Facility Initial Credentialing Application
Carelon Behavioral Health

Please indicate below each plan designation requested for this application submission

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

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

☐ Completed Facility/Program Application (Attached)

☐ Completed Service Location Addendum(s) - One Per Service Location (Attached)

☐ Copies of all applicable state or agency licenses

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

☐ Completed W-9 form or IRS Letter

☐ NPI (National Provider Identification)

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

☐ The Americans with Disabilities Act (ADA) Form

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

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

☐ Certification(s):

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

NON-ACCREDITED ORGANIZATIONS:

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

INDIVIDUAL TAX IDENTIFICATION NUMBERS AND NPI NUMBERS:

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

Once the application is completed, please return to the following:
Fax: 866-612-7790
Email: **Initialapplications@carelon.com**
Carelon Behavioral Health
Attn: Facility Credentialing
PO Box 989
Latham NY 12110

GENERAL INFORMATION

Primary NPI _____ Tax ID: _____

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

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

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

Credentialing Contact Email Address_____Website _____

A. Facility Points of Contact

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

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

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

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

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

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

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

Corporate Name _____ Contact Name _____ Title

Mailing Address Line 1 _____ Mailing Address Line 2 _____

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

Email Address_____

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

- ☐ General Hospital
- ☐ Free Standing Intensive Outpatient
- ☐ Community Mental Health Center
- ☐ Federally Qualified Health Center
- ☐ Free Standing Partial/Day Treatment
- ☐ Residential Treatment Center
- ☐ Free Standing Substance Abuse Rehab
- ☐ Other: _____
- ☐ Free Standing Acute Psychiatric
- ☐ Home Health Agency
- ☐ SAMSHA LAB/REM Certified Facility
- ☐ Comprehensive Safety Net Provider

D. Business Classification

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

E. License/Certification

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

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

Other_____

Medicaire #_____ Medicaid #_____

Provider Profile / Malpractice Claims History

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

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

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

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

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

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

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

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

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

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

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

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

MALPRACTICE CLAIM INFORMATION WORKSHEET

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

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

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

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

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

III. DEMOGRAPHIC DATA

This information is for demographic purposes only, and will not be used for credentialing. This information will be used in the aggregate, to supply data to state and federal government agencies, as part of the state and federal contracting process.

Please be advised that the following information will be disclosed only to the state and federal government for the purposes outlined above.

1. Could your business be classified as a small business, as defined by the Small Business Administration?

*Small Business Enterprise is defined as a corporation, partnership, sole proprietorship, or other legal entity formed for the purpose of making a profit, which is independently-owned and operated, has **either** fewer than 100 employees **or** less than $1,000,000 (one million dollars) in annual gross receipts.*

☐ Yes ☐ No

2. Could your business be classified as a women-owned business, as defined by the Department of Minority Enterprises?

Women-Owned Business is defined as a business enterprise at least 50 percent of which is owned by women or (in the case of a publicly-owned business) where at least 51 percent of the stock is owned by women.

☐ Yes ☐ No

3. Could your business be classified as a minority-owned business, as defined by the Department of Minority Enterprises?

Minority-Owned Business is defined as a business enterprise that is owned and controlled by one or more socially and / or economically disadvantaged persons. Such disadvantages may arise from cultural, racial, chronic economic circumstances or background or other similar cause. Such persons include but are not limited to African Americans, Hispanic Americans, Asian Americans, American Indians, Eskimos and Aleuts.

☐ Yes ☐ No

4. *This question is optional.
If your business could be classified as a minority-owned business, which of the following categories would it fall under may check more than one?

☐ African American ☐ Hispanic American ☐ Asian American

☐ American Indian ☐ Eskimo ☐ Aleuts

☐ Other, please specify:_____

PARTICIPATION STATEMENT

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

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

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

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

Facility Name

Authorized Signature

Name of Person Completing Form

Title

Date (MM/DD/YYYY)

INSTRUCTIONS:

Please complete this form for each site location associated with the facility and indicate ALL services for the location.
If more than fifteen locations, provide the SAME services, please complete one (1) form, and submit a roster in PDF format of all other locations providing the SAME services.

