



Initial Doula Paperwork Checklist

Please complete the initial doula paperwork which consists of the Disclosure Form(s) and W-9. Once these forms have been completed and are accepted, our contracting team will present you with a contract to sign and send back. Once it is signed and sent back to us, our contracting team will counter-sign it on our end, and you will be assigned an effective date of your participation as an in-network doula with UnitedHealthcare Community Plan of New Jersey.

Document	Disclosure Form (Individual and/or Entity)
Description	<p>UnitedHealthcare Community Plan (“UnitedHealthcare”) is required to collect disclosure of ownership, controlling interest and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid and/or the Children’s Health Insurance Program (CHIP) managed care program by UnitedHealthcare or by a delegate of UnitedHealthcare, pursuant to a Medicaid and/or CHIP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455.</p>
Instructions	<p>An <i>Individual doula</i> is their own independent entity. Click below for the online form-fillable form: <u>Individual Disclosure of Ownership and Control Interest Form – Online Version</u></p> <p>A <i>Doula entity</i> includes one or more doulas who provide services under a group entity. Click below for the online form-fillable form: <u>Entity Disclosure of Ownership and Control Interest Form – Online Version</u></p> <p>Please note the following when filling out the form(s):</p> <ol style="list-style-type: none"> 1. Doulas who operate as a sole proprietor should fill out the <u>Individual Disclosure of Ownership and Control Interest Form – Online Version</u> 2. Doulas who operate a doula group or organization with one or more doulas under their Tax ID should fill out the <u>Entity Disclosure of Ownership and Control Interest Form – Online Version</u> 3. Doulas who are part of a doula entity (group or organization) and who do not own its NPI or Tax ID will not need to fill out the <u>Individual Disclosure of Ownership and Control Interest Form – Online Version</u> if the doula will operate under the same Tax ID as the group.

	<p>4. If you do not have a business practice location, you can use your residential address. There must be a physical location listed.</p> <p>5. If you have a P.O. Box, you can add it by following the directions listed under the section <i>Additional Addresses</i>.</p> <p>Note: We do not publish any doula physical/residential addresses in our <u>Community Doula List</u>.</p>
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Document	W-9
Description	Request for Taxpayer Identification Number and Certification
Instructions	<p>Please note the following when filling out the form(s):</p> <ol style="list-style-type: none"> 1. Fill out all form-fillable applicable fields in the W-9 form. 2. The W-9 form can be found by visiting <u>About Form W-9, Request for Taxpayer Identification Number and Certification Internal Revenue Service (irs.gov)</u> and clicking on <u>Form W-9 (Rev. March 2024) (irs.gov)</u>. 3. Instead of saving and sending your filled out document, you will need to print it as a pdf and then send it back.

If you have any questions, please reply back to the email where you received this checklist from, or email uhccpnj@uhc.com.

Individual Providers

Disclosure of Ownership, Controlling Interest & Management Statement and Attestation of Criminal Convictions, Sanctions, Exclusions, Debarment or Termination

UnitedHealthcare Community Plan (“UnitedHealthcare”) is required to collect disclosure of ownership, controlling interest and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid and/or the Children’s Health Insurance Program (CHIP) managed care program by UnitedHealthcare or by a delegate of UnitedHealthcare, pursuant to a Medicaid and/or CHIP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455.

Required information includes:

- 1) The identity of all owners and others with a controlling interest;
- 2) Certain business transactions as described in 42 CFR §455.105;
- 3) The identity of managing employees, agents and others in a position of influence or authority; and
- 4) criminal conviction information for the provider, owners, agents and managing employees. The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Providers participating in UnitedHealthcare’s Medicaid and/or CHIP managed care networks must complete and submit the disclosure statement below in accordance with the terms of their participation agreement and as a condition of participation in Medicaid and/or CHIP. Failure to submit the requested information may result in claims denials, exclusion from UnitedHealthcare’s network, or termination of an existing provider agreement.

This statement should be submitted with the initial contract and updated:

- Every three (3) years
- Upon renewal of the participation agreement
- At any time there is a revision to the information
- Within 35 days of a request for updated information.

Detailed instructions and a glossary for capitalized terms can be found at the end of this form.

Tips to Avoid Delays in Processing Your Disclosure Form

- ✓ For any question answered with a “Yes” response, please fill out all subsequent fields.
- ✓ Every field must have a response. “N/A”, “non-applicable” and “applied for” are acceptable.
- ✓ If fields are left blank, the form will be returned for corrections/completeness.
- ✓ If the form is unreadable due to illegible handwriting, the form will not be processed.
- ✓ All attachments must indicate which section they apply to.

Individual Provider/Sole Proprietor Information

Type of provider Please choose appropriate category: <input type="radio"/> Individual Member of a Medical Group <input type="radio"/> Individual Contracted Practitioner <input type="radio"/> Sole Proprietor <input type="radio"/> HCBS Provider <input type="radio"/> Other: _____		Name of Person Completing the Form	
		Title	
		Phone Number	
Group Affiliation? <input type="radio"/> Yes <input checked="" type="radio"/> No		Fax	
If affiliated with a Group, do you have a Private Practice as well? <input type="radio"/> Yes <input checked="" type="radio"/> No		Email	
In which state(s) do you participate in Medicaid and/or CHIP? NJ			
Legal Name:		DBA Name:	
Practice Address:			
Street	City	State	Zip
Additional Addresses Do you have additional addresses? <input type="radio"/> Yes <input type="radio"/> No: If Yes, list all practice locations on an attachment labeled “Additional Addresses”. Note: At least one physical location must be listed, either in the chart above or on the attachment.			
** Individual Provider SSN #: 	Medicaid ID #: <input type="radio"/> Applied for Medicaid ID <input type="radio"/> Not Applicable	Individual Provider NPI #: <input type="radio"/> Applied for NPI <input type="radio"/> Not Applicable	
Federal Tax Identification #: Enter SSN if billing with SSN	Entity/Group Medicaid ID #: <input type="radio"/> Applied for Medicaid ID <input type="radio"/> Not Applicable	Entity/Group NPI #: <input type="radio"/> Applied for NPI <input type="radio"/> Not Applicable	

****SSN is required per 42 CFR § 455.104.**

Section I: Ownership Information

Section I, Question 1: List individual(s) and/or organization(s) with a **Direct or Indirect Ownership** of 5% or more in your practice.

Refer to the Glossary to determine who should be listed as an Owner and/or to calculate Ownership Interest

Yes There are individual(s) and/or entity(ies) that have a 5% or greater ownership interest.

List the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership Interest in the Individual Provider of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership Interest of 5% or greater. (42 CFR §455.104(b)(1))

Sole Proprietors: List the name, primary address, date of birth (DOB) and Social Security Number (SSN) of the Sole Proprietor.

Note: If there is 1 owner, fill out the chart below. If there are 2 or more owners, you **must** attach a list with the required fields labeled "Section I, Question 1". Do you have a list to attach? **Yes** **No**

No There is no individual or entity that owns 5% or more of this practice.

Name of Owner	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	* * SSN (individual) TIN (entity) <i>List both as applicable</i>	% Interest
		Street City State Zip		

Section II: Identification of All Individuals & Entities with a Controlling Interest

Section II, Question 1: Do you have any **Officers or Directors**? **Yes** **No** **N/A**

If **Yes**, list all officers and directors, including each member of the Board of Directors or Governing Board; include the name, date of birth (DOB), address, and Social Security Number (SSN), and applicable title or position (42 CFR §455.104(b)(1)).

Note: If there are 1-2 directors, fill out the chart below. If there are 3 or more directors, you **must** attach a list with the required fields labeled "Section II, Question 1". Do you have a list to attach? **Yes** **No**

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)
		Street
Title	** SSN	City
		State Zip
Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)
		Street
Title	** SSN	City
		State Zip

****SSN is required per 42 CFR § 455.104.**

Section II, Question 2: Are there any other individuals or entities with a **Controlling Interest** (e.g., business partner, etc.)?

Yes No N/A

If Yes, list the name, address, date of birth (DOB) and Social Security Number (SSN) for each person having a Controlling Interest in the Provider Entity. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having a Controlling Interest. (42 CFR §455.104(b)(1))

Note: If there is 1 individual/entity, fill out the chart below. If there are 2 or more individuals/entities, you **must** attach a list with the required fields labeled "Section II, Question 2". Do you have a list to attach? Yes No

Name of Individual or Entity	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	
		Street	
Title (as applicable)	** SSN (individual) TIN (entity)		City
			State Zip

Section III: Ownership & Controlling Interest in Other Disclosing Entities

Section III, Question 1: Do any of the individuals or entities *identified in Section I* as an owner have an Ownership or Controlling Interest in any **Other Disclosing Entity**? Yes No N/A

Refer to the Glossary and Instructions to determine who should be listed as an Owner in Other Disclosing Entities

If Yes, list the name and the SSN or TIN of the Other Disclosing Entity in which the Owner identified in **Section I** also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3))

Note: If there are 1-2 owners, fill out the chart below. If there are 3 or more owners, you **must** attach a list with the required fields labeled "Section III, Question 1". Do you have a list to attach? Yes No

Name of Owner from Section I	Name of Other Disclosing Entity	Other Disclosing Entity's SSN (individual) or TIN (entity)

****SSN is required per 42 CFR § 455.104.**

Section IV: Ownership & Controlling Interest in Subcontractors

Section IV, Question 1:

Do you have a Direct or Indirect Ownership Interest of 5% or more in any **Subcontractor**? Yes No

Refer to the Glossary and Instructions to determine who should be listed as a Subcontractor

If Yes, does another individual or organization also have an **Ownership or Controlling Interest** in the same Subcontractor?

Yes No

If Yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you also have Direct or Indirect Ownership Interest of 5% or more. (42 CFR §455.104(b)(1)&(2))

Note: If there is 1 subcontractor, fill out the chart below. If there are 2 or more subcontractors, attach a list with the required fields labeled "Section IV, Question 1". Do you have a list to attach? Yes No

Legal Name of Subcontractor	Subcontractor TIN/SSN		
Name of Other Individual/Entity with Ownership or Controlling Interest			
Other Individual/Entity's Complete Address (Street/City/State/ZIP)	Street City	State	Zip
Other Entity's TIN:	* *Other Individual's SSN:	Other Individual's DOB (mm/dd/yyyy)	% Interest in Subcontractor

Section V: Familial Relationships

Section V, Question 1: Are any of the individuals identified in Sections I, II, III or IV related to each other? Yes No

If Yes, list the individuals identified and the relationship to each other (e.g., spouse, sibling, parent, child) (42 CFR §455.104(b)(2))

Note: If there are 1-2 relationships, fill out the chart below. If there are 3 or more relationships, you **must** attach a list with the required fields labeled "Section V, Question 1". Do you have a list to attach? Yes No

Name of Individual #1:	Name of Individual #2:	Relationship

**SSN is required per 42 CFR § 455.104.

Section VI: Management & Control

Section VI, Question 1: Do you have any **Managing Employees** or anyone that exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of your practice (e.g., general manager, business manager, administrator or dept. manager, etc.)? Yes No

All Managing Employees must be listed. Include all Managing Employees' information including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104)

Sole Proprietors: If there are no managing employees, please list the name, date of birth (DOB), address, Social Security Number (SSN) and title of the Sole Proprietor.

Note: If there are 1-3 managing employees, fill out the chart below. If there are 4 or more managing employees, attach a list with the required fields labeled "Section VI, Question 1". Do you have a list to attach? Yes No

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN**	Title
		<input type="text"/> Street <input type="text"/> City <input type="text"/> State <input type="text"/> Zip		
		<input type="text"/> Street <input type="text"/> City <input type="text"/> State <input type="text"/> Zip		
		<input type="text"/> Street <input type="text"/> City <input type="text"/> State <input type="text"/> Zip		

Section VI, Question 2: Do you have any Agents? Yes No See Glossary for definition

If Yes, list all Agents that have been delegated the authority to obligate or act on behalf of you, the Individual Provider, (e.g., purchasing agent, broker, etc.) including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104).

Note: If there is 1 agent, fill out the chart below. If there are 2 or more agents, attach a list with the required fields labeled "Section VI, Question 2". Do you have a list to attach? Yes No

Section VII: Criminal Convictions, Sanctions, Exclusions, Debarment or Terminations

Section VII, Question 1:

Have you, or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee **ever been convicted of a crime** related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title XX program since the inception of those programs? Yes No

If Yes, list those persons and the required information below. (42 CFR §455.106)

Note: If providing additional documentation, you **must** attach a list with the required fields labeled "Section VII, Question 1". Do you have a documentation to attach? Yes No

Name	DOB (mm/dd/yyyy)	SSN (individual) or TIN (entity)
Complete Address (Street/City/State/Zip)		
Street		
City	State	Zip
Matter of the Offense		
State of Conviction	Date of Conviction (mm/dd/yyyy)	Date of Reinstatement (mm/dd/yyyy) <small>*Enter N/A if not reinstated</small>

Section VII, Question 2:

Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee ever been **sanctioned, excluded or debarred** from Medicaid, Medicare, CHIP or a Title XX program? Yes No

If Yes, list those persons and the required information below. (42 CFR §455.436)

Note: If providing additional documentation, you **must** attach a list with the required fields labeled "Section VII, Question 2". Do you have additional documentation to attach? Yes No

Name	DOB (mm/dd/yyyy)	SSN (individual) or TIN (entity)
Complete Address (Street/City/State/Zip)		
Street		
City	State	Zip
Reason for Sanction, Exclusion or Debarment		
List all States where currently excluded:	Date(s) of Sanctions, Exclusions or Debarments (mm/dd/yyyy)	Date of Reinstatement (mm/dd/yyyy) * Enter N/A if not reinstated

Section VII, Question 3:

Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee ever been **terminated** from participation Medicaid, Medicare, CHIP or a Title XX program? Yes No

If Yes, list those persons and the required information below.

Note: If providing additional documentation, you **must** attach a list with the required fields labeled "Section VII, Question 2". Do you have a documentation to attach? Yes No

Name	DOB (mm/dd/yyyy)	SSN (individual) or TIN (entity)
Complete Address (Street/City/State/Zip)		
Street		
City	State	Zip
Reason for Termination		
State that originated Termination	Date of Termination (mm/dd/yyyy) <small>*Enter N/A if not reinstated</small>	Date of Reinstatement (mm/dd/yyyy) <small>*Enter N/A if not reinstated</small>
		Medicare billing privileges revoked? <input type="radio"/> Yes <input checked="" type="radio"/> No

At any time during the Contract or Credentialing period, it is your responsibility to promptly provide notice of convictions, sanctions, exclusions, debarments and terminations (See Fed. Register, Vol. 44, No. 138)

Section VIII: Business Transaction Information

Section VIII is not required at the time of supplying this form but may be required upon request of CMS. By signing this form, you are acknowledging that you will supply the following information within 35 days if requested by the Secretary of Health and Human Services or the Medicaid agency.

Section VIII, Question 1: Business Transactions – Subcontractors

List the information for Subcontractors with whom you have had business transactions totaling more than \$25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)). See *Glossary for definition*.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractor's Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN/TIN, and Subcontractor Owner's Address

Section VIII, Question 2: Significant Business Transactions – Wholly Owned Suppliers

List the information for any Wholly Owned Supplier with whom you have had any Significant Business Transactions exceeding the lesser of \$25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period (42 CFR §455.105(b)(2)). See *Glossary for definition*.

- Name of Supplier, Supplier's SSN (individual) or TIN (entity), and Supplier's Address

Section VIII, Question 3: Significant Business Transactions – Subcontractors

List the information for Subcontractor with whom you have had any Significant Business Transactions exceeding the lesser of \$25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period (42 CFR §455.105(b)(2)). See *Glossary for definition*.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractor's Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN/TIN, and Subcontractor Owner's Address

Through signature below, I hereby certify that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation and denial of claims. **Individual Providers must sign the form.**

*Signature must be a wet signature or an e-signature from a state-approved source (ex. Adobe Sign)

*If fields are left blank, the form will be returned for corrections/completeness.

Signature (Individual Provider *must* sign form)

Title

Full Name (please print)

Date

Phone Number

Fax Number

Email Address

Instructions for Disclosure of Ownership/Controlling Interest and Management Statement

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. (For example: Section I Ownership Information, continued). Please see Glossary for definitions of capitalized terms.

Section I: Individual Provider Ownership Information:

Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more in your entity. If the owner is a corporation: the primary business address must be listed and every business location and P.O. Box address. Date of Birth and SSN* must be included for each individual owner.

Section II: Identification of All Individuals & Entities with a Controlling Interest:

Please list the required information for each individual or organization that has a Controlling Interest in your individual practice. Individuals with a Controlling Interest include officers and directors of a governing board, as well as business partners (see Glossary for definition). Date of Birth and SSN* must be included for each individual with controlling interest.

Answer "Yes" to this section if an individual or entity had an ownership or controlling interest in your practice of medicine outside of your membership or employment in a medical group.

Section III: Ownership & Controlling Interest in Other Disclosing Entities:

If any of the individuals or entities listed in Section I and/or Section II as having ownership or controlling interest in your individual practice also have ownership or controlling interest of 5% or more in any other entities, identify those entities in Section III. This information is to identify shared and interconnected ownership and controlling interests.

Section IV: Ownership & Controlling Interest in Subcontractors:

If you have a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

Section V: Familial Relationships:

Report whether any of the persons listed in Sections I, II, III or IV are related to each other and identify the parties and their relationship. Relationships must be disclosed if the parties are spouses, parent/child, or siblings.

Section VI: Management & Control:

1. List the required information for all employees that hold a position of Managing Employee within your individual private practice.
 2. List the required information for all Agents that have the authority to act on your behalf.
- Date of Birth and SSN* must be included for each Managing Employee and Agent.

