1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
831-430-5560

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

530 West 16th Street, Ste. B
Merced, CA 95340-4710
209-381-530

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 Durable Medical Equipment application and additional documents required to begin the credentialing process.

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

- Declaration of Confidentiality (enclosed)
- Certification Regarding Debarment (enclosed)
- Language Verification Form (enclosed)
- Taxpayer Identification Form (W-9) (enclosed)
- Copy of current business license
- Copy of Home Medical Device Retailer License/Home Medical Retailer Exempt License
- Copy of Sellers Permit
- Copy of general/professional liability coverage with limits of $1,000,000/claim and $3,000,000/aggregate
- Copy of current NPI number
- Copy of Fictitious Business Name Statement

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

Durable Medical Equipment Provider Application

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

Durable Medical Equipment Provider 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 Medical License(s)
- Business License (if applicable)
- W-9 Form
- Seller's Permit (if applicable)
- Liability Insurance Face Sheet
- NPI Verification (CMS/NPPES Conformation)
- Home Medical Device Retailer Exempted License (if applicable)
- Home Medical DEI/ICE Retailer License (if applicable)
- Fictious Business Name Statement

PRACTICE INFORMATION

Please check all that apply:

☐ Sole Proprietor ☐ Partnership (attach legible copy of agreement) ☐ Government entity

☐ Corporation ☐ Limited Liability Company (LLC) ☐ Nonprofit Corporation

Corporate Number: _____ LLC Number: _____ Type of nonprofit:_____

State Incorporated: _____ State Registered/Filed: _____ ☐ Other: _____

Legal Name of applicant or provider (as listed with the IRS):				
Doing Business As (DBA), if different:		Business Telephone Number: ( )		
Is this a fictitious business name? ☐ Yes ☐ No	If yes, list the Fictitious Business Name Statement Number.		Effective Date:	
Business Address:	City:	County:	State:	Zip Code:
Pay-To Address:	City:	County:	State:	Zip Code:
Contract Address:	City:	County:	State:	Zip Code:
E-Mail Address:				
National Provider Identification (NPI):		Medi-Cal Number:		
Primary Taxonomy Code:	Taxonomy Code:		Taxonomy Code:	
Taxpayer Identification Number (TIN):		Social Security Number: If sole proprietor is not using a TIN.		
Any local business license number/ permits:	Medicare/Other NPI/Medicare Billing Number:		Seller's Permit Number:	
Office Contact Name:	Phone Number:		Fax Number:	

Durable Medical Equipment Provider Application

If you have a Second Practice/Office, please list all information:				
Legal Name of applicant or provider (as listed with the IRS):				
Doing Business As (DBA), if different:		Business Telephone Number: ( )		
Is this a fictitious business name? ☐ Yes ☐ No	If yes, list the Fictitious Business Name Statement Number.		Effective Date:	
Business Address:	City:	County:	State:	Zip Code:
Pay-To Address:	City:	County:	State:	Zip Code:
Contract Address:	City:	County:	State:	Zip Code:
E-Mail Address:				
National Provider Identification (NPI):				
Primary Taxonomy Code:	Taxonomy Code:	Taxonomy Code:		
Taxpayer Identification Number (TIN):				
Office Contact Name:	Phone Number:	Fax Number:		

Wheelchair Accessible: ☐ Yes ☐ No Other special access arrangements? _____

Number of blocks to the Nearest Public Transportation Stop: _____

Please List any foreign languages fluently spoken by you or your staff.	
Languages Spoken by Staff (specify staff position)	Languages Spoken by Provider

Durable Medical Equipment Provider Application

A. Do you have a retail business open and available to the general public which meets all local laws and ordinance regarding business licensing and operations and is readily identifiable as a place in which you sell, rent, or lease durable medical equipment, incontinence medical supplies, and/or medical supply items? ☐ Yes ☐ No

If no, please explain:

B. Do you have adequate inventory and staff to meet both your current and your anticipated sales and service requirement? ☐ Yes ☐ No

If no, please explain:

C. Does your business have regular and permanently posted business hours? ☐ Yes ☐ No

Business days and hours of operation: Days:_____ Hours: _____

D. Does your business have permanently attached signage that identifies the name of the business as stated on this application? ☐ Yes ☐ No

E. Do you have the necessary equipment, office supplies, and facilities available to carry out your business, including storing and retrieving such records as are necessary to fully disclose the type and extent of services provided to Medi-Cal beneficiaries? ☐ Yes ☐ No

F. Does your business involve the trade, sale, rental, or transfer of upholstered-furniture (including wheelchair) or beddings? ☐ Yes ☐ No

If yes, provide your Home Medical Device Retailer License number _____, or your retail furniture and bedding dealer's license or retail furniture dealer's license number _____.

G. Does your business involve the trade, sale, rental, or transfer of medical devices or durable medical equipment/devices for use in the home to treat acute or chronic illness or injuries? ☐ Yes ☐ No

If yes, provide your Home Medical Device Retailer license number _____.

