practitioner named below is a sole proprietor or the practitioner. (ITEMS 2-6 ARE NOT APPLICABLE, PROCEED TO SIGN AND DATE AT THE BOTTOM OF THE FORM.) ☐ Federal/State Owned - Check this box if: the facility named below is entirely state or federally funded. (ITEMS 2-6 ARE NOT APPLICABLE, PROCEED TO SIGN AND DATE AT THE BOTTOM OF THE FORM.)	
INDIVIDUALNAME: SSN (if Individual Ownership):	
DOING BUSINESS AS:	ORGANIZATION NAME:
FEDERAL TAX ID:	MINORITY WOMEN OWNED BUSINESS ENTERPRISE (MWOBE):

II. OwnershipandControlInformation

List each office and/or individual, 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% or more ownership/control interest, complete for managing employees.

NAME AND TITLE	% OF OWNERSHIP	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

List those persons named that are related to each other (spouse, parent, child or sibling). Attach additional pages if necessary.

NAME AND TITLE	RELATIONSHIP	DOB

Does any owner of the disclosing entity also have an ownership or controlling interest of 5% or more in any other entity? Attach additional pages if necessary.

☐ NOT APPLICABLE. See box at beginning of form, OR no owner or managing employee has ownership or controlling interest of 5% or more in any other entity.

NAME AND TITLE	% OF OWNERSHIP	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

III. SUBCON TRACTOR 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 if necessary.

☐ NOT APPLICABLE. See box at beginning of form, OR there are no owners or managing employees that have controlling interest in any subcontract in which the disclosing entity has direct or indirect ownership of 5% or more.

NAME AND TITLE	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

Please provide the ownership name and address of any subcontractor with whom you have had a business transaction totaling more than $25,000 during the most recent 12-month period.

NAME AND TITLE	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

IV. CRIMINAL OFFENSES

List each officer and/or individual who has ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity who 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 if necessary.

☐ NOT APPLICABLE. See box at beginning of form,OR there are no owners or managing employees that have been convicted of a criminal offence.

NAME AND TITLE	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

V. SUSPENSION OR DEBARMENT

Have you, or 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 Medicare, Medicaid or Title XXVIII, XIX or XX service programs. If yes, list each person below. Attach additional pages as necessary. The current lists of excluded individuals can be found at: https://exclusions.oig.hhs.gov/ and https://www.sam.gov/portal/SAM/#1

☐ NOT APPLICABLE. See box at beginning of form, OR there are no owners or managing employees that have been suspended, excluded, and debarred from participation in Medicare, Medicaid or other service programs.

NAME AND TITLE	DOB	SSN	NPI	LICENSE#	TAX ID#	ADDRESS

VI. STATUS CHANGES

Is a change of ownership anticipated within the next year?	☐ Yes	☐ No
If yes, list date of change in operations.	☐ Yes	☐ No
Is the facility operated by a management company or leased in whole or by part of another organization?	☐ Yes	☐ No
Has there been a past bankruptcy or do you anticipate filing for bankruptcy within the next year?	☐ Yes	☐ No
If yes, when	☐ Yes	☐ No

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

Whoever knowingly and will fully 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 where the entity already participates, a termination of its agreement or contract with Plan/Network. By signature I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.

Printed (or typed) NAME and

Title of person completing this form: _____ Date: _____

Signature: _____

Completely fill in the form above in Adobe Acrobat or Adobe Reader, and then electronically sign by clicking in the box above. You cannot make changes to this form once it has been electronically signed and you cannot save a partially completed form. If you do not have Adobe Reader or Adobe Acrobat, print this form and fill it in by hand. Signature stamps not accepted.