Section VII: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations:

List your own criminal convictions, exclusions, sanctions, debarments and terminations, and for any person who has an Ownership or Controlling Interest, or is an Agent or Managing Employee of your individual private practice. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs. Review all necessary databases to verify this information.

Section VIII: Business Transaction Information:

The following is not required at this time, but will need to be provided within 35 days of request from the Secretary of Health and Human Services or the Medicaid agency:

1. List the Ownership of any Subcontractors that you, as an Individual Provider, have had business transactions totaling more than \$25,000 within the last twelve (12) month period ending on the date of the request.
2. List any **Significant Business Transaction** between yourself and any Wholly Owned Supplier during the past 5 years.
3. List any **Significant Business Transaction** between yourself and any Subcontractor during the past 5 years.

Remember that a **Significant Business Transaction** is defined as any transaction or series of related transactions that exceeds the lesser of \$25,000 or 5% of a provider's operating expenses during any one fiscal year. Do not list transactions that are managed by a medical group or independent provider association (IPA); only list your own individual practice business transactions, if applicable.

GLOSSARY

Individual Provider: a healthcare practitioner who is solely contracted with UnitedHealthcare or is a member of a group or facility contracted with UnitedHealthcare and who is licensed or certified by the state in which he/she delivers services and is credentialed and/or enrolled as a Medicaid or CHIP participating provider.

HCBS Provider: an *Individual Provider* who provides Home and Community Based Services for Medicaid beneficiaries.

Direct Ownership Interest: an individual or entity that possesses equity in the capital, the stock, or the profits of the Individual Provider's practice (disclosing entity). Ownership Interest also includes an interest in any mortgage, deed of trust, note, or other obligations (42 CFR §455.101).

In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported (42 CFR §455.102).

Indirect Ownership Interest: an individual or entity that has an ownership interest in an entity that has an ownership interest in the Individual Provider's practice (disclosing entity) (42 CFR §455.101).

The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported (42 CFR §455.102).

Controlling Interest: An individual or entity that has: (1) An officer or director of a disclosing entity that is organized as a corporation; or (2) A partner in a disclosing entity that is organized as a partnership (42 CFR §455.101)

Other Disclosing Entity: any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XV III, or XX of the Act. This includes: (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XV III); (b) Any Medicare intermediary or carrier; and (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act (42 CFR §455.101).

Significant Business Transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand (\$25,000) or five percent (5 %) of the Individual Provider's total operating expenses (42 CFR §455.101).

Subcontractor: (a) an individual, agency, or organization to which the Individual Provider has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement (42 CFR §455.101).

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm) (42 CFR §455.101).

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Individual Provider or by a person(s) or other entity with an ownership or control interest in the Individual Provider's practice (42 CFR §455.101).

Agent: any person who has been delegated the authority to obligate or act on behalf of the Individual Provider (42 CFR §455.101).

Managing Employee: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency (42 CFR §455.101).



Provider Entity Disclosure of Ownership, Controlling Interest and Management Statement

UnitedHealthcare Community Plan (“UnitedHealthcare”) is required to collect disclosure of ownership, controlling interest and management information from providers that participate in the Medicaid and/or the Children’s Health Insurance Program (CHIP) managed care network pursuant to a Medicaid and/or CHIP contracts with the State Agency and the federal regulations set forth in 42 CFR Part §455.

Required information includes:

- 1) The identity of all owners and others with a controlling interest;
- 2) Certain business transactions as described in 42 CFR §455.105;
- 3) The identity of managing employees, agents and others in a position of influence or authority; and
- 4) Criminal conviction information for the provider, owners, officers, directors, agents and managing employees.

The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Providers participating in UnitedHealthcare’s Medicaid and/or CHIP managed care networks must complete and submit the disclosure statement below in accordance with the terms of their participation agreement and as a condition of participation in Medicaid and/or CHIP. Failure to submit the requested information may result in claims denials, exclusion from UnitedHealthcare’s network, or termination of an existing provider agreement.

This statement should be submitted with the initial contract and updated:

- Every three (3) years
- Upon renewal of the participation agreement
- At any time there is a revision to the information
- Within 35 days of a request for updated information.

Individual physician and health care professional members of a group practice that are credentialed (by UnitedHealthcare or a delegate) and contracted as a participating provider in UnitedHealthcare’s Medicaid or CHIP managed care network must submit a signed Individual Provider Statement attesting to the requirements under these regulations at the time of credentialing, enrollment, or contracting as requested by UnitedHealthcare or by a delegate of UnitedHealthcare.

Detailed instructions and a glossary for capitalized terms can be found at the end of this form.

Tips to Avoid Delays in Processing Your Disclosure Form

- ✓ For any question answered with a “Yes” response, please fill out all subsequent fields.
- ✓ Every field must have a response. “N/A”, “non-applicable” and “applied for” are acceptable.
- ✓ If fields are left blank, the form will be returned for corrections/completeness.
- ✓ If the form is unreadable due to illegible handwriting, the form will not be processed.
- ✓ All attachments must indicate which section they apply to.

Contracted Provider Entity Information

Type of disclosing entity <small>*Please choose one (1) category that indicates how the disclosing entity is structured per the IRS:</small> <input type="radio"/> Partnership <input type="radio"/> Non-Profit <input type="radio"/> Corporation <input type="radio"/> Limited Liability Corporation (LLC) <input type="radio"/> Government/Public Entity <input type="radio"/> HCBS Provider <input type="radio"/> Other: _____	Name of Person Completing the Form Title Phone Number Fax Email		
In which state(s) do you participate in Medicaid and/or CHIP?			
Legal Name (“Provider Entity”):	DBA Name (if different from Provider Entity Legal Name):		
Complete Address <ul style="list-style-type: none">• Must include at least one street address• Corporations must include the primary business and every business address (including P.O. Box addresses)• Hospital systems must include address of the corporate headquarters			
Street	City	State	Zip
Additional Addresses Do you have additional addresses? <input type="radio"/> Yes <input type="radio"/> No If Yes, please label the attachment “Additional Addresses”. List all Practice/Business locations on the attachment.			
Federal Tax ID#:	Medicaid ID #: <input type="checkbox"/> Applied for Medicaid ID <input type="checkbox"/> Not Applicable	National Provider ID (NPI) #: <input type="checkbox"/> Applied for NPI	
As applicable, if Provider Entity is a provider group or facility, attach a roster of all individual providers/practitioners that bill under the provider group/facility TIN for Medicaid. include: Provider name, address, NPI, date of birth, and social security number.			
Do you have a roster to attach? <input type="radio"/> Yes <input type="radio"/> No If Yes, please label the attachment with “Roster”			

Section I: Identification of All Owners

Section I, Question 1: List all individual(s) and/or organization(s) with a **Direct or Indirect Ownership** of 5% or more.

