Facility Recred Credentialing Application
Carelon Behavioral Health

Please indicate below each plan designation requested for this application submission

☐ Carelon Behavioral Health ☐ MBHP/HNE(Mass. Behavioral Health Partnership/Health New England)
☐ MEC(Michigan Engagement Center)

FACILITY CHECKLIST (2 pages)
To ensure timely processing of your application, please return the following:

☐ Completed Facility/Program Application (Attached)

☐ Completed site info form

☐ Copies of all applicable state or agency licenses

☐ Copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identifies the limits of liability of $1mil/$3mil and the policy period (documents must show "Professional Liability")

☐ Completed W-9 form or IRS Letter

☐ NPI (National Provider Identification)

☐ Staff Roster if applicable **(Required for WA state DCR's)**
Facility Roster We encourage you to submit roster updates via our template through the ProviderConnect portal. If you are unable to submit the roster via **ProviderConnects**, we ask that the completed excel roster be returned via email to **facilityrosters@carelon.com**.

☐ Accreditation Certificate(s):
- AAAHC – Accreditation Association for Ambulatory Health Care
- AOA – American Osteopathic Association
- CARF – Council on Accreditation of Rehabilitation Facilities
- CHAP – Community Health Accreditation Program
- COA – Council On Accreditation
- DNV – Det Norske Veritas
- HFAP – Healthcare Facilities Accreditation Program
- TJC – The Joint Commission

☐ Current CMS / State Site Visit / Survey (If not Accredited) (Not required if deemed rural) https://findahealthcenter.hrsa.gov/

☐ Certification(s):

- Other State licensure reports (i.e., Dept. of Human Services, Dept. of Mental Health and Mental Retardation)
    - Please Specify:
- SAMHSA – Substance Abuse and Mental Health Services Administration
- NDA Approval Letter - Department of Health and Human Services Spravato (esketamine) **(INCLUDE COPY OF LETTER)**
- CLIA - Clinical Laboratory Improvement Amendments, if applicable
- Medicaid
- Medicare

☐ Quality Assurance Policies & Procedures (QA P&P)

☐ Hiring Policies (Employment & Background Policies)

NON-ACCREDITED ORGANIZATIONS:

If your organization is not accredited by TJC, CARF, COA, AOA, CHAP, AAAHC, DNV or HFAP, then a site review of your Facility/Program will need to be conducted based upon the need for providers in your area. A site survey preparation document will be sent to you in advance of the site survey which will be scheduled at a mutually agreed upon date. A copy of a CMS Certification letter or on site survey results performed by the State may be accepted in lieu of an on-site review by Carelon or its preferred vendor. If your facility is located in a rural area as defined by the US Census Bureau, no site visit is necessary. If adding satellite clinic locations and the policies and processes are the same as main site, no additional site visits needed.

INDIVIDUAL TAX IDENTIFICATION NUMBERS AND NPI NUMBERS:

Carelon Credentials and Contracts facilities based on single Tax Identification Numbers (TIN's/EIN's). If your organization bills under multiple Tax Identification Numbers, you will need to complete multiple application packets. However, if your organization has multiple NPI (National Provider Identification) numbers, please include that information in this application with an explanation to which programs and/or locations to which the multiple NPI numbers apply.

GENERAL INFORMATION

Primary NPI _____ Tax ID: _____

Legal Name (as registered with the IRS) _____ DBA/Trade Name _____

Credentialing Contact Mailing Address Line 1 _____ Credentialing Contact Mailing Address Line 2 _____

City _____ State _____ Zip _____ Phone Number _____ Fax Number _____

Credentialing Contact Email Address_____Website _____

A. Facility Points of Contact

Chief Executive Officer Name _____ Phone Number _____ Ext _____ Managed Care Director Name _____ Email Address _____

Credentialing Contact Person Name _____ Phone Number _____ Ext _____ Billing/Claims Contact Name _____ Email Address _____

Contracting Contact Person Name _____ Phone Number _____ Ext _____ Fax Number _____ Email Address _____

Chief Medical Officer Name _____ Phone Number _____ Ext _____ Chief Clinical Officer Name _____ Email Address _____

Business Manager Name _____ Phone Number _____ Ext _____ Information Systems Mgr Name _____ Email Address _____

President of the Board of Directors _____ Phone Number _____ Ext _____ Chief Financial Officer Name _____ Email Address _____

