



FAMILY PACT (PLANNING, ACCESS, CARE, AND TREATMENT) PROGRAM DISCLOSURE STATEMENT (Section 24005, Welfare and Institutions Code)

Applicant or provider legal name	Date	FOR STATE USE ONLY
Medi-Cal provider number	National Provider Identifier (NPI)	

IMPORTANT:

- Read all instructions before completing the application.
- Public providers are governmental agencies that are owned or operated by a state, county, city, or another local governmental agency.
- If a corporation, complete this information for each of the following individuals, including but not limited to: owners, directors, shareholders, and others.
- Licensed community clinics are not required to answer questions 2-6.
- Type or print clearly and sign in blue ink.

• Return completed forms to: California Department of Public Health
MCAH/OFP Branch
Family PACT Provider Enrollment
1615 Capitol Avenue, MS 8307
P.O. Box 997420
Sacramento, CA 95899-7420
(916) 650-0285

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

1. Specify type of Applicant or Provider:

- Partnership*
 Unincorporated Sole Proprietorship
 Corporation**
 Licensed Community Clinic
 Public providers **(Stop here and sign page 7)**

* Attach a copy of the fully executed partnership agreement.

** Attach certified copies of Articles of Incorporation, certified copy of Statement of Officers, and copy of Certification of Good Standing issued by the Secretary of State.

2. List the requested information below for each person with an ownership or control interest in applicant or provider, including corporate officers and directors for corporations and all partners in partnerships. If additional sheets are needed, use copies of this page and attach to the application package. Each person listed below shall complete Attachment A.

Full legal name (last) _____ (first) _____ (middle) _____

Residence address (number, street)	City	State	Nine-digit ZIP code
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Driver's license number or state-issued identification number (attach legible copy): _____

Is this person related to any other person with an ownership or control interest in applicant or provider? Yes No

If yes, please describe: Spouse Parent Child Sibling Other (explain): _____

Full legal name (last) _____ (first) _____ (middle) _____

Residence address (number, street)	City	State	Nine-digit ZIP code
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Driver's license number or state-issued identification number (attach legible copy): _____

Is this person related to any other person with an ownership or control interest in applicant or provider? Yes No

If yes, please describe: Spouse Parent Child Sibling Other (explain): _____

Full legal name (last) _____ (first) _____ (middle) _____

Residence address (number, street)	City	State	Nine-digit ZIP code
------------------------------------	------	-------	---------------------

Driver's license number or state-issued identification number (attach legible copy): _____

Is this person related to any other person with an ownership or control interest in applicant or provider? Yes No

If yes, please describe: Spouse Parent Child Sibling Other (explain): _____

Applicant or provider legal name	Date
Medi-Cal provider number	NPI

3. List the requested information for each person, including corporate officers and directors for corporations and all partners in partnerships, with an ownership or control interest in any subcontractor in which applicant or provider has a direct or indirect ownership interest of 5 percent or more. If additional sheets are needed, make copies of this page and attach to the application package.

Full legal name (last) (first) (middle)

Residence address (number, street) City State Nine-digit ZIP code

Subcontractor full name

Subcontractor address (number, street) City State Nine-digit ZIP code

Is this person related to any other person with an ownership or control interest in applicant or provider listed in number 1? Yes No
 If yes, please describe: Spouse Parent Child Sibling Other (explain): _____

Full legal name (last) (first) (middle)

Residence address (number, street) City State Nine-digit ZIP code

Subcontractor full name

Subcontractor address (number, street) City State Nine-digit ZIP code

Is this person related to any other person with an ownership or control interest in applicant or provider listed in number 1? Yes No
 If yes, please describe: Spouse Parent Child Sibling Other (explain): _____

Full legal name (last) (first) (middle)

Residence address (number, street) City State Nine-digit ZIP code

Subcontractor full name

Subcontractor address (number, street) City State Nine-digit ZIP code

Is this person related to any other person with an ownership or control interest in applicant or provider listed in number 1? Yes No
 If yes, please describe: Spouse Parent Child Sibling Other (explain): _____

Full legal name (last) (first) (middle)

Residence address (number, street) City State Nine-digit ZIP code

Subcontractor full name

Subcontractor address (number, street) City State Nine-digit ZIP code

Is this person related to any other person with an ownership or control interest in applicant or provider listed in number 1? Yes No
 If yes, please describe: Spouse Parent Child Sibling Other (explain): _____

Full legal name (last) (first) (middle)

Residence address (number, street) City State Nine-digit ZIP code

Subcontractor full name

Subcontractor address (number, street) City State Nine-digit ZIP code

Is this person related to any other person with an ownership or control interest in applicant or provider listed in number 1? Yes No
 If yes, please describe: Spouse Parent Child Sibling Other (explain): _____

Applicant or provider legal name	Date
Medi-Cal provider number	NPI

4. List the requested information for each person, including corporate officers and directors for corporations and all partners in partnerships, with an ownership or control interest in any subcontractor with whom the applicant or provider has had business transactions totaling more than \$25,000 during the 12-month period preceding the date of the application, or preceding the date on the California Department of Health Care Services' and/or California Department of Public Health's request for such information. If additional sheets are needed, please use copies of this page and attach to the application package.