Refer to the Glossary to determine who should be listed as an Owner and/or to calculate Ownership Interest

Yes There are individual(s) and/or entity(ies) that have a 5% or greater ownership interest.

Individuals: List the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having a 5% or greater Ownership Interest in the Entity.

Entities: List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having 5% or greater Ownership Interest. (42 CFR§455.104(b)(1))

Note: If there are 1-3 owners, fill out the chart below. If there are 4 or more owners, you **must** attach a list with the required fields labeled "Section I, Question 1". Do you have a list to attach? **Yes** **No**

No There is no individual or entity that has a 5% or greater ownership interest.

Note: If there are owners, but all have less than 5% ownership, select "No" above and include a comment in the chart below.

Name of Owner	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	* * SSN (individual) TIN (entity) <i>List both as applicable</i>	% Interest
		Street City State Zip		
		Street City State Zip		
		Street City State Zip		

Section II: Identification of All Individuals & Entities with a Controlling Interest

Section II, Question 1:

Does the Provider Entity have a **Board of Directors** or other governing body? **Yes** **No**

If **Yes**, list each member of the Board of Directors or Governing Board for corporations, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104(b)(1))

Note: If there are 1-2 directors, fill out the chart below. If there are 3 or more directors, you **must** attach a list with the required fields labeled "Section II, Question 1". Do you have a list to attach? **Yes** **No**

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	* * SSN
		Street City State Zip	
		Street City State Zip	

Section II, Question 2:

Does the Provider Entity have any **Officers or Directors** (e.g., CEO, VP of Finance, etc.)? Yes No

If **Yes**, list all corporate officers and directors, including the name, date of birth (DOB), address, and Social Security Number (SSN) and applicable title or position (42 CFR §455.104(b)(1))

Note: If there are 1-2 officers/directors, fill out the chart below. If there are 3 or more officers/directors, you **must** attach a list with the required fields labeled "Section II, Question 2". Do you have a list to attach? Yes No

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	* * SSN	Title
		Street City State Zip		
		Street City State Zip		

Section II, Question 3: Are there any other individuals or entities with a **Controlling Interest** in the Provider Entity (e.g., business partners, etc.)? Yes No

If **Yes**, list the name, address, date of birth (DOB) and Social Security Number (SSN) for each person having a Controlling Interest in the Provider Entity. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having a Controlling Interest. (42 CFR §455.104(b)(1))

Note: If there is 1 individual/entity, fill out the chart below. If there are 2 or more individuals/entities, you **must** attach a list with the required fields labeled "Section II, Question 3". Do you have a list to attach? Yes No

Name of Individual or Entity	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	* * SSN (individual) TIN (entity)	Title (as applicable)
		Street City State Zip		

***SSN is required per 42 CFR § 455.104.*

Section III: Ownership & Controlling Interest in Other Disclosing Entities

Section III, Question 1: Do any of the individuals or entities identified in **Section I** as an owner have an Ownership or Controlling Interest in any **Other Disclosing Entity?** Yes No

Refer to the Glossary and Instructions to determine who should be listed as an Owner in Other Disclosing Entities

If Yes, list the name and the SSN or TIN of the Other Disclosing Entity in which the Owner identified in **Section I** also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3))

Note: If there are 1-2 owners, fill out the chart below. If there are 3 or more owners, you **must** attach a list with the required fields labeled "Section III, Question 1". Do you have a list to attach? Yes No

Name of Owner Listed in Section I	Name of Other Disclosing Entity	Other Disclosing Entity's SSN (individual) or TIN (entity)

Section IV: Ownership & Controlling Interest in Subcontractors

Section IV, Question 1:

Does the Provider Entity have a Direct or Indirect Ownership Interest of 5% or more in any **Subcontractor?** Yes No

Refer to the Glossary and Instructions to determine who should be listed as a Subcontractor

If Yes, does another individual or organization also have an **Ownership or Controlling Interest** in the same Subcontractor?

Yes No

If Yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which the Provider Entity also has Direct or Indirect Ownership Interest of 5% or more. (42 CFR §455.104(b)(1)&(2))

Note: If there are 1-2 subcontractors, fill out the chart below. If there are 3 or more subcontractors, attach a list with the required fields labeled "Section IV, Question 1". Do you have a list to attach? Yes No

Legal Name of Subcontractor	Subcontractor TIN/SSN		
Name of Other Individual/Entity with Ownership or Controlling Interest			
Other Individual/Entity's Complete Address (Street/City/State/Zip)	Street	City	State Zip
Other Entity's TIN	Other Individual's SSN	Other Individual's DOB (mm/dd/yyyy)	% Interest in Subcontractor
Legal Name of Subcontractor	Subcontractor TIN/SSN		
Name of Other Individual/Entity with Ownership or Controlling Interest			
Other Individual/Entity's Complete Address Street/City/State/Zip)	Street	City	State Zip
Other Entity's TIN	Other Individual's SSN	Other Individual's DOB (mm/dd/yyyy)	% Interest in Subcontractor

Section V: Familial Relationships

Section V, Question 1: Are any of the individuals identified in Sections I, II, III or IV related to each other? Yes No

If Yes, list the individuals identified and the relationship to each other (e.g., spouse, sibling, parent, child) (42 CFR §455.104(b)(2))

Note: If there are 1-2 relationships, fill out the chart below. If there are 3 or more relationships, you **must** attach a list with the required fields labeled "Section V, Question 1". Do you have a list to attach? Yes No

Name of Individual #1:	Name of Individual #2:	Relationship

Section V, Question 2: Provider Groups Only: Are any provider members of the group related to the listed owners or those with a controlling interest? Yes No

If Yes, list the following information for each group provider member related to the listed owners and those with a controlling interest.