B. Corporate Health System (Please complete if Facility/Program is part of a corporate health system):

Corporate Name _____ Contact Name _____ Title

Mailing Address Line 1 _____ Mailing Address Line 2 _____

City _____ State _____ Zip _____ Phone Number _____ Fax Number _____

Email Address_____

C. Facility Description (Select one description from the following list that best describes the facility:)

- ☐ General Hospital
- ☐ Free Standing Intensive Outpatient
- ☐ Community Mental Health Center
- ☐ Equestrian Center
- ☐ Free Standing Partial/Day Treatment
- ☐ Residential Treatment Center
- ☐ Free Standing Substance Abuse Rehab
- ☐ Other:
- ☐ Free Standing Acute Psychiatric
- ☐ Home Health Agency
- ☐ SAMSHA LAB/REM Certified Facility

D. Business Classification

a. Ownership (Must Check 1):	☐ Private	☐ Public	☐ Government
b. Status (Must Check 1):	☐ For-Profit	☐ Not-for-profit	
c. Pennsylvania Medicaid Only:	☐ Single County	☐ Base Service Unit	☐ Not Applicable
d. Colorado Medicaid Only:	☐ Rural Health Center	☐ Federally Qualified Health Center	

E. License/Certification

This organization is accredited or certified by one or more of the following:

☐ AAAHC	☐ CARF	☐ COA	☐ HFAP
☐ AOA	☐ CHAP	☐ DNV	☐ TJC

Other_____

Medicaire #_____ Medicaid #_____

Provider Profile / Malpractice Claims History

Please attach a detailed explanation for any questions below (1-5) that were answered "YES":

A. Please answer the following questions regarding your organization's behavioral health program(s):

1) Has the facility/program had professional liability insurance refused, revoked, declined or accepted on special terms in the past five years? ☐ Yes ☐ No

2) Has any government agency suspended, revoked, or taken other action against the facility/program's license to conduct business in the past five years? (To include Medicaid /Medicare) ☐ Yes ☐ No

3) Have any memberships in professional organizations and/or accreditations been revoked, reduced, denied, or suspended by others or voluntarily given up by the facility/program in the last five years, or are any actions now under way which may lead to such sanctions? ☐ Yes ☐ No

4) Have any owners, officers, or shareholders of the facility/program ever been convicted of a crime, excluding misdemeanors? ☐ Yes ☐ No

5) Has the facility/program ever been previously denied acceptance into the Carelon Network, disenrolled from the Carelon Network, or withdrawn from Carelon Network participation? ☐ Yes ☐ No

Please complete the malpractice claim information worksheet on the following page for any questions below (6-7) that were answered "YES":

6) Has the facility/program had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? If Yes, enter the total number: ☐ Yes ☐ No

7) If the facility/program is not TJC, AOA, CARF, COA, CHAP or AAAHC accredited, please answer the following question: Has the facility/program been a defendant in five (5) or more lawsuits within the past five (5) years in regard to the practice of behavioral health treatment or any lawsuits in the past five (5) years where there has been awards or payments of $250,000.00 (two hundred and fifty thousand dollars) or more? If Yes, enter the total number: ☐ Yes ☐ No ☐ N/A Only if accredited

8) Does the facility/program comply with §1128 of the Social Security Act by not hiring, continuing to employ, or contracting with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities (to include owners, officers, employees, subcontractors, and others identified in §1128)? ☐ Yes ☐ No

Please attach a detailed explanation for question 8 if answered "NO":

MALPRACTICE CLAIM INFORMATION WORKSHEET

B. Please attach information on what the organization's response was to the allegations and what steps were taken to prevent any future incidents for each claim listed below. This page can be copied to accommodate additional claim information.

1. Date of Occurrence:	Date Claim Filed:	Date of Settlement:		
Allegations and Action Taken:				
Case Settled:	☐ In Court	☐ Out-of-Court	☐ With Prejudice	☐ Without Prejudice
Total Amount Paid to Claimant on Behalf of Facility/Program: $				

2. Date of Occurrence:	Date Claim Filed:	Date of Settlement:		
Allegations and Action Taken:				
Case Settled:	☐ In Court	☐ Out-of-Court	☐ With Prejudice	☐ Without Prejudice
Total Amount Paid to Claimant on Behalf of Facility/Program: $				

3. Date of Occurrence:	Date Claim Filed:	Date of Settlement:		
Allegations and Action Taken:				
Case Settled:	☐ In Court	☐ Out-of-Court	☐ With Prejudice	☐ Without Prejudice
Total Amount Paid to Claimant on Behalf of Facility/Program: $				