If any locations provide DIFFERENT/ ADDITIONAL services, you must complete a form for the location(s) providing different/additional services (photocopy as needed).
Any locations or programs not identified will not be credentialed.

Service Location __ of ___

			Billing Address: (Please confer with your Billing Dept.)	
SITE NPI				
SITE NAME			**TAX ID**	
SERVICE ADDRESS LINE 1			**BILLING ADDRESS LINE 1**	
SERVICE ADDRESS LINE 2			**BILLING ADDRESS LINE 2**	
CITY	**STATE**	**ZIP**	**CITY**	**STATE** **ZIP**
PHONE NUMBER			**PHONE NUMBER**	
MEDICARE NUMBER	**MEDICAID NUMBER**		**OASAS PRU ID (NY SPECIFC)**	

THIS LOCATION IS				
FQHC ☐	**ARTICLE 28** ☐	**ARTICLE 31** ☐	**ARTICLE 32** ☐	**COMPREHENSIVE SAFETY NET** ☐

PROVIDER ACCESIBLE BY PUBLIC TRANSPORTATION	**YES** ☐	**NO** ☐
AMERICAN DISABLILITES	**YES** ☐	**NO** ☐
COMPLIANT SCHOOL BASED	**YES** ☐	**NO** ☐

PROGRAMS OFFERED AT LOCATION (NATIONAL)	# OF UNITS	AGE 0-12	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE(S)
23-HOUR OBSERVATION	N/A	☐	☐	☐	☐	F.HOB
ABA	N/A	☐	☐	☐	☐	P.ABA
AMBULATORY DETOX / OUTPATIENT – MEDICALLY SUPERVISED WITHDRAWAL	N/A	☐	☐	☐	☐	P.OCA P.ODA
CRISIS INTERVENTION	N/A	☐	☐	☐	☐	P.CRI
CRISIS STABILIZATION	N/A	☐	☐	☐	☐	F.CR
DAY TREATMENT (PSYCHIATRIC)	N/A	☐	☐	☐	☐	P.DP
DAY TREATMENT (SUBSTANCE USE)	N/A	☐	☐	☐	☐	P.DC
DAY TREATMENT DUAL DIAGNOSIS	N/A	☐	☐	☐	☐	P.DX
DAY TREATMENT EATING DISORDER	N/A	☐	☐	☐	☐	P.DE
EMPLOYEE ASSISTANCE PROGRAM(EAP)	N/A	☐	☐	☐	☐	P.EAP
HALFWAY HOUSE	N/A	☐	☐	☐	☐	F.HWH
HOME HEALTH	N/A	☐	☐	☐	☐	P.HOM
INPATIENT(ACUTE) DETOXIFICATION		☐	☐	☐	☐	F.AD
INPATIENT DUAL DIAGNOSIS		☐	☐	☐	☐	F.AX
INPATIENT EATING DISORDER		☐	☐	☐	☐	F.AE
INPATIENT PSYCHIATRIC (190-DAY LIFETIME LIMIT)		☐	☐	☐	☐	F.190
INPATIENT PSYCHIATRIC		☐	☐	☐	☐	F.AP
INPATIENT SUBSTANCE USE REHAB		☐	☐	☐	☐	F.AC
INTENSIVE OUTPATIENT (PSYCHIATRIC)	N/A	☐	☐	☐	☐	P.IP
INTENSIVE OUTPATIENT (SUBSTANCE USE)	N/A	☐	☐	☐	☐	P.IC
INTENSIVE OUTPATIENT DUAL DIAGNOSIS	N/A	☐	☐	☐	☐	P.IX
INTENSIVE OUTPATIENT EATING DISORDER	N/A	☐	☐	☐	☐	P.IE
MOBILE CRISIS	N/A	☐	☐	☐	☐	F.CRM P.MOB
MULTI-SYSTEMIC THERAPY	N/A	☐	☐	☐	☐	P.MST
OUTPATIENT CLINIC (PSYCHIATRIC)	N/A	☐	☐	☐	☐	P.CP P.OPP
OUTPATIENT CLINIC (SUBSTANCE USE)	N/A	☐	☐	☐	☐	P.CC P.OPR
OUTPATIENT CLINIC DUAL DIAGNOSIS	N/A	☐	☐	☐	☐	P.CX
PARTIAL HOSPITAL DUAL DIAGNOSIS		☐	☐	☐	☐	P.PX
PARTIAL HOSPITALEATING DISORDER		☐	☐	☐	☐	P.PE
PARTIAL HOSPITALIZATION (PSYCHIATRIC)		☐	☐	☐	☐	P.PP
PARTIAL HOSPITALIZATION (SUBSTANCEUSE)		☐	☐	☐	☐	P.PC
PEER DELIVERED	N/A	☐	☐	☐	☐	P.PDS
PEER SUPPORT	N/A	☐	☐	☐	☐	F.PES
RESIDENTIAL REHABILITATION – MEDICAID ONLY		☐	☐	☐	☐	F.RRE
RESIDENTIAL REINTEGATION – MEDICAID ONLY		☐	☐	☐	☐	F.RRI

