



## ENROLLMENT DISCLOSURE STATEMENT ILLINOIS MEDICAL ASSISTANCE PROGRAM

**1. Identifying Information**

Provider Name	DBA Name	Provider No.	NPI
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Provider Office Street Address

City, County, State	Zip Code	Telephone (    )
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2. (a) List the name, address, and SSN/EIN of each person and/or entity with direct or indirect ownership or control interest in the disclosing entity or any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. List any additional names, addresses, and SSN/EIN under "Remarks" on page 2.

Name	Address	SSN/EIN

(b) If any persons listed in 2(a) are related to each other as spouse, parent, child, sibling, grandparent, grandchild, uncle, aunt, niece, nephew, cousin or relative by marriage, list that relationship (i.e. John Smith and Mary White are siblings).

(c) Check type of entity:    Sole Proprietorship    Partnership    Corporation    Unincorporated Associations  
 Other, please specify \_\_\_\_\_

List the name, address, and SSN of the Directors, Officers, Partners, and Managing Employees of the Disclosing Entity. List any additional names, addresses, and SSN under "Remarks" on page 2.

Name	Address	SSN

(d) Are any of the individuals/entities listed in 2(a) also current or previous owners of other Medicare/Medicaid entities?

Yes    No   If yes, for each affiliation list the individual/entity name from 2(a); the name, address, and provider number of the affiliated entity, along with the affiliation date. List any additional information as needed under "Remarks" on page 2.

Individual/Entity (2(a))	Name of Affiliated Entity	Affiliated Entity's Address	Affiliated Entity's Provider Number	Date of Affiliation

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3. Has there been a change in ownership or control for the disclosing entity within the last year?  Yes  No

If yes, give date and name of prior owner(s) \_\_\_\_\_

If the prior owner is a relative of anyone listed in 2(a), state the individual from 2(a) and the relationship (spouse, parent, child, sibling, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage).

4. List any person who: (1) Has ownership or control interest in the disclosing entity, or is an agent, or managing employee of the disclosing entity; and (2) Has been convicted of a criminal offense:

Name	Ownership Interest/Position	Criminal Offense	Date

5. List any person who: (1) Has ownership or control interest in the disclosing entity, or is an agent, or managing employee of the disclosing entity; and (2) Has been sanctioned (previously or currently) by any health care related program including, but not limited to, Medicare, Medicaid, or the Title XX services program since the inception of those Programs.

Name	Sanction	Date	State

**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 WITH THE DEPARTMENT.**

\_\_\_\_\_  
Name of Authorized Representative (Typed)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Remarks: