Ownership and Business Management Form

FACILITY NAME: ____

1. **Identify the persons and entities with 5% or greater direct or indirect ownership or controlling interest in the Applicant.** ***(If additional space is needed, continue on a separate sheet of paper and clearly label).*** **Please be sure that the address listed on the form matches the address on the Applicant's State Identification Card.**

NAME: ____

ADDRESS: ____

TELEPHONE: ____

NAME: ____

ADDRESS: ____

TELEPHONE: ____

NAME: ____

ADDRESS: ____

TELEPHONE: ____

NAME: ____

ADDRESS: ____

TELEPHONE: ____

NAME: ____

ADDRESS: ____

TELEPHONE: ____

Ownership and Business Management Form

NAME: ______________________________

ADDRESS: ______________________________

TELEPHONE: ______________________________

NAME: ______________________________

ADDRESS: ______________________________

TELEPHONE: ______________________________

NAME: ______________________________

ADDRESS: ______________________________

TELEPHONE: ______________________________

2. **List the name, address, and health care experience of the individual who is responsible for the overall business direction of the Application.** ***(If additional space is needed, continue on a separate sheet of paper and clearly label).*** **(Project Director)**

NAME: ______________________________

ADDRESS: ______________________________

*****Resume, Degree and Transcripts must be submitted.**

☐ **Resume, Degree and Transcript Submitted**

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3. **List the name, address, and health care experience of the individual to be appointed by the Applicant to act on its behalf in the overall management and operation of the facility/NTP regardless of form of ownership.** ***(If additional space is needed, continue on a separate sheet of paper and clearly label).*** **(Facility Director)**

NAME: ____

ADDRESS: ____

*****Resume, Degree and Transcripts must be submitted.**

☐ **Resume, Degree and Transcript Submitted**

4. **If you are also applying for a Certificate of Approval as a Narcotic Treatment Program, provide the name, address and health care experience of the individual who will serve as the Medical Director.** ***(If additional space is needed, continue on a separate sheet of paper and clearly label).*** ***(If only applying to do Telehealth, please skip to #5)***

NAME: ____

ADDRESS: ____

*****Resume, Degree and Transcripts must be submitted.**

☐ **Resume, Degree and Transcript Submitted**

5. **Have you ever applied to DDAP to open a facility before? If so, what the name listed on the application? (*If additional space is needed, continue on a separate sheet of paper and clearly label).***

☐ **YES (explanation below)** ☐ **NO**

NAME OF FACILITY ON APPLICATION: ______________________________

WHEN YOU APPLIED: ______________________________________

OUTCOME: ____

Ownership and Business Management Form

NAME OF FACILITY ON APPLICATION: ______________________

WHEN YOU APPLIED: ______________________

OUTCOME: ______________________

NAME OF FACILITY ON APPLICATION: ______________________

WHEN YOU APPLIED: ______________________

OUTCOME: ______________________

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6. **Names, addresses, and type(s) or facilities/NTPs currently or previously owned, managed, or operated by Applicant(s): (*If additional space is needed, continue on a separate sheet of paper and clearly label).***

APPLICANT NAME: ______________________

FACILITY NAME: ______________________

FACILITY ADDRESS: ______________________

FACILITY TYPE: ______________________

APPLICANT NAME: ______________________

FACILITY NAME: ______________________

FACILITY ADDRESS: ______________________

FACILITY TYPE: ______________________

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APPLICANT NAME: ______________________________

FACILITY NAME: ______________________________

FACILITY ADDRESS: ______________________________

FACILITY TYPE: ______________________________

APPLICANT NAME: ______________________________

FACILITY NAME: ______________________________

FACILITY ADDRESS: ______________________________

FACILITY TYPE: ______________________________

APPLICANT NAME: ______________________________

FACILITY NAME: ______________________________

FACILITY ADDRESS: ______________________________

FACILITY TYPE: ______________________________

7. **Description of any adverse action taken by any state or federal agency against any of the facilities/NTPs identified in #5 and any documentation regarding the action taken and its resolution.** ***(If additional space is needed, continue on a separate sheet of paper and clearly label).***

☐ **YES (explanation below)** ☐ **NO**

____

____

Ownership and Business Management Form

8. **Have any of the facilities/NTPs identified and/or individual(s) identified in this document been subject of CRIMINAL CHARGES?** ***(If additional space is needed, continue on a separate sheet of paper and clearly label).***

☐ **YES (If yes, provide information below)** ☐ **NO (If no, skip to #9)**

FACILITY OR INDIVIDUAL NAME: ______________________________

NATURE OF CRIME: ____________________ **DATE(S):** ________________

Provide documentation regarding the action taken and its resolution in the space provided below: (Must attach official court documents)

____

____

FACILITY OR INDIVIDUAL NAME: ______________________________

NATURE OF CRIME: ____________________ **DATE(S):** ________________

Provide documentation regarding the action taken and its resolution in the space provided below: (Must attach official court documents)

____

____

FACILITY OR INDIVIDUAL NAME: ______________________________

NATURE OF CRIME: ____________________ **DATE(S):** ________________

Provide documentation regarding the action taken and its resolution in the space provided below: (Must attach official court documents)

____

____

Pennsylvania
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Alcohol Programs

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FACILITY OR INDIVIDUAL NAME: ______________________________

NATURE OF CRIME: ____________________ **DATE(S):** ______________

Provide documentation regarding the action taken and its resolution in the space provided below: **(Must attach official court documents)**

____

____

9. Have any of the facilities/NTPs identified and/or individual(s) identified in this document been subject of CIVIL FRAUD CHARGES? ***(If additional space is needed, continue on a separate sheet of paper and clearly label).***

☐ **YES (If yes, provide information below)** ☐ **NO (If no, skip to #10)**

FACILITY OR INDIVIDUAL NAME: ______________________________

NATURE OF CRIME: ____________________ **DATE(S):** ______________

Provide documentation regarding the action taken and its resolution in the space provided below: **(Must attach official court documents)**

____

____

FACILITY OR INDIVIDUAL NAME: ______________________________

NATURE OF CRIME: ____________________ **DATE(S):** ______________

Provide documentation regarding the action taken and its resolution in the space provided below: **(Must attach official court documents)**

____

____

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FACILITY OR INDIVIDUAL NAME: ____________________

NATURE OF CRIME: ____________________ **DATE(S):** ____________________

Provide documentation regarding the action taken and its resolution in the space provided below: (Must attach official court documents)

____

____

FACILITY OR INDIVIDUAL NAME: ____________________

NATURE OF CRIME: ____________________ **DATE(S):** ____________________

Provide documentation regarding the action taken and its resolution in the space provided below: (Must attach official court documents)

____

____

10. Have any of the facilities/NTPs identified and/or individual(s) identified in this document been subject to MEDICARE AND/OR MEDICAID FRAUD AND/OR ABUSE? *(If additional space is needed, continue on a separate sheet of paper and clearly label).*

☐ YES (If yes, provide information below) **☐ NO (If no, skip to #11)**

FACILITY OR INDIVIDUAL NAME: ____________________

NATURE OF CRIME: ____________________ **DATE(S):** ____________________

Provide documentation regarding the action taken and its resolution in the space provided below: (Must attach official court documents)

____

____

Pennsylvania
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FACILITY OR INDIVIDUAL NAME: ____

NATURE OF CRIME: ___________________________ **DATE(S):** ____________________

Provide documentation regarding the action taken and its resolution in the space provided below: (Must attach official court documents)

____

____

11. Been ordered to pay a civil monetary penalty (other than previously listed)? ***(If additional space is needed, continue on a separate sheet of paper and clearly label).*** **(Must attach official court documents)**

☐ **YES (If yes, provide information below)** ☐ **NO**

____

____

12. Is there any ongoing fraud and abuse investigations involving any facility or individual(s) previously identified in this document? ***(If additional space is needed, continue on a separate sheet of paper and clearly label).*** **(Must attach official court documents)**

☐ **YES (If yes, provide information below)** ☐ **NO**

____

____

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13. A description of the Applicant's intentions with respect to the level of charity and uncompensated care to be provided. **(Must fill in this section, can't just put N/A)**

____

____

I (the applicant) acknowledge that my signature is verification that I have completed this checklist truthfully and accurately, and I understand that my statements herein are made subject to the penalties of 18 Pa.C.S.§4904 (relating to unsworn falsification to authorities).

____
APPLICANT PRINT NAME

____ ______________________
APPLICANT SIGNATURE **DATE**