1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Suite 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

Dear Sir or Madam:

Thank you for your interest in joining the Central California Alliance for Health (the Alliance) provider network. We greatly value your partnership in better serving our community. Enclosed is the Allied Health Professional application and additional documents required to begin the credentialing process.

The following document copies *must* accompany the enclosed application:

- Addendum A & B (enclosed)
- Language Verification Form (enclosed)
- Declaration of Confidentiality (enclosed)
- Certification Regarding Debarment (enclosed)
- Taxpayer Identification Form (W-9) (enclosed)
- Current State professional license
- Copy of current NPI number
- Copy of professional liability coverage with limits of $1,000,000/claim and $3,000,000/aggregate
- General liability (premise) coverage
- Curriculum Vitae (with dates in MM/YYYY format)

Medi-Cal Certification is required

Beginning January 1, 2018, federal law requires that all Alliance-contracted providers are screened and enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-for-Service Program. Providers have the right to be screened and enrolled directly through DHCS, but still need to complete the Alliance credentialing process which is separate from DHCS screening and enrollment. See the next page for additional information.

All provider applications are reviewed by the Alliance Peer Review and Credentialing Committee or a Medical Director. To ensure timely processing of your application, we require that you complete and return all documents listed above as soon as possible. Forms may be submitted in the following ways:

Mail: 1600 Green Hills Road, Scotts Valley, CA 95066 Attn: Credentialing

Email: credentialing@ccah-alliance.org

Fax: 831-430-5528

We appreciate your cooperation in the credentialing process and if you have any questions, please contact us at the email above.

Sincerely,

CCAH – Credentialing Department

DHCS Medi-Cal Provider Screening and Enrollment Requirement

Beginning January 1, 2018, federal law requires that all Alliance-contracted providers are screened and enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-for-Service Program. If you are already screened and enrolled through DHCS, you have successfully met this requirement.

Alliance providers have two options for enrolling with the Medi-Cal Fee-for-Service Program. Providers may enroll through (1) DHCS; or (2) through a Managed Care Plan that has a screening and enrollment

process substantially equivalent to that of the Department of Health Care Services (DHCS).

- If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal Fee for
- Service (FFS) beneficiaries and contract with the Alliance.
- If the provider enrolls through a Managed Care Plan, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.
- The Alliance is working to implement a screening and enrollment process, which we anticipate
- will go live no later than 2019. Until such time as the Alliance screening and enrollment process is implemented, providers contracted with the Alliance are required to enroll directly with DHCS.

Enrollment through DHCS

- Providers will use the DHCS standardized application form(s) when applying for participation in the DHCS Medi-Cal Program. The application forms are available on the DHCS website at www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. DHCS also has a new online portal for enrollment, available at pave.dhcs.ca.gov/sso/login.do. To create an account, click on the "Sign Up" button at the top right corner of the page.

Upon successful enrollment through DHCS, providers will have satisfied the Alliance screening and enrollment requirement. Please note that absent successful screening and enrollment through DHCS, a contracted provider's status with the Alliance may change after January 1, 2018.

If you have questions about these new requirements, please contact Alliance Provider Services at 800-700-3874 ext. 5504.

For more information contact your Alliance Provider Services Representative at 800-700-3874 ext. 5504

Allied Health Professional Credentialing Application

INSTRUCTIONS		
This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**		
*State License and/or applicable certificates	*Professional Liability Insurance Face Sheet ($1M Per Occurrence/$3M	* W-9 Form
*Curriculum Vitae (Optional)	*National Practitioner Identification (NPI)	*Business License

IDENTIFYING INFORMATION			
Last Name:	First Name:	Middle:	
Is there any other name under which you are known? Name(s):			
Home Mailing Address:	City:	State:	Zip:
Home Telephone Number:	Home Fax Number:		
Social Security Number:	Gender:	□ Male	□ Female
Citizenship:	Date of Birth:		
Professional Type:			

PRACTICE INFORMATION				
Business Legal Name (as listed with IRS):				
Business Address:	City:	County:	State:	Zip Code:
Business Billing Address (if different):	City:	County:	State:	Zip Code:
Business Contract Address (if different):	City:	County:	State:	Zip Code:
Office Manager:	Business Telephone Number:	Business Fax Number:		
Email Address:	Tax ID # under which you bill:			
Please indicate what services you provide:				
Office Days and Hours:				
Number of blocks to nearest public transportation stop?				
Wheelchair Accessible: □ Yes □ No Other special access arrangements?				

