Physician Office Laboratory Evaluation Program
Wadsworth Center
New York State Department of Health
Empire State Plaza
Albany, New York 12237

Disclosure of Ownership and Controlling Interest Statement

Submission of this application form to provide full and accurate disclosure of ownership and financial interests in the physician office laboratory is required by New York State Law. Failure to do so may result in the denial of the application and/or termination of CLIA application and/or registration. Please answer all questions as of the date the application is submitted.

PART I – Identifying Information

Name of Facility			
Address/Location			
City	State	Zip	Tax ID

PART II – Ownership Information

A. List names, addresses for individuals, and the EIN for organizations having direct or indirect ownership or a controlling interest in the facility.

Name(s)	Address(es)	Employee Identification Number

B. Type of facility.

Sole Proprietorship   Partnership   Corporation   Other (Specify)

C. If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations.

D. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

Yes   No

PART III – Declarations

A. Answer the following questions by selecting "Yes" or "No". If any questions are answered "Yes", list the names and addresses of individuals or corporations.

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.
Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or controlling interest in the provider, or is an agent or managing employee of the provider.

Yes No

If "Yes", list name(s) and address(es) of person(s) here.

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

Yes No

If "Yes", list name(s) and address(es) of person(s) here and explain/describe any charges and convictions.

PART IV - Checklist

The following forms and supporting documentation are attached, as applicable:

CLIA Application for Certification Form CMS-116.

IRS-issued letter showing the facility's name and federal tax identification number (EIN, TIN). The verification letter is commonly referred to as form SS-4. If you do not have an SS-4 verification letter, contact the IRS at 1-800-829-4933 to request a copy.

A copy of the director's current license to practice in New York State, if applicable.

If you have a management contract, please submit a copy with your application. If you do not have a management contract, please include a statement to that effect in the space below.
Management contract: Any laboratory that is operated and/or managed by an individual or entity on behalf of the owner must provide a copy of the written agreement (management contract) setting up the business relationship.

Qualification requirements for Laboratory Directors of Moderate Complexity Testing Facilities.

Qualification requirements for Laboratory Director of High Complexity Testing Facilities.

For Changes in Ownership: A copy of the executed contract governing the change of ownership, e.g., Bill of Sale is required. The executed contract must demonstrate that the CLIA certificate has been legally transferred from the old owner(s) to the new owner(s) in order for the change of ownerhsip to be processed.

Please note that LLCs and LLPs are not generally accepted into the New York State Department of Health Physician Office Laboratory Evaluation Program (POLEP) due to their respective membership structures. We will at this time allow an LLC or LLP into POLEP provided you submit a signed letter from the facility's ownership indicating that if at any time the membership structure changes you will notify POLEP. Depending on these changes your facility may have to transition to the New York State Department of Health Clinical Laboratory Evaluation Program.

Part V - Signature

Providing false or misleading information in this statement may lead to denial of the application and/or termination of the CLIA application and/or registration.

I hereby affirm that the information provided on this form and all attachments is true to the best of my knowledge.

______________________________	______________________________
Name of Authorized Representative	**Title**
______________________________	______________________________
Phone Number	**E-mail Address**
______________________________	______________________________
Signature	**Date**

The completed Disclosure of Ownership and Controlling Interest Statement must be submitted to the New York State Department of Health Physician Office Laboratory Evaluation Program.

By e-mail as an attachment to (Preferred Method):

clia@health.ny.gov

By mail to:

Physician Office Laboratory Evaluation Program
Wadsworth Center
New York State Department of Health
Empire State Plaza
Albany, New York 12237