carelon

PROGRAMS OFFERED AT LOCATION (NATIONAL)	# OF UNITS	AGE 0-12	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE(S)
RESIDENTIAL STABILIZATION – MEDICAID ONLY		☐	☐	☐	☐	F.RST
RESIDENTIAL TREATMENT (PSYCHIATRIC)		☐	☐	☐	☐	F.RP
RESIDENTIAL TREATMENT (SUBSTANCE USE)		☐	☐	☐	☐	F.RC
RESIDENTIAL TREATMENT EATING DISORDER		☐	☐	☐	☐	F.RE
RESIDENTIAL TREATMENT DUAL DIAGNOSIS		☐	☐	☐	☐	F. RX
TREATMENT GROUP HOME	N/A	☐	☐	☐	☐	F.GPH
TELEHEALTH SERVICES (PSYCHIATRIC)	N/A	☐	☐	☐	☐	P.THM P.TPS
TELEHEALTH SERVICES (SUBSTANCE USE)	N/A	☐	☐	☐	☐	P.THD

MAT SERVICES (NATIONAL)	# OF UNITS	AGE 0-12	AGE 13-17	AGE 18-64	AGE 65+	SAMHSA CERTIFIED	PROGRAM CODE
OPIOID TREATMENT PROGRAM (OTP) (SAMHSACERTIFICATION REQUIRED)	N/A	☐	☐	☐	☐	Yes ☐ No ☐	F.NRO
OPIOID TREATMENT – METHADONE MAINTENANCE THERAPY *INDICATE # OF DAYS PER WEEK IN # OF UNITS COLUMN*		☐	☐	☐	☐	N/A	P.MM P.OMM
OPIOID TREATMENT - SUBOXONE		☐	☐	☐	☐	N/A	P.SXN
OPIOID TREATMENT - VIVITROL		☐	☐	☐	☐	N/A	P.VVT

ASAM SERVICES	# OF UNITS	AGE 0-12	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE
ASAM 3.1 – ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER DIEM		☐	☐	☐	☐	F.AS1
ASAM 3.2 WM - ALCOHOL AND/OR DRUG SERVICES, ACUTE DEXTOXIFICATION		☐	☐	☐	☐	F.A2W
ASAM 3.3 – ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER DIEM		☐	☐	☐	☐	F.AS3
ASAM 3.5 – ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER DIEM		☐	☐	☐	☐	F.A5S
ASAM 3.7 – ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER DIEM		☐	☐	☐	☐	F.AS7
ASAM 3.7 WM – ALCOHOL AND/OR DRUG SERVICES, ACUTE DETOXIFICATION		☐	☐	☐	☐	F.A7W