4. Date of Occurrence:	Date Claim Filed:	Date of Settlement:		
Allegations and Action Taken:				
Case Settled:	☐ In Court	☐ Out-of-Court	☐ With Prejudice	☐ Without Prejudice
Total Amount Paid to Claimant on Behalf of Facility/Program: $				

PARTICIPATION STATEMENT

The Facility grants (i) Carelon and its credentialing verification organizations (CVO) (individually and collectively as “Carelon Entity”) permission and consent to obtain and verify information contained in this application and, as part of this process, to consult with State licensing agencies, accreditation agencies, malpractice insurance carriers, and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain or verify information concerning the Facility’s professional competence and qualifications.

The Facility also grant permission and consent for all persons, organizations, or other entity to release to Carelon Entity all information they have in their control that relates to the Facility’s competence or ability to render clinical services in a professional, cost effective manner. The Facility releases Carelon Entity and each of their respective employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating the Facility’s application.

The Facility further authorizes Carelon Entity (other than CVO) to release to any of their affiliates, any information that is included in this application or obtained during such investigation related to my application, but only to the extent permitted by law and only for the limited purposes of credentialing being undertaken by or on behalf of the receiving Carelon Entity in regard to the Facility’s credentialing status before that Carelon Entity. As used herein, the term “Carelon" shall mean, individually and collective, as applicable, Carelon and each of their respective subsidiaries and affiliates.

The signatory of this application represents and warrants that it is authorized to bind the Facility to the terms of this application without the requirement of any further action being undertaken. The signatory certifies that the information in this application is true, correct and complete, and that s/he understands and agrees that any information entered in this application, which subsequently is found to be false, may result in the termination of the contract.

Facility Name

Authorized Signature

Name of Person Completing Form

Title

Date (MM/DD/YYYY)

SITE INFORMATION FORM

Please list all active site information thats providing Behavioral Health services or provide excel spreadsheet with this information.

*****If adding facility services to contract please complete Locations & Services Form - Click Here***

Site Location Address: *Street, City, State, Zip*	**Billing Address:** *Street, City, State, Zip*	**TaxID#**	**NPI#**	**Medicaid #** *(If applicable)*	**Medicare#** *(If applicable)*	**Services in System that NO LONGER meet requirements (enter program codes)** *(Beacon credentialing ONLY. Facilities do NOT complete this section)*
	☐ Check if billing address is same for other sites.					☐ Check If services no longer meet requirements for all other locations

Attestation Statement:

My signature below indicates that all of the information provided above, and in any attachments to this application document, is true and correct to the best of my knowledge.

Signature_____ **Date:**_____

carelon℠

****Complete only if not accredited****

FACILITY SITE VISIT ATTESTATION

Facility Name:_____ **TAX ID**: _____

Primary Location:

_____

Street City State Zip

Satellite Locations: (attach additional sheet if necessary)

_____

Street City State Zip

_____

Street City State Zip

_____

Street City State Zip

Attestation Statement:

My signature below certifies that all facility locations listed above are requesting to be associated to the Carelon provider network. The facility is attesting that all locations will be required to adhere to policies and procedures as set forth by the above facility name pertaining to the following criteria:

1. Adequate parking with parking on premises or in immediate vicinity readily available.
2. Accessible to the disabled or alternative arrangements to serve those with special needs.
3. Restrooms available to members and accessible for disabled.
4. Member access to a telephone on premises.
5. Elevator if the office is above the first floor; elevators regularly inspected and posted.
6. Office is well maintained, in reasonably good repair and has appropriate professional appearance.
7. Adequate seating in the waiting area and treatment areas.
8. Office and/or emergency exit(s) clearly marked.
9. Working smoke detector/fire alarm/sprinkler system present.
10. All documents including appointment schedules, treatment records and forms are kept out of public view and in a secured location not accessed by unauthorized persons.
11. Confidential verbal communication is not audible to unauthorized persons.
12. Computer screens with patient information are kept out of public view and are accessible only by authorized persons.
13. Appointments available for:
    i. Life-threatening emergencies available immediately or within 30 minutes
    ii. Non-life-threatening emergencies available within 6 hours
    iii. Urgent needs available within 48 hours
14. Routine appointments available within 10 calendar days.
15. Ability to track member waiting time for scheduled appointments?
16. Adequate mechanism for members to contact him/her after hours and in emergency situations.
17. Member rights & responsibilities should be provided to members or posted in either waiting or treatment areas.
18. Grievance procedures should be provided to members or posted in either waiting or treatment areas.
19. Practitioner's degree and license posted in public view.
20. Written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including, but not limited to members with limited English proficiency.