Note: If there are 1-2 relationships, fill out the chart below. If there are 3 or more relationships, you **must** attach a list with the required fields labeled "Section V, Question 2". Do you have a list to attach? Yes No

Name of group provider	Relationship	DOB (mm/dd/yyyy)	SSN**

Section VI: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations*

Section VI, Question 1:

Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity **ever been convicted of a crime** related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title XX program since the inception of those programs? Yes No

If Yes, list those persons and the required information below. (42 CFR §455.106)

Note: If providing additional documentation, you **must** attach a list with the required fields labeled "Section VI, Question 1". Do you have additional documentation to attach? Yes No

Name		
DOB (mm/dd/yyyy)	SSN (individual) or TIN (entity)	State of Conviction

Complete Address (Street/City/State/Zip)

Street

City

State

Zip

Matter of the Offense

Date of Conviction (mm/dd/yyyy) Date of Reinstatement (mm/dd/yyyy) *Enter N/A if not reinstated

*At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (See Fed. Register, Vol. 44, No. 138)

**SSN is required per 42 CFR § 455.104.

Section VI, Question 2:

Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **sanctioned, excluded or debarred** from Medicaid, Medicare, CHIP or a Title XX program? Yes No

If Yes, list those persons and the required information below. (42 CFR §455.436)

Note: If providing additional documentation, you **must** attach a list with the required fields labeled "Section VI, Question 2". Do you have additional documentation to attach? Yes No

Name

DOB (mm/dd/yyyy)

SSN (individual) or TIN (entity)

Complete Address (Street/City/State/Zip)

Street

City	State	Zip
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Reason for Sanction, Exclusion or Debarment

Date(s) of Sanctions, Exclusions or Debarments (mm/dd/yyyy)

Date of Reinstatement

(mm/dd/yyyy) *Enter N/A if not reinstated

List all States where currently excluded:

Section VI, Question 3:

Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? Yes No

If Yes, list those persons and the required information below.

Note: If providing additional documentation, attach a list with the required fields labeled "Section VI, Question 3". Do you have additional documentation to attach? Yes No

Name

DOB (mm/dd/yyyy)

SSN (individual) or TIN (entity)

Complete Address (Street/City/State/Zip)

Street

City	State	Zip
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Reason for Termination

Date of Termination (mm/dd/yyyy)

State that originated Termination

Date of Reinstatement (mm/dd/yyyy)

*Enter N/A if not reinstated

Medicare billing privileges revoked?

Yes No

Section VII: Business Transaction Information

Section VII is not required at the time of supplying this form but may be required upon request of CMS. By signing this form, you are acknowledging that you will supply the following information within 35 days if requested by the Secretary of Health and Human Services or the Medicaid agency.

Section VII, Question 1: Business Transactions - Subcontractors

List the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than \$25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) See *Glossary for definition*.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractor's Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN/TIN, and Subcontractor Owner's Address

Section VII, Question 2: Significant Business Transactions – Wholly Owned Suppliers

List the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of \$25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period (42 CFR §455.105(b)(2)) See *Glossary for definition*.

- Name of Supplier, Supplier's SSN (individual) or TIN (entity), and Supplier's Address

Section VII, Question 3: Significant Business Transactions – Subcontractors

List the information for Subcontractor with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of \$25,000 or 5% of operating expenses during any one fiscal year in the past 5-year period (42 CFR §455.105(b)(2)) See *Glossary for definition*.

- Name of Subcontractor, Subcontractor's SSN (individual) or TIN (entity), and Subcontractor's Address
- Name of Subcontractor's Owner, Subcontractor's Owner's SSN/TIN, and Subcontractor Owner's Address

Section VIII: Management & Control

Section VIII, Question 1: List all **Managing Employees** or anyone that exercises operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of the Provider Entity (e.g., general manager, business manager, administrator or dept. manager, etc.). See *Glossary for definition*

All Managing Employees must be listed. Include all Managing Employees' information including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104(b)(4))

Note: If there are 1-4 managing employees, fill out the chart below. If there are 5 or more managing employees, attach a list with the required fields labeled "Section VIII, Question 1". Do you have a list to attach? Yes No

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip) Street City State Zip	SSN**	Title
		Street City State Zip		

Section VIII, Question 2: Does the Provider Entity have any **Agents**? Yes No

If Yes, list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity (e.g., purchasing agent, broker, etc.), including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104)

See Glossary for definition.

Note: If there are 1-2 agents, fill out the chart below. If there are 3 or more agents, attach a list with the required fields labeled "Section VIII, Question 2". Do you have a list to attach? Yes No

Name	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	SSN**
		Street City State Zip	
		Street City State Zip	

**SSN is required per 42 CFR § 455.104.

Through signature below, I hereby certify that I have the authority to legally bind the entity and that any employees or contractors providing services pursuant to a contract with UnitedHealthcare Community Plan are screened with the applicable background check including, but not limited to, verification against the OIG's List of Excluded Individuals & Entities and any applicable state, federal or other governmental exclusion or sanction databases and that the information provided herein is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of a claim and/or termination of the contract.

*Signature must be a wet signature or an e-signature from a state-approved source (ex. Adobe Sign)

*If fields are left blank, the form will be returned for corrections/completeness.

Signature

Title (indicate if authorized Agent)

Full Name (please print)

Date

Phone Number

Fax Number

Email Address

Instructions for Disclosure of Ownership/Controlling Interest and Management Statement

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. (For example: Section I Ownership Information, continued). Please see Glossary for definitions of capitalized terms.

Section I: Identification of All Owners:

Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more in your entity. If the Owner is a corporation, please list the primary business address as well as every business location and P.O. Box address. Date of Birth and SSN* must be included for each individual owner.