Allied Health Professional Credentialing Application

OTHER MEMBERS OF YOUR OFFICE:			

ADDITIONAL LOCATION:				
Business Legal Name (as listed with IRS):				
Business Address:	City:	County:	State:	Zip Code:
Office Manager:	Business Telephone Number:	Business Fax Number:		
Email Address:	Tax ID # under which you bill:			
Please indicate what services you provide:				
Office Days and Hours:				
Number of blocks to nearest public transportation stop?				
Wheelchair Accessible: □ Yes □ No Other special access arrangements?				

PROFESSIONAL LICENSURE			
California License Number:	Type:	Issue Date:	Expiration Date:
Business License number:		Issue Date:	Expiration Date:
Medi-Cal License Number:			
NPI Number:	Taxonomy Code:		

ALL OTHER STATE PROFESSIONAL LICENSES				
State:	License Number:	Type:	Issue Date:	Expiration Date:
State:	License Number:	Type:	Issue Date:	Expiration Date:
State:	License Number:	Type:	Issue Date:	Expiration Date:

Allied Health Professional Credentialing Application

UNDERGRADUATE EDUCATION			
Undergraduate School:			
Mailing Address:			
City:	State:	Zip:	
Degree Received:	Date of Graduation:		

ADVANCED DEGREE/TRAINING			
Institution:			
Mailing Address:			
City:	State:	Zip:	
Degree Received:	Date of Graduation:		
Did you successfully complete the program? □ Yes □ No (If "No," please explain on separate sheet.)			
Institution:			
Mailing Address:			
City:	State:	Zip:	
Degree Received:	Date of Graduation:		
Did you successfully complete the program? □ Yes □ No (If "No," please explain on separate sheet.)			
Institution:			
Mailing Address:			
City:	State:	Zip:	
Degree Received:	Date of Graduation:		
Did you successfully complete the program? □ Yes □ No (If "No," please explain on separate sheet.)			

PROFESSIONAL LIABILITY			
Name of Insurance Company:			
Insurance Policy Number:	Date Policy Issued: (mm/dd/yyyy)	Expiration date of policy: (mm/dd/yyyy)	
Address:	City:	State:	Zip Code:

If yes to any of the below, please provide details per the attached claims information sheet. Please explain any surcharges to your professional liability coverage on a separate sheet.

Have any judgments been made against you, settlements been agreed to, or are there any filed and served professional liability lawsuits against you pending? **Please include any cases pending or resolved through arbitration.** □ Yes □ No

Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance? □ Yes □ No

Allied Health Professional Credentialing Application

WORK HISTORY			
Chronologically list all work history activities since the completion of professional training (use extra sheets if necessary). Please explain any gaps on a separate page.			
Current Practice/Employer:			
Mailing Address:			
City:	State:	Zip:	
Telephone Number:	Fax Number:		
From:	To:		
Practice/Employer:			
Mailing Address:			
City:	State:	Zip:	
Telephone Number:	Fax Number:		
From:	To:		
Practice/Employer:			
Mailing Address:			
City:	State:	Zip:	
Telephone Number:	Fax Number:		
From:	To:		

HOSPITAL OR OTHER INSTITUTIONAL AFFILIATIONS				
Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations and have had previous				
Name of Hospital:	Department:			
Hospital Address:	City:	County:	State:	Zip Code:
Professional Designation and status:	From:	To:		
Name of Hospital:	Department:			
Hospital Address:	City:	County:	State:	Zip Code:
Professional Designation and status:	From:	To:		
Name of Hospital:	Department:			
Hospital Address:	City:	County:	State:	Zip Code:
Professional Designation and status:	From:	To:		

ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through K is "yes," or if your answer to L is "no," please provide full details on separate sheet.