BLOCK GRANT SERVICES (KANSAS SPECIFIC)	# OF UNITS	AGE 0-12	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE
ACUTE DETOXIFICATION TREATMENT MODALITY	N/A	☐	☐	☐	☐	F.AD
SOCIAL DETOX	N/A	☐	☐	☐	☐	F.SD
INPATIENT TREATMENT MODALITY (HOSPITAL BASED RESIDENTIAL)	N/A	☐	☐	☐	☐	F.RC
INTERMEDIATE TREATMENT MODALITY(RESIDENTIAL)	N/A	☐	☐	☐	☐	F.IT
REINTEGRATION TREATMENT MODALITY(RESIDENTIAL)	N/A	☐	☐	☐	☐	F. RR
ALCOHOL AND DRUG ASSESSMENT AND REFERRAL PROGRAM (KCPC ASSESSMENT)	N/A	☐	☐	☐	☐	P.AST
INTENSIVE OUTPATIENT TREATMENT MODALITY	N/A	☐	☐	☐	☐	P. IC
CASE MANAGEMENET SERVICES	N/A	☐	☐	☐	☐	P.CM
OUTPATIENT TREATMENT MODALITY– INDIVIDUAL COUNSELING	N/A	☐	☐	☐	☐	P. I1
OUTPATIENT TREATMENT MODALITY – GROUP COUNSELING	N/A	☐	☐	☐	☐	P. G1
PEER SUPPORT (PLEASE PROVIDE CERTIFICATION)	N/A	☐	☐	☐	☐	F.PES
CRISIS INTERVENTION	N/A	☐	☐	☐	☐	P.CRI
MEDICATION ASSISTED TREATMENT	N/A	☐	☐	☐	☐	P.MDM
REFER TO FEE SCHEDULE FOR ADDITIONAL REQUIREMENTS*						

DRIVING UNDER THE INFLUENCE - DUI (KANSAS SPECIFIC)	# OF UNITS	AGE 0-12	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE
REFER TO FEE SCHEDULE FOR ADDITIONAL REQUIREMENTS*						
EDUCATIONAL GROUP	N/A	☐	☐	☐	☐	P.EDG

PROBLEM GAMBLING (KANSAS SPECIFIC)	# OF UNITS	AGE 0-12	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE
REFER TO FEE SCHEDULE FOR ADDITIONAL REQUIREMENTS*						
PROBLEM GAMBLING RESIDENTIAL	N/A	☐	☐	☐	☐	P.GM

29-I VOLUNTARY FOSTER CARE SERVICES (NEW YORK SPECIFIC)	# OF UNITS	AGE 0-12	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE
FOSTER CARE – ALCOHOL & DRUG TESTING		☐	☐	☐	☐	F.ALC
FOSTER CARE – DEVELOPMENTAL TESTING		☐	☐	☐	☐	F.DTA
FOSTER CARE – NEURO PSYCH TESTING/EVAL SERVICES		☐	☐	☐	☐	F.NET
FOSTER CARE – OFFICE VISIT / PSYCHOTROPIC MEDICATION TREATMENT		☐	☐	☐	☐	P.NOF
FOSTER CARE – PSYCHIATRIC DIAGOSTIC EXAM		☐	☐	☐	☐	F.DIA
FOSTER CARE – PSYCHOTHERAPY (INDIVIDUAL & FAMILY)		☐	☐	☐	☐	F.PTH
FOSTER CARE – PSYCHOTHERAPY GROUP		☐	☐	☐	☐	F.GTH
FOSTER CARE – SCREENING-DEVELOPMENTAL / EMOTIONAL / BEHAVIORAL		☐	☐	☐	☐	F.DES
FOSTER CARE – SMOKING CESSATION TREATMENT		☐	☐	☐	☐	F.SMO

ADULT HARP & HCBS SERVICES (NEW YORK SPECIFIC)	# OF UNITS			AGE 18-64	AGE 65+	PROGRAM CODE
EDUCATION SUPPORT SERVICES	N/A	N/A	N/A	☐	☐	P.ESS
HABILITATION/RESIDENTIAL SUPPORT SERVICES	N/A	N/A	N/A	☐	☐	P.HRS
INTENSIVE SUPPORTED EMPLOYMENT	N/A	N/A	N/A	☐	☐	P.ISE
MOBILE CRISIS INTERVENTION	N/A	N/A	N/A	☐	☐	P.MCI
ONGOING SUPPORTED EMPLOYMENT	N/A	N/A	N/A	☐	☐	P.OSE
PREVOCATIONAL SERVICES	N/A	N/A	N/A	☐	☐	P.PVS
PROVIDERTRAVEL SUPPLEMENT	N/A	N/A	N/A	☐	☐	F.TRV
TRANSITIONAL EMPLOYMENT	N/A	N/A	N/A	☐	☐	P.TRE