Section II: Identification of All Individuals & Entities with a Controlling Interest:

Please list the required information for each individual or organization that has a Controlling Interest in your entity. Individuals with a Controlling Interest include officers and directors of a corporation, as well as the governing board (see *Glossary for definition*). Date of Birth and SSN* must be included for each individual with controlling interest.

Section III: Ownership & Controlling Interest in Other Disclosing Entities:

If any of the individuals or entities listed in Section I and/or Section II as having ownership or controlling interest in this entity also have ownership or controlling interest of 5% or more in any other entities, identify those entities in Section III. This information is to identify shared and interconnected ownership and controlling interests.

Section IV: Ownership & Controlling Interest in Subcontractors:

If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership or a Controlling Interest of 5% or more in that same Subcontractor, please identify the Subcontractor and provide the required information for the additional individuals and entities.

Section V: Familial Relationships:

Report whether any of the persons listed in Sections I, II, III and/or IV are related to each other and identify the parties and their relationship. Relationships must be disclosed if the parties are spouses, parent/child, or siblings.

Section VI: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations:

List your own criminal convictions, exclusions, sanctions, debarments and terminations, and for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs. Review all necessary databases to verify this information.

Section VII: Business Transaction Information:

The following is not required at this time, but will need to be provided within 35 days of request from the Secretary of Health and Human Services or the Medicaid agency:

1. List the Ownership of any Subcontractors that you have had business transactions totaling more than \$25,000 within the last twelve (12) month period ending on the date of the request.
2. List any **Significant Business Transaction** between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any **Significant Business Transaction** between your entity and any Subcontractor during the past 5 years.

Remember that a **Significant Business Transaction** is defined as any transaction or series of related transactions that exceeds the lesser of \$25,000 or 5% of a provider's operating expenses during any one fiscal year.

Section VIII: Management & Control:

1. List the required information for all employees that hold a position of Managing Employee within your entity.
 2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.
- Date of Birth and SSN* must be included for each Managing Employee and Agent.

CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

*Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104; please see Section 4313 of the Balanced Budget Act of 1997, amended Section 1124, and the Federal Register Vol. 76 No. 22. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.

GLOSSARY

Provider Entity: an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing entity.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

Direct Ownership Interest: An individual or entity that possesses equity in the capital, the stock, or the profits of the disclosing entity. Ownership Interest also includes an interest in any mortgage, deed of trust, note, or other obligations (42 CFR §455.101).

In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported (42 CFR §455.102).

Indirect Ownership Interest: An individual or entity that has an ownership interest in an entity that has a direct or indirect ownership interest in the disclosing entity (42 CFR §455.101).

The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported (42 CFR §455.102).

Controlling Interest: An individual or entity that has: (1) An officer or director of a disclosing entity that is organized as a corporation; or (2) A partner in a disclosing entity that is organized as a partnership (42 CFR §455.101)

Other Disclosing Entity: any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XV III, or XX of the Act. This includes: (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XV III); (b) Any Medicare intermediary or carrier; and (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act (42 CFR §455.101).

Significant Business Transaction: any business transaction or series of related that, during any one fiscal year, exceeds the lesser of \$25,000 or five percent (5 %) of a Provider Entity's total operating expenses (42 CFR §455.101).

Subcontractor: (a) an individual, agency, or organization to which a Provider Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement (42 CFR §455.101) (42 CFR §455.101).

Supplier: an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm) (42 CFR §455.101).

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity (42 CFR §455.101).

Agent: any person who has been delegated the authority to obligate or act on behalf of a Provider Entity (42 CFR §455.101).

Managing Employee: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency (42 CFR §455.101).

Request for Taxpayer Identification Number and Certification

Go to www.irs.gov/FormW9 for instructions and the latest information.

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

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See <i>Specific Instructions</i> on page 3.	<p>1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)</p> <p>2 Business name/disregarded entity name, if different from above.</p> <p>3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes.</p> <p><input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate</p> <p><input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____</p> <p>Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.</p> <p><input type="checkbox"/> Other (see instructions) _____</p> <p>3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions _____</p> <p>5 Address (number, street, and apt. or suite no.). See instructions.</p> <p>6 City, state, and ZIP code</p> <p>7 List account number(s) here (optional)</p>
	<p>4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):</p> <p>Exempt payee code (if any) _____</p> <p>Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____</p> <p>(Applies to accounts maintained outside the United States.)</p>
	Requester's name and address (optional)

Part I Taxpayer Identification Number (TIN)

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 instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number	_____ - _____ - _____
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 for Part II, later.

Sign Here	Signature of U.S. person	Date
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General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

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-NEC (nonemployee compensation).
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers).
- Form 1099-S (proceeds from real estate transactions).
- Form 1099-K (merchant card and third-party network transactions).
- Form 1098 (home mortgage interest), 1098-E (student loan interest), and 1098-T (tuition).
- Form 1099-C (canceled debt).
- Form 1099-A (acquisition or abandonment of secured property).

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

Caution: If you don't return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding*, later.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued);
2. Certify that you are not subject to backup withholding; or
3. Claim exemption from backup withholding if you are a U.S. exempt payee; and
4. Certify to your non-foreign status for purposes of withholding under chapter 3 or 4 of the Code (if applicable); and
5. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting is correct. See *What Is FATCA Reporting*, later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding. Payments made to foreign persons, including certain distributions, allocations of income, or transfers of sales proceeds, may be subject to withholding under chapter 3 or chapter 4 of the Code (sections 1441–1474). Under those rules, if a Form W-9 or other certification of non-foreign status has not been received, a withholding agent, transferee, or partnership (payor) generally applies presumption rules that may require the payor to withhold applicable tax from the recipient, owner, transferor, or partner (payee). See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

The following persons must provide Form W-9 to the payor for purposes of establishing its non-foreign status.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the disregarded entity.
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the grantor trust.
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust and not the beneficiaries of the trust.