Full legal name (last)	(first)	(middle)
Residence address (number, street)	City	State
		Nine-digit ZIP code

Explain: _____

Full legal name (last)	(first)	(middle)
Residence address (number, street)	City	State
		Nine-digit ZIP code

Explain: _____

Full legal name (last)	(first)	(middle)
Residence address (number, street)	City	State
		Nine-digit ZIP code

Explain: _____

Full legal name (last)	(first)	(middle)
Residence address (number, street)	City	State
		Nine-digit ZIP code

Explain: _____

Full legal name (last)	(first)	(middle)
Residence address (number, street)	City	State
		Nine-digit ZIP code

Explain: _____

Full legal name (last)	(first)	(middle)
Residence address (number, street)	City	State
		Nine-digit ZIP code

Explain: _____

Applicant or provider legal name	Date
Medi-Cal provider number	; NPI

5. List any significant business transactions which exceeds the lesser of \$25,000 annually or 5 percent of an applicant's total operating expenses, between the applicant or provider, including corporate officers and directors for corporations and all partners in partnerships, and any wholly owned supplier, during the five-year period ending on the date of the application, or ending on the date of the written request by the Department for such information. If additional sheets are needed, use copies of this page and attach to the application package.

Name of supplier _____

Explain: _____

Name of supplier _____

Explain: _____

Name of supplier _____

Explain: _____

Name of supplier _____

Explain: _____

Name of supplier _____

Explain: _____

Name of supplier _____

Explain: _____

Name of supplier _____

Explain: _____

Applicant or provider legal name	Date
Medi-Cal provider number	; NPI

6. List any significant business transactions between the applicant or provider, including corporate officers and directors for corporations and all partners in partnerships, and any subcontractor, during the three-year period ending on the date of the application, or ending on the date of the written request by the Department for such information. If additional sheets are needed, use copies of this page and attach to the application package.

Name of subcontractor

Explain:

Name of subcontractor

Explain:

Name of subcontractor

Explain:

Name of subcontractor

Explain:

Name of subcontractor

Explain:

Name of subcontractor

Explain:

Name of subcontractor

Explain:

Applicant or provider legal name	Date
Medi-Cal provider number	NPI

7. a. Has applicant, provider, any person with an ownership or control interest in applicant or provider, agent, or managing employee ever been convicted of any felony or misdemeanor involving fraud or abuse in any government program? Yes No
 If yes, please give the name, date of conviction, and explain:

b. Has applicant, provider, any person with an ownership or control interest in applicant or provider, agent, or managing employee ever been found liable for fraud or abuse in any civil proceeding? Yes No
 If yes, please give the name, date of judgement, and explain:

c. Has applicant, provider, any person with an ownership or control interest in applicant or provider, agent, or managing employee ever entered into a settlement in lieu of conviction for fraud or abuse? Yes No
 If yes, please give the name, date of settlement, and explain:

8. Has applicant or provider ever participated in another state's Medicaid program? Yes No
 If yes, please provide the following information:

State	Full Legal or Business Name	Medicaid Provider Number(s)	NPI

9. Has applicant or provider ever been suspended from a Medicare or Medicaid program including Medi-Cal? Yes No
 If yes, please provide the following information:

State(s) in which action was taken	Effective Date(s) of Suspension(s)	Date(s) of Reinstatement(s), as applicable	Medicare and/or Medicaid Provider Number(s)	NPI

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

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

State(s) in Which Action Was Taken	Effective Date(s) of Licensing Authority's Action

11. Has any licensing authority ever disciplined the applicant or provider? Yes No
 If yes, please provide the following information:

State(s) in Which Action Was Taken	Effective Date(s) of Licensing Authority's Action

Applicant or provider legal name	Date
Medi-Cal provider number	NPI number

12. Has applicant or provider otherwise lost or surrendered that license, certificate, or other approval while a disciplinary hearing was pending? Yes No
 If yes, please attach a copy of the written confirmation from the licensing authority that his/her professional privileges have been restored and provide the following information:

State(s) in Which Action Was Taken	Effective Date(s) of Licensing Authority's Action

I declare under penalty of perjury under the laws of the State of California that the foregoing Application (CDPH 4468), Provider Agreement (CDPH 4469), Practitioner Agreement (CDPH 4470), and Disclosure Statement (CDPH 4471) information is true, accurate, and complete to the best of my knowledge and belief.