CORE SERVICES (NEW YORK SPECIFIC)	# OF UNITS			AGE 18-64	AGE 65+	PROGRAM CODE
COMMUNITY PSYCHIATRIC SUPPORT & TREATMENT (CORE)	N/A	N/A	N/A	☐	☐	P.CPD
PEER SUPPORTS (CORE)	N/A	N/A	N/A	☐	☐	P.PPD
FAMILY SUPPORT AND TREATMENT (CORE)	N/A	N/A	N/A	☐	☐	P.FSC
PSYCHOSOCIAL REHABILITATION (CORE)	N/A	N/A	N/A	☐	☐	P.PSD

CHILDREN'S HCBS SERVICES (NEW YORK SPECIFIC)	# OF UNITS	AGE 0-20	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE
CAREGIVER FAMILY SUPPORTS & SERVICES	N/A	☐	N/A	N/A	N/A	F.CFI
CAREGIVER FAMILY SUPPORTS & SERVICES – GROUP OF 2	N/A	☐	N/A	N/A	N/A	F.CFG
CAREGIVER FAMILY SUPPORTS & SERVICES – GROUP OF 3	N/A	☐	N/A	N/A	N/A	F.CFG
COMMUNITY HCBS HABILITATION - INDIVIDUAL	N/A	☐	N/A	N/A	N/A	F.HCH
COMMUNITY HCBS HABILITATION - GROUP OF 2	N/A	☐	N/A	N/A	N/A	F.HCH
COMMUNITY HCBS HABILITATION - GROUP OF 3	N/A	☐	N/A	N/A	N/A	F.HCH
COMMUNITY SELF-ADVOCACY & SUPPORT – GROUP 2	N/A	☐	N/A	N/A	N/A	F.CAG
COMMUNITY SELF-ADVOCACY & SUPPORT – GROUP OF 3	N/A	☐	N/A	N/A	N/A	F.CAG
COMMUNITY SELF-ADVOCACY & SUPPORT - INDIVIDUAL	N/A	☐	N/A	N/A	N/A	F.CSI
CRISIS RESPITE – LESS THAN 4 HOURS	N/A	☐	N/A	N/A	N/A	F.CRT
CRISIS RESPITE – MORE THAN 12 LESS THAN 24 HOURS	N/A	☐	N/A	N/A	N/A	F.CRT
CRISIS RESPITE – MORE THAN 4 HOURS LESS THAN 12 HOURS	N/A	☐	N/A	N/A	N/A	F.CRT
DAY HCBS HABILITATION - INDIVIDUAL	N/A	☐	N/A	N/A	N/A	F.HDH
DAY HCBS HABILITATION - GROUP OF 2	N/A	☐	N/A	N/A	N/A	F.HDH
DAY HCBS HABILITATION - GROUP OF 3	N/A	☐	N/A	N/A	N/A	F.HDH
PALLIATIVE CARE EXPRESSIVE THERAPY	N/A	☐	N/A	N/A	N/A	F.PET
PALLIATIVE CARE MASSAGE THERAPY	N/A	☐	N/A	N/A	N/A	F.PMT
PLANNED RESPITE – INDIVIDUAL PER DIEM	N/A	☐	N/A	N/A	N/A	F.PPR
PLANNED RESPITE – INDIVIDUAL (UNDER 4 HOURS)	N/A	☐	N/A	N/A	N/A	F.PPR
PLANNED RESPITE – GROUP LESS THAN 4 HOURS	N/A	☐	N/A	N/A	N/A	F.PPG
PREVOCATIONAL SERVICES - INDIVIDUAL	N/A	☐	N/A	N/A	N/A	F.PVI
PREVOCATIONAL SERVICES – GROUP OF 2	N/A	☐	N/A	N/A	N/A	F.PVG
PREVOCATIONAL SERVICES – GROUP OF 3	N/A	☐	N/A	N/A	N/A	F.PVG
SUPPORTED EMPLOYMENT	N/A	☐	N/A	N/A	N/A	F.SUP