See Pub. 515 for more information on providing a Form W-9 or a certification of non-foreign status to avoid withholding.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person (under Regulations section 1.1441-1(b)(2)(iv) or other applicable section for chapter 3 or 4 purposes), do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515). If you are a qualified foreign pension fund under Regulations section 1.897(l)-1(d), or a partnership that is wholly owned by qualified foreign pension funds, that is treated as a non-foreign person for purposes of section 1445 withholding, do not use Form W-9. Instead, use Form W-8EXP (or other certification of non-foreign status).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a saving clause. Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if their stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first Protocol) and is relying on this exception to claim an exemption from tax on their scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include, but are not limited to, interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third-party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester;
2. You do not certify your TIN when required (see the instructions for Part II for details);
3. The IRS tells the requester that you furnished an incorrect TIN;
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only); or
5. You do not certify to the requester that you are not subject to backup withholding, as described in item 4 under "*By signing the filled-out form*" above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier.

What Is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all U.S. account holders that are specified U.S. persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you are no longer tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

- **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note for ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040 you filed with your application.

- **Sole proprietor.** Enter your individual name as shown on your Form 1040 on line 1. Enter your business, trade, or "doing business as" (DBA) name on line 2.

- **Partnership, C corporation, S corporation, or LLC, other than a disregarded entity.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

- **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. Enter any business, trade, or DBA name on line 2.

- **Disregarded entity.** In general, a business entity that has a single owner, including an LLC, and is not a corporation, is disregarded as an entity separate from its owner (a disregarded entity). See Regulations section 301.7701-2(c)(2). A disregarded entity should check the appropriate box for the tax classification of its owner. Enter the owner's name on line 1. The name of the owner entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For

example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, enter it on line 2.

Line 3a

Check the appropriate box on line 3a for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3a.

IF the entity/individual on line 1 is a(n) ...	THEN check the box for ...
• Corporation	Corporation.
• Individual or	Individual/sole proprietor.
• Sole proprietorship	
• LLC classified as a partnership for U.S. federal tax purposes or	Limited liability company and enter the appropriate tax classification: P = Partnership, C = C corporation, or S = S corporation.
• LLC that has filed Form 8832 or 2553 electing to be taxed as a corporation	
• Partnership	Partnership.
• Trust/estate	Trust/estate.

Line 3b

Check this box if you are a partnership (including an LLC classified as a partnership for U.S. federal tax purposes), trust, or estate that has any foreign partners, owners, or beneficiaries, and you are providing this form to a partnership, trust, or estate, in which you have an ownership interest. You must check the box on line 3b if you receive a Form W-8 (or documentary evidence) from any partner, owner, or beneficiary establishing foreign status or if you receive a Form W-9 from any partner, owner, or beneficiary that has checked the box on line 3b.

Note: A partnership that provides a Form W-9 and checks box 3b may be required to complete Schedules K-2 and K-3 (Form 1065). For more information, see the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

If you are required to complete line 3b but fail to do so, you may not receive the information necessary to file a correct information return with the IRS or furnish a correct payee statement to your partners or beneficiaries. See, for example, sections 6698, 6722, and 6724 for penalties that may apply.

Line 4 Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third-party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space on line 4.

1 — An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2).

- 2—The United States or any of its agencies or instrumentalities.
- 3—A state, the District of Columbia, a U.S. commonwealth or territory, or any of their political subdivisions or instrumentalities.
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities.
- 5—A corporation.
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or territory.
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission.
- 8—A real estate investment trust.
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940.
- 10—A common trust fund operated by a bank under section 584(a).
- 11—A financial institution as defined under section 581.
- 12—A middleman known in the investment community as a nominee or custodian.
- 13—A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
• Interest and dividend payments	All exempt payees except for 7.
• Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
• Barter exchange transactions and patronage dividends	Exempt payees 1 through 4.
• Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 5. ²
• Payments made in settlement of payment card or third-party network transactions	Exempt payees 1 through 4.

¹ See Form 1099-MISC, Miscellaneous Information, and its instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) entered on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37).

B—The United States or any of its agencies or instrumentalities.

C—A state, the District of Columbia, a U.S. commonwealth or territory, or any of their political subdivisions or instrumentalities.

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i).

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i).

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state.

G—A real estate investment trust.

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940.

I—A common trust fund as defined in section 584(a).

J—A bank as defined in section 581.

K—A broker.

L—A trust exempt from tax under section 664 or described in section 4947(a)(1).

M—A tax-exempt trust under a section 403(b) plan or section 457(g) plan.

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, enter "NEW" at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have, and are not eligible to get, an SSN, your TIN is your IRS ITIN. Enter it in the entry space for the Social security number. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at www.SSA.gov. You may also get this form by calling 800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/EIN. Go to www.irs.gov/Forms to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to www.irs.gov/OrderForms to place an order and have Form W-7 and/or Form SS-4 mailed to you within 15 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and enter "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, you will generally have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon. See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier, for when you may instead be subject to withholding under chapter 3 or 4 of the Code.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.

You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third-party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor ²
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
6. Sole proprietorship or disregarded entity owned by an individual	The owner ³
7. Grantor trust filing under Optional Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))**	The grantor*

For this type of account:	Give name and EIN of:
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity ⁴
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing Form 1041 or under the Optional Filing Method 2, requiring Form 1099 (see Regulations section 1.671-4(b)(2)(i)(B))**	The trust

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name on line 1, and enter your business or DBA name, if any, on line 2. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

* Note: The grantor must also provide a Form W-9 to the trustee of the trust.

** For more information on optional filing methods for grantor trusts, see the Instructions for Form 1041.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information, such as your name, SSN, or other identifying information, without your permission to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax return preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity, or a questionable credit report, contact the IRS Identity Theft Hotline at 800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 877-777-4778 or TTY/TDD 800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 800-366-4484. You can forward suspicious emails to the Federal Trade Commission at spam@uce.gov or report them at www.ftc.gov/complaint. You can contact the FTC at www.ftc.gov/idtheft or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see www.IdentityTheft.gov and Pub. 5027.

Go to www.irs.gov/IdentityTheft to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their laws. The information may also be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payors must generally withhold a percentage of taxable interest, dividends, and certain other payments to a payee who does not give a TIN to the payor. Certain penalties may also apply for providing false or fraudulent information.