13. Printed name of individual provider or the individual signing the disclosure on behalf of a group	14. Signature <i>(blue ink only)</i>
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15. Executed at: _____, _____ on _____
(City) (State) (Date)

**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 California Department of Health Care Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 24005. The consequences of not supplying the mandatory information requested are denial of enrollment as a Family PACT provider and issuance of the Family PACT provider number or denial of continued enrollment as a Family PACT provider and deactivation of all Family PACT provider numbers used by the provider to obtain reimbursement from the Family PACT program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Family PACT 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, Health Care Financing Administration, Office of the Inspector General, Medicaid, and licensing programs in other states. If more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, (916) 323-1945.

Applicant or provider legal name		Date
Medi-Cal provider number	NPI number	

A COPY OF THIS ATTACHMENT SHALL BE COMPLETED AND SUBMITTED TO APPLICANT OR PROVIDER BY EACH PERSON LISTED ON PAGE ONE OF THIS FAMILY PACT DISCLOSURE STATEMENT. APPLICANT OR PROVIDER SHALL SUBMIT ALL PAGES OF ATTACHMENT A WITH THE APPLICATION PACKAGE.

Your name (Person listed for Number 1 on Disclosure Statement): _____

1. List the name and address of any other health care provider you also have an ownership or control interest in. If additional sheets are needed, use copies of this page and attach to the application package.

Full name of health care provider _____

Address (number, street)	City	State	Nine-digit ZIP code
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Full name of health care provider _____

Address (number, street)	City	State	Nine-digit ZIP code
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Full name of health care provider _____

Address (number, street)	City	State	Nine-digit ZIP code
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Full name of health care provider _____

Address (number, street)	City	State	Nine-digit ZIP code
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Full name of health care provider _____

Address (number, street)	City	State	Nine-digit ZIP code
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Full name of health care provider _____

Address (number, street)	City	State	Nine-digit ZIP code
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2. a. Have you ever been convicted of any felony or misdemeanor involving fraud or abuse in any government program? Yes No
If yes, please explain:

- b. Have you ever been found liable for fraud or abuse in any civil proceeding? Yes No
If yes, please explain:

- c. Have you ever entered into a settlement in lieu of conviction for fraud or abuse, within the previous five years? Yes No
If yes, please explain:

Applicant or provider legal name	Date
Medi-Cal provider number	NPI number

Page ____ of ____ pages

3. Have you ever participated in the Medi-Cal program? Yes No
 If yes, please provide the following information:

Name(s)	Medi-Cal Provider Number(s)	NPI

4. Have you ever participated in another state's Medicaid program? Yes No
 If yes, please provide the following information:

State	Full Legal or Business Name	Medicaid Provider Number(s)	NPI

5. Have you ever been suspended from a Medicare or Medicaid program including Medi-Cal? Yes No
 If yes, please provide the following information:

Effective Date(s) of Suspension(s)	Date(s) of Reinstatement(s), as applicable	Medicare and/or Medicaid Provider Number(s)	NPI

6. Has your individual license, certificate, or other approval to provide health care, ever been suspended or revoked? Yes No
 If yes, please attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

Action Taken	Where	Effective Date(s) of Licensing Authority's Action

7. Have you otherwise lost or surrendered your license, certificate, or other approval while a disciplinary hearing was pending? Yes No
 If yes, please attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

Action Taken	Where	Effective Date(s) of Licensing Authority's Action

8. Have you ever been disciplined by any licensing authority? Yes No
 If yes, provide the following information:

Action Taken	Where	Effective Date(s) of Licensing Authority's Action

INSTRUCTIONS FOR THE FAMILY PLANNING, ACCESS, CARE, AND TREATMENT PROGRAM DISCLOSURE STATEMENT

IMPORTANT: Governmental agencies including state, county, city, and other local governmental agencies do not complete this form. Remember to note in the upper right-hand corner of each page of this Family PACT Disclosure Statement the page numbers and the total number of pages to be submitted with the application package. References back to information already provided in a previous section is permissible.