_____ _____ _____

Signature of Applicant Title Date

_____

Name (Please Print)

Directions:

In order to comply with Federal law (42 CFR 420.200 - 420.206 and 455.100- 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program or any line of business that provides healthcare for federal employees. The Centers for Medicaid and Medicare Services (CMS) requires Carelon Health Options, Inc. to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal and state health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid.

Please complete the following 2 pages below and fax the completed forms to: **866-612-7795.** This form is required if you wish to participate or continue to participate in the plan. You are also reminded that any changes to this information in the future must be reported to Carelon Health Options, Inc. within 35 business days of the change and updated information will be requested upon recredentialing. Please provide information for Owners, persons with Control interests, Agents and Managing employees of the Provider Entity. Attach a separate sheet/report if needed.

Definitions:

Provider Entity: Any individual or entity engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in that State if such licensure or certification is required by State law or regulation.

Master List: The list of owners the provider will be disclosing on form.
- All owners on the master list, must include their Home Address, SSN, DOB, % of Ownership
- If any owners are a Non-Profit agency please indicate the following:
    - Name of Entity
    - Owner DOB & Owner SSN leave Blank.
    - N/A in the % of Ownership column,
    - Check YES in the Non-Profit column.
    - Business address of Entity

Owner: is a person or business entity which owns 5% or more of the assets, stock or profits of the Provider Entity.
- This 5% may be Direct ownership or Indirect ownership i.e., an individual might own 50% of a company that owns the actual Provider Entity meaning their indirect ownership is 50%.
- In addition to ownership of stock, (2) Owner is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the Provider Entity.

Control Interest is someone who directs the Provider Entity and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership.

Managing Employee is someone who makes the day to day decisions for the Provider Entity. These individuals include office or billing managers for smaller providers, and for larger Provider Entities the heads of the major operating groups of the provider like, Head of Accounting, or Director of same day services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

Debarred or Excluded means an individual or entity that is not allowed to do business with the Federal government, including healthcare programs receiving Federal funding or reimbursement.

Terminated means the Provider lost the right to bill a State's Medicaid or CHIP programs for a cause related to fraud or abuse.

Immediate Family is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. Member of Household is, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Agent is an individual who has the legal ability to bind the Provider Entity, i.e., the Provider Entity may use an Agent to obtain contracts for it.

Subcontractor is a person or company that this Provider Entity has contracted with to do some of the Provider Entities' management functions, i.e., billing agent, or provide medical services i.e. a medical lab.

Supplier means an individual, agency, or organization from which the Provider Entity purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy.)

I. Identifying Information

___________________________ Name of Person Completing Form

_________________________________ Phone Number of Person Completing Form

___________________________ Provider's Name

Provider Entity Information:

______________________________ Name of Entity

_______________________________ Entity DBA (If Different from Entity Name)

_______________ Entity Tax ID

_______________________ Entity NPI Number

______________________________ Practice Address Line 1

______________________________ Practice Address Line 2

__________________ City

____ State

______ ZIP

II. OWNER OR CONTROL INFORMATION *(If more than 4 owners, please submit make copies of this page)*

A. Master List:

Owners must have minimum of 5% ownership to be considered part of the Master List. Totals of Master list must equal 100%, unless the agency is Non-Profit.

OWNER NAME	OWNER DOB	OWNER SSN	% OF OWNERSHIP	Non-Profit
				Yes ☐ No ☐

OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP

OWNER NAME	OWNER DOB	OWNER SSN	% OF OWNERSHIP	Non-Profit
				Yes ☐ No ☐

OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP

OWNER NAME	OWNER DOB	OWNER SSN	% OF OWNERSHIP	Non-Profit
				Yes ☐ No ☐

OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP

OWNER NAME	OWNER DOB	OWNER SSN	% OF OWNERSHIP	Non-Profit
				Yes ☐ No ☐

OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP

B. Specific Questions

1. Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent, child or sibling? If attaching a report, please indicate corresponding columns below.
Yes ☐ No ☐

NAME OF FIRST RELATED PERSON	NAME OF SECOND RELATED PERSON	TYPE OF RELATIONSHIP

2. Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider Entity**? ? If attaching a report, please indicate corresponding columns below.
Yes ☐ No ☐