CHILDREN'S CTFSS SERVICES (NEW YORK SPECIFIC)	# OF UNITS	AGE 0-20				PROGRAM CODE
CHILDRENS MOBILE CRISIS INTERVENTION - 2 LP 90-180 MINUTES	N/A	☐	N/A	N/A	N/A	F.CM1
CHILDRENS MOBILE CRISIS INTERVENTION - 2 LP OVER 3HR	N/A	☐	N/A	N/A	N/A	F.CM2
CHILDRENS MOBILE CRISIS INTERVENTION - 1 LP - F2F FOLLOW UP	N/A	☐	N/A	N/A	N/A	F.CM3
CHILDRENS MOBILE CRISIS INTERV - 1 PEER F2F - FOLLOW UP	N/A	☐	N/A	N/A	N/A	F.CM4
CHILDRENS MOBILE CRISIS INTERV - 1 LP 1 PEER F2F - FOLLOW UP	N/A	☐	N/A	N/A	N/A	F.CM5
CHILDRENS MOBILE CRISIS INTERV - 1 LP TELEPHONIC - FOLLOW UP	N/A	☐	N/A	N/A	N/A	F.CM6
CHILDRENS MOBILE CRISIS INTERV - 1 PEER TELEPHONIC - FOLLOW UP	N/A	☐	N/A	N/A	N/A	F.CM7
CPST SERVICE PROFESSIONAL - (ONSITE)	N/A	☐	N/A	N/A	N/A	F.CSP
CPST SERVICE PROFESSIONAL - (OFFSITE)	N/A	☐	N/A	N/A	N/A	F.COI
CPST SERVICE PROFESSIONAL GROUP - (ONSITE)	N/A	☐	N/A	N/A	N/A	F.CSG
CPST SERVICE PROFESSIONAL GROUP - (OFFSITE)	N/A	☐	N/A	N/A	N/A	F.COG
CRISIS INTERVENTION – 1 LICENSED PRACTITIONER	N/A	☐	N/A	N/A	N/A	F.CLP
CRISIS INTERVENTION – 1 LP AND PEER SUPPORT	N/A	☐	N/A	N/A	N/A	F.CPE
CRISIS INTERVENTION – 2 CLINICIANS 1 LP	N/A	☐	N/A	N/A	N/A	F.C90
CRISIS INTERVENTION – 2 LP'S	N/A	☐	N/A	N/A	N/A	F.C2P
FAMILY PEER SUPPORT SERVICE - (FPSS) PROFESSIONAL	N/A	☐	N/A	N/A	N/A	F.FSP
FAMILY PEER SUPPORT SERVICE - (FPSS) GROUP	N/A	☐	N/A	N/A	N/A	F.FSG
FPSS/YPSS (OFFSITE)	N/A	☐	N/A	N/A	N/A	F.FOI F.YOI
FPSS/YPST GROUP (OFFSITE)	N/A	☐	N/A	N/A	N/A	F.FOG
OLP COUNSELING INDIVIDUAL	N/A	☐	N/A	N/A	N/A	F.OCI

CHILDREN'S CTFSS SERVICES (NEW YORK SPECIFIC)	# OF UNITS	AGE 0-20				PROGRAM CODE
OLP CRISIS	N/A	☐	N/A	N/A	N/A	F.OLC
OLP CRISIS COMPLEX CARE	N/A	☐	N/A	N/A	N/A	F.OCC
OLP CRISIS TRIAGE	N/A	☐	N/A	N/A	N/A	F.OCT
OLP FAMILY COUNSELING	N/A	☐	N/A	N/A	N/A	F.OLF
OLP GROUP	N/A	☐	N/A	N/A	N/A	F.OCG
OTHER LICENSED PROFESSIONAL - OLP LICENSED EVALUATION	N/A	☐	N/A	N/A	N/A	F.OLE
PSR SERVICE PROFESSIONAL (ONSITE)	N/A	☐	N/A	N/A	N/A	F.PSP
PSR SERVICE PROFESSIONAL (OFFSITE)	N/A	☐	N/A	N/A	N/A	F.OPP
PSR SERVICE PROFESSIONAL GROUP (ONSITE)	N/A	☐	N/A	N/A	N/A	F.PSG
PSR SERVICE PROFESSIONAL GROUP (OFFSITE)	N/A	☐	N/A	N/A	N/A	F.OPS
YOUTH PEER SUPPORT & TRAINING (YPSS) - INDIVIDUAL	N/A	☐	N/A	N/A	N/A	F.YSP
YOUTH PEER SUPPORT & TRAINING (YPSS) - GROUP (YPSS)	N/A	☐	N/A	N/A	N/A	F.YSG