1. Check the appropriate box and provide the requested information.
2. List full legal name, including last, first, and middle names, for each person or corporation with an ownership or control interest in applicant or provider (including officers and directors of an applicant or provider that is organized as a corporation and partners in an applicant or provider that is organized as a partnership) as listed with the Internal Revenue Service (IRS).
 - Person with an ownership or control interest means a person or corporation that:
 - has an ownership interest of 5 percent or more in an applicant or provider;
 - has an indirect ownership interest equal to 5 percent or more in an applicant or provider;
 - has a combination of direct and indirect ownership, indirect ownership interest equal to 5 percent or more in an applicant or provider;
 - 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;
 - **is an officer or director of an applicant or provider that is organized as a corporation;**
 - **is a partner in an applicant or provider that is organized as a partnership.**
 - 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.
 - 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.
 - 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.
 - 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 indirect ownership interest in the applicant or provider and shall be reported.
 - 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.
 - Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.
 - Residence means the address where the named person lives.
 - Driver's license number or state identification number means the driver's license or identification number issued by the state of residence. Attach a legible copy with the application.
 - Check the box that defines the relationship between person named in number 1 and applicant or provider, if applicable.
3. List the requested information regarding anyone that has an ownership or control interest in a subcontractor that applicant or provider also has a direct or indirect ownership interest in.
 - Subcontractor means an individual, agency, or organization: (1) to which applicant or provider has contracted or delegated some of its management functions or responsibilities of providing medical care services, equipment, or supplies to its patients, and (2) with whom an applicant or provider has entered into a contract, agreement, purchase order, lease or leases for property, space, supplies, equipment, or services provided under the Family PACT agreement.
 - Ownership interest means the possession of equity in the capital, the stock, or the profits of the applicant or provider.
 - Capital means the total of all money invested in, and property or services contributed to, an applicant's or provider's business enterprise for the purpose of starting, acquiring, equipping, and operating the applicant's or provider's business enterprise.
 - Indirect ownership interest means an ownership interest in any entity that has an ownership interest in the applicant or provider, including an ownership interest in any entity that has an indirect ownership interest in the applicant or provider.
4. List the requested information for any person named in number 1 that has an ownership or control interest in any subcontractor with whom the applicant or provider has had business transactions totaling more than \$25,000 during the 12-month period immediately preceding the date of this application, or immediately preceding the date on the Department's request for such information.
5. List the requested information regarding significant business transactions between any wholly-owned supplier and applicant or provider during the five years prior to the date on the application or the period ending on the date of the Department's written request for such information.
 - Significant Business Transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 or 5 percent of a applicant's or provider's total operating expenses.

- Wholly Owned Supplier means a supplier whose total ownership interest is held by an applicant or provider or by a person, persons, or other entity with an ownership or control interest in an applicant or provider.
6. List the requested information regarding significant business transactions between any subcontractor and applicant or provider during the five years prior to the date on the application or the period ending on the date of the Department's written request for such information. (See numbers 2 and 4 above.)
 7. Check the appropriate boxes and explain any "Yes" answers.
 8. Check the appropriate box and list the state(s), name(s) applicant or provider used when participating in another state Medicaid program, and all applicable provider numbers.
 9. Check the appropriate box and, if applicable, provide the effective date(s) of suspension(s), date(s) of reinstatement, and Medicare and/or Medicaid including Medi-Cal provider number and NPI.
 10. Check the appropriate box and, if appropriate, list the requested information and attach a copy of the letter(s) of reinstatement.
 11. Check the appropriate box and, if appropriate, list the requested information.
 12. Check the appropriate box and, if appropriate, list the requested information.
 13. Print the name of the individual provider individual signing on behalf of a group.
 14. An original signature (**blue ink only**) of the individual listed in number 13 is required.
 15. Include the city, state, and date in the statement regarding where and when the application was signed.

Attachment A Completion Instructions

1. Provide the name and address of all health care providers other than applicant or provider in which you also have an ownership or control interest. (See number 2 above for definitions.)
2. Check the appropriate boxes and explain any "Yes" answers.
3. Check the appropriate box and list all previous Medi-Cal provider numbers and NPI, if appropriate.
4. Check the appropriate box and list the state(s), name(s) applicant or provider used when participating in another state Medicaid program, and all applicable provider numbers.
5. Check the appropriate box and, if appropriate, list the requested information and attach a copy of the letter(s) of reinstatement.
6. Check the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was suspended or revoked and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
7. Check the appropriate box and, if applicable, and list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was lost or surrendered while a disciplinary hearing was pending and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
8. Check the appropriate box and, if applicable, indicate where the action was taken and the effective date of the action.