NAME OF OTHER PROVIDER ENTITY	ADDRESS	CITY	STATE	ZIP	TAX ID

3. Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Tricare or the CHIP services program since the inception of those programs?
Yes ☐ No ☐

NAME ON COURT RECORDS	SSN/TIN	MATTER OF OFFENSE	CONVICTION DATE	EXCLUSION PERIOD (IF APPLICABLE)

4. Have any of the individuals or entities on the **Master List** ever been **Debarred or Excluded** from participation in Federal Government contracts (Medicaid, Medicare, CHIP or Tricare)?
Yes ☐ No ☐

WHEN WERE YOU DEBARRED	LENGTH OF DEBARMENT	REASON FOR DEBARMENT

5. Has any person or entity on the **Master List** ever been **Terminated or had Civil Monetary Penalties** from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)?
Yes ☐ No ☐

PRACTICING STATE WHEN TERMINATED	REASON FOR TERMINATION	DATE OF TERMINATION

6. Did anyone on the **Master List** obtain their **Direct or Indirect Ownership** interest 1) as a result of a transfer of Direct or Indirect ownership from someone who was about to be Excluded or Terminated from participation in a Federal healthcare program, or was in fact Excluded or terminated from participation in a federal healthcare program and 2) where the original **Owner** is or was a member of the **current Owner's Immediate Family** or M**ember of** the current owner's household, at the time of the transfer of ownership? If attaching a report, please indicate corresponding columns below.
Yes ☐ No ☐

NAME OF ORIGINAL OWNER	SSN OR TAX ID OF ORIGINAL OWNER	PLACE OF TRANSFER	DATE OF TRANSFER

7. Do you have any **Subcontractor** in which this **Provider Entity** has a Direct or Indirect **Ownership** interest of at least a 5%?
(A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** management functions, i.e., billing agent, or provide medical services i.e. a medical lab) If attaching a report, please indicate corresponding columns below
Yes ☐ No ☐

NAME OF SUBCONTRACTOR	ADDRESS	CITY	STATE	ZIP	TAX ID

8. For each **Subcontractor(s)** listed in question 7 above please provide the following information for the individuals with Direct or Indirect **Ownership** or **Control Interest** in the **Subcontractor(s).** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary. If attaching a report, please indicate corresponding columns below.

NAME	ADDRESS	CITY	STATE	ZIP	TAX ID	% OF OWNERSHIP	TITLE

9. Is any persons from question 7, in the list above related to any person in the **Master List**? If attaching a report, please indicate corresponding columns below.

NAME OF FIRST RELATED PERSON	NAME OF SECOND RELATED PERSON	TYPE OF RELATIONSHIP

III. BUSINESS TRANSACTIONS

1. Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your **Provider Entities'** total operating expenses *or* $25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.7a. in which you have an **Direct or Indirect Ownership interest**. If attaching a report, please indicate corresponding columns below.

NAME	ADDRESS	CITY	STATE	ZIP

2. Does the **Provider Entity** *wholly own* a **Supplier**? If attaching a report, please indicate corresponding columns below.
Yes ☐ No ☐ If yes, supply the following information about the **Supplier:**

NAME	ADDRESS	CITY	STATE	ZIP	NPI	TAX ID

Answer the following questions by checking '"Yes" or "No'. If any of the questions are answered "Yes," list names and addresses of individuals or corporations and/or provide date and an explanation on a separate sheet of paper:

1. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's organization's or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVRN providers only) Yes ☐ No ☐
2. Has there been a change in ownership or control within the last year? Yes ☐ No ☐
3. Do you anticipate any change of ownership or control within the year? Yes ☐ No ☐
4. Do you anticipate filing for bankruptcy within the year? Yes ☐ No ☐
5. Is this facility, agency, institution or organization operated by a management company, or leased in whole or part by another organization? Yes ☐ No ☐
6. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? Yes ☐ No ☐
7. Is this facility, agency, institution or organization chain affiliated? (If yes, list name, address of Corporation, and EIN) Yes ☐ No ☐
8. If the answer to Question 7 is No, was the facility, agency, institution or organization ever affiliated with a chain? Yes ☐ No ☐
9. (For Facilities Only) Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years? Yes ☐ No ☐

IV. Signature

Carelon Health Options, Inc. may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below MUST be the written signature of an individual who can legally bind this Provider Entity;

_____ Name of Entity Owner

_____ Signature of Entity Owner

_____ Title

_____ Date

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) [a]

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

Other (see instructions) [a]

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Social security number

			–			–				

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** [a] **Date** [a]

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)