MEDICAID ADVANTAGE PLUS (NEW YORK SPECIFIC)	# OF CAPACITY			AGE 10-20	AGE 21+	PROGRAM CODE
ASSERTIVE COMMUNITY TREATMENT (ACT)		N/A	N/A	☐	☐	P.ACT

MEDICAID ADVANTAGE PLUS (NEW YORK SPECIFIC)	# OF CAPACITY	AGE 0-12	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE
ADULT INTENSIVE CARE RESIDENCE	N/A	☐	☐	☐	☐	F.NCR
ADULT RESIDENTIAL CRISIS SUPPORT	N/A	☐	☐	☐	☐	F.NCS
CHILDRENS CRISIS RESIDENCE	N/A	☐	☐	☐	☐	F.NCC
COMMUNITY INTEGRATION COUNSELING	N/A	☐	☐	☐	☐	P.COM
CONTINUING DAYTREATMENT		☐	☐	☐	☐	P.CDT
INTENSIVE CRISIS RESIDENCE (ICR) 18-20 YEARS	N/A	☐	☐	☐	☐	F.NIC
INTENSIVE CRISIS STABILIZATION CENTER	N/A	☐	☐	☐	☐	F.ICS
INTENSIVE PSYCHIATRIC REHABILITATION TREATMENT	N/A	☐	☐	☐	☐	P.IPR
MOBILE CRISIS	N/A	☐	☐	☐	☐	F.CRM P.MOB
MOBILE CRISIS INTERVENTION SERVICES – TELEPHONIC CRISIS	N/A	☐	☐	☐	☐	F.CPT
MOBILE CRISIS INTERVENTION SERVICES – FOLLOW UP	N/A	☐	☐	☐	☐	F.MCF
MOBILE MENTAL HEALTH TREATMENT	N/A	☐	☐	☐	☐	P.MMH
NYS OMH LICENSED COMMUNITY RESIDENCES	N/A	☐	☐	☐	☐	P.NYS
PARTIAL HOSPITALIZATION – COLLATERAL	N/A	☐	☐	☐	☐	F.PHC
PARTIAL HOSPITALIZATION – CRISIS	N/A	☐	☐	☐	☐	F.PCR
PARTIAL HOSPITALIZATION – GROUP COLLATERAL	N/A	☐	☐	☐	☐	F.PHG
PARTIAL HOSPITALIZATION – REGULAR	N/A	☐	☐	☐	☐	F.PHR
PEER MENTORING	N/A	☐	☐	☐	☐	P.PEM
PERSONALIZED RECOVERY ORIENTED SERVICES (PROS)	N/A	☐	☐	☐	☐	P.PRO
POSITIVE BEHAVIORAL INTERVENTION SUPPORTS (PBIS)	N/A	☐	☐	☐	☐	P.PBI
RESIDENTIAL CRISIS SUPPORT 18-20 YEARS	N/A	☐	☐	☐	☐	F.NRC
SUPPORTIVE CRISIS STABILIZATION CENTER	N/A	☐	☐	☐	☐	F.SCS
STRUCTURED DAYPROGRAM	N/A	☐	☐	☐	☐	P.SDP