A. Has your license/certification to practice in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or certification, or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?

Yes □ No □

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?

Yes □ No □

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, professional school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?

Yes □ No □

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes □ No □

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any professional education program?

Yes □ No □

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed , or is any such action pending?

Yes □ No □

G. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes □

Yes □ No □

H. Do you presently use any drugs illegally?

Yes □ No □

I. Do you have a history of chemical dependency/substance abuse?

J. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?

Yes □ No □

ATTESTATION QUESTIONS

K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes □ No □

L. Are you able to perform all the services required by your agreement with the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?

Yes □ No □

I hereby affirm that the information submitted to Central California Alliance for Health (the Alliance) and any addenda thereto is true, current, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name: _____

Signature: _____ **Date:** _____

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations

{HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state 3 laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be

required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

I also agree to notify this Healthcare Organization in writing, within five (5) days from the occurrence of receiving any written or oral notice of any adverse action, including, without limitation, any accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter or reprimand, public approval, and any formal restriction, probation, suspension or revocation of licensure; any adverse action taken by any Healthcare Organization, or a report with the National Practitioner Data Bank; a conviction of any felony or a misdemeanor of moral turpitude; any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions; or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is current, correct, complete, and true to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

Print Name: _____

Signature _____ **Date:** _____

3. The intent of this release is to apply at a minimum, protections comparable to those available in California

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices. The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of the application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address:_____ City: _____ State: _____ Zip: _____

APPLICANT SIGNATURE (Stamp is Not Acceptable): _____

PRINTED NAME: _____

DATE: _____

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise conclude professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/settled claims to report (and sign below to attest).*

I. Practitioner Identifying Information

Last Name: _____ First Name: _____ Middle: _____

II. Case Information

Patient's Name: _____ Patient Gender ◯ Male ◯ Female Patient DOB: _____

City, County, State where lawsuit filed: _____ Court Case number, if known: _____ Date of alleged incident serving as basis for the lawsuit/ arbitration: _____ Date suit filed: _____

Location of incident:
☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify) _____

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.) _____

Allegation

_____

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ◯ Yes ◯ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

_____

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name: _____ Telephone Number: _____ Fax Number: _____

III. Status of Lawsuit/Arbitration (check one)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $

☐ Judgment rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $

☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE (Stamp is Not Acceptable)	**PRINTED NAME**	**DATE**

New Provider Training

As a new provider joining the Alliance, you are required to complete the Alliance new provider training.

After reviewing the information in the New Provider Training, please sign below to acknowledge that you have received these training materials and the date of your review.

New Provider Training Non-PCP

I have completed my review of the new provider training materials from the Central California Alliance for Health.

_____

Signature of Provider

_____

Date

The form below is a requirement of our Medi-Cal contract with the State. Please review and sign below where indicated.

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF DHS COMPUTER FILES FOR THE MEDI-CAL PROGRAM DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized / maintained by the Department of Health Services, I, _____ , agree not to divulge
(Provider name)

any information obtained in the course of my assignment to unauthorized persons, and agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to the Plan, myself, my employees, fiscal agents, State and federal personnel who require the information in the performance of their duties, and to such others as may be authorized by the Department of Health Services.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signature of Provider

_____
Date

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIERED COVERED TRANSACTIONS

Instructions for Certification

1. By signing and submitting this certification as part of this proposal, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances, including but not limited to suspension, debarment, or exclusion from participation in any federally-funded health care program following its previous certification.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to check the List of Parties Excluded from Federal Procurement and No procurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system or records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48
CFR part 9, subpart 9.4, suspended, debarred, ineligible or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency
with which this transaction originated may pursue available remedies, including suspension and/or debarment.

(1) The prospective lower tier participant certifies, by submitting this proposal and signing below, that neither it or its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency, or is excluded as the result of state or federal action from participation in any federally-funded health care program.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

_____

Signature

_____

Printed Name

_____

Date

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: Individual/Sole proprietor Corporation Partnership
Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
Other (see instructions) ▶

Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (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 your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number

or

Employer identification number

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).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

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. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If 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).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Cat. No. 10231X