DISCLOSURE OF OR CHANGE IN OWNERSHIP AND CONTROL INTEREST

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 North Sound Behavioral Health Organization (North Sound BHO) to enter into an agreement or contract with the individual and/or entity or in 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 North Sound BHO from paying for items or services furnished, ordered, or prescribed by excluded persons. North Sound BHO 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.

I. **Identifying Information**	
OWNER TYPE (check one) ☐ Individual Ownership ☐ Organization Ownership	FEDERAL TAX ID/SSN
DOING BUSINESS AS	MINORITY WOMEN OWNED BUSINESS ENTERPRISE (MWOBE):
ORGANIZATION NAME	

II. Ownership and Control Information			
List each officer 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 employee.			
FIRST NAME	LAST NAME	SSN/TIN	DOB
ADDRESS			
FIRST NAME	LAST NAME	SSN/TIN	DOB
ADDRESS			
FIRST NAME	LAST NAME	SSN/TIN	DOB
ADDRESS			
FIRST NAME	LAST NAME	SSN/TIN	DOB
ADDRESS			

List those persons named 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/TIN	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE
III. Subcontractor Information		
NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE
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 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/TIN	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN/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 (OIG), Health and Human Services (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/TIN	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE

VI. Status Changes	
Is a change of ownership anticipated within the next year?	Yes ☐ No ☐
If yes, list date of change in operations:	
Is this facility operated by a management company or leased in whole or part by 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? _____	
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 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.	
NAME, SIGNATURE AND TITLE OF INDIVIDUAL COMPLETING THIS FORM	DATE

SUBMISSION INFORMATION

Please submit completed forms by mail, email, or by fax to the below:

North Sound Behavioral Health Organization
ATTN: Contracts Manager
301 Valley Mall Way, Suite 110
Mount Vernon, WA 98273
Fax: 360-416-7017
Email: deliverables@northsoundbho.org