H. Does your business involve the trade, sale, rental, or transfer of dangerous or legend drugs and/or dangerous or legend medical equipment? ☐ Yes ☐ No

If yes, provide your Home Medical Device Retailer Exemptee license number _____.

I. Does the applicant provide custom rehabilitation equipment and custom rehabilitation technology services to Medi-Cal beneficiaries? ☐ Yes ☐ No

If yes, does the applicant have on staff, either as an employee or independent contractor, or does the applicant have a contractual relationship with, a qualified rehabilitation professional who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment? ☐ Yes ☐ No

J. Applicant or provider business activities include the sale, rental, and/or lease of the type of items checked below. Give the percentage of each business activity in which the applicant or provider engages. Total the percentages at the end of this question. Percentages must total 100 percent.

☐ Beds	_____	%
☐ Wheelchairs	_____	%
☐ Ostomy supplies (describe):	_____	%

Durable Medical Equipment Provider Application

☐ Oxygen therapy equipment and supplies (describe):		%
☐ Urinary catheters, bags, etc. (describe):		%
☐ Incontinence medical supplies (describe):		%
☐ Infusion equipment and supplies (describe):		%
☐ Other (describe):		%
	Total:	%

Proof of Liability Insurance			
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:
Insurance Policy Amounts: Occurrence: $		Aggregate: $	

Information about Individual Signing this Application		
Print name:		☐ Male ☐ Female
Driver's license or state-issued identification number:	Date of Birth:	Social Security Number:

I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider pursuant to Title 22, CCR section 51000.30(a)(2)(B).

Signature of provider:_____Title: _____

Date: _____

Durable Medical Equipment Provider Application

ATTESTATION QUESTIONS
Please answer the following questions "yes" or "no." ***If your answer to questions A through I is "yes," or if your answer to J is "no," please provide full details on separate sheet.***
A. Have you, as applicant provider, ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you, the applicant/provider, 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
B. As the applicant/provider, 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 program, medical society, professional association, medical school faculty position or other health delivery entity or systems), 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
C. Has the individual license, certificate, or other approval to provide health care of the applicant/provider ever been suspended or revoked? ☐ Yes ☐ No
D. Have you, as applicant/provider, ever been convicted of any crime (other than a minor traffic violation)?
E. Do you, as applicant/provider, presently use any drugs illegally? ☐ Yes ☐ No
F. Do you, as applicant/provider, have any history of chemical dependency/substance abuse? ☐ Yes ☐ No
G. Have any judgments been entered against you, as applicant/provider,, or settlements been agreed to by you, as applicant/provider, with the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you, as applicant/provider, pending? ☐ Yes ☐ No
H. As applicant/provider, has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you as applicant provider 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 liability insurance or its coverage of any procedures? ☐ Yes ☐ No
I. Do you, the applicant/provider, currently participate or have you ever participated as a provider in the Medi-cal program or in another state's Medicaid program? ☐ Yes ☐ No
J. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, 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 in this document, and any attachments hereto, are true, accurate, and complete to the best of my knowledge and belief. I agree to provide Central California Alliance for Health with any updated information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the Alliance or its authorized representatives or required by the credentialing criteria of the Alliance.

Print Name: _____

Signature: _____ **Date:** _____

Durable Medical Equipment Provider Application

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 fr

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. In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (I) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding min

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, 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 participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on all pages.

Print Name Here: _____

Signature: _____ **Date:** _____

3. The intent of this release is to apply at a minimum, protections comparable to those available in California to any action, regardless of where such action is brought.

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

Provider Language Verification Form

Provider Office/Clinic Name:_____

Address:_____

Telephone:_____ Fax:_____ Email:_____

In order to comply with State of California requirements and to meet the needs of Limited English Proficient (LEP) members, the Alliance assesses the language capabilities of our provider network on an annual basis. The information submitted on this form will be reflected in our Provider Directory. Please call the Provider Services Department at (831) 430-5504 if you have any questions.

If additional space is needed, please copy this form before completion

List all providers (MD, DO, NP, PA) who are <u>fluent</u>* in any language *other than English*	**Language(s) spoken fluently by provider *other than English***
1	
2	
3	
4	
5	
6	
7	
8	

Are there **other medical staff** (RN, LVN, MA) who are fluent in a language other than English?

☐ **No** ☐ **Yes - Check box and list all languages below** *(not necessary to list staff names)*

Language(s):_____

Are there **non-medical staff** (Receptionist, Scheduler) who are fluent in a language other than English?

☐ **No** ☐ **Yes - Check box and list all languages below** *(not necessary to list staff names)*

Language(s):_____

Physician/Administrator Signature:_____Date:_____

**Fluent: Able to speak and understand a language easily and accurately on all levels related to patient care; able to understand and participate in any conversation within the range of one's experience with a high degree of precision; able to fully comprehend a language, unaffected by rate of speech.*

Please Fax Completed Form to Provider Services at (831) 430-5857

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