CARELON BEHAVIORAL HEALTH OF PENNSYLVANIA	# OF UNITS	AGE 0-20	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE
ACUTE PARTIAL HOSPITALIATION	N/A	☐	☐	☐	☐	F.AHO
ADOLESCENT DIVERSION AND STABILIZATION UNIT	N/A	☐	☐	☐	☐	P.DAS
ADULT FAMILY FOCUSED SOLUTIONS BASED SERVICES- INDIVIDUAL	N/A	☐	☐	☐	☐	P.FFA
ASSERTIVE COMMUNITY TX TEAM/ COMMUNITY TX TEAMS	N/A	☐	☐	☐	☐	P.CTT
BEHAVIORAL HEALTH HOTLINE SVC (TELEPHONE CRISIS)	N/A	☐	☐	☐	☐	F.CPT
BSU DIAGNOSTIC ASSESSMENT, BY NON-PHYSICIAN (MH DIAGNOSTIC ASSESSMENT)	N/A	☐	☐	☐	☐	P.BSU
CLOZAPINE SUPPORT	N/A	☐	☐	☐	☐	P.ZPE
COMMUNITY MENTAL HEALTH/OTHER (MOBILE MEDS)	N/A	☐	☐	☐	☐	F.MDM
CRISIS INTERVENTION SVC (MOBILE CRISIS)	N/A	☐	☐	☐	☐	F.CRM
CRISIS INTERVENTION SVC (WALK-IN CRISIS)	N/A	☐	☐	☐	☐	F.CRW
CRISIS INTERVENTION SVC, MH SVCS (CRISIS RESIDENTIAL)	N/A	☐	☐	☐	☐	F.CRH
DUAL DIAGNOSIS TREATMENT TEAM	N/A	☐	☐	☐	☐	P.DTT
EATING DISORDERTREATMENT	N/A	☐	☐	☐	☐	P.OED
EXTENDED ACUTE CARE- INPATIENT	N/A	☐	☐	☐	☐	F.EAC
FAMILY BASED SERVICES	N/A	☐	☐	☐	☐	P.FBS
FEDERALLYQUALIFIED HEALTH CLINIC	N/A	☐	☐	☐	☐	F.QHC
INDIVIDUAL THERAPYPARENT-CHILD INTERACTION THERAPY(PCIT)	N/A	☐	☐	☐	☐	P.PCT
INTENSIVE BEHAVIORALHEALTHSERVICES	N/A	☐	☐	☐	☐	P.IBH
LABORATORY	N/A	☐	☐	☐	☐	P.LAB
LONG TERM REHAB 3.5 H HIGHEST INTENSITY	N/A	☐	☐	☐	☐	F.NLR
LONG TERMSTRUCTURED RESIDENTIAL	N/A	☐	☐	☐	☐	P.LTR
MULTI-SYSTEMIC THERAPY	N/A	☐	☐	☐	☐	P.MST
PSYCH REHAB CLUBHOUSE	N/A	☐	☐	☐	☐	P.PSC
RESOURCE COORDINATION SUBSTANCE USE DISORDER; CASE MANAGEMENT (SUD RC)	N/A	☐	☐	☐	☐	F.RCO

CONTINUED CARELON BEHAVIORAL HEALTH OF PENNSYLVANIA	# OF UNITS	AGE 0-20	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE
SINGLE COUNTY AUTHORITY (SCA) SERVICE PLAN ASSESSMENT	N/A	☐	☐	☐	☐	P.SCA
SMOKING AND TOBACCO USE CESSATION	N/A	☐	☐	☐	☐	F.SMC
SUBSTANCE USE DISORDER CASE COORDINATION	N/A	☐	☐	☐	☐	P.DAC
SUBSTANCE USE DISORDER ICM SUBSTANCE USE DISORDER SERVICES; CASE MANAGEMENT (SUD ICM)	N/A	☐	☐	☐	☐	P. GC
SUBSTANCE USE DISORDER OP IN AN ALTERNATIVE SETTING - INDIVIDUAL	N/A	☐	☐	☐	☐	P.ALT
SUBSTANCE USE DISORDER RECOVERY SPECIALIST	N/A	☐	☐	☐	☐	P.DAR
TARGETED CASE MANAGEMENT (BLENDED CASE MANAGEMENT)	N/A	☐	☐	☐	☐	P.BCM
TRAUMA FOCUSED SERVICES	N/A	☐	☐	☐	☐	P.TFS
WITHDRAWAL MANAGEMENT 3.7	N/A	☐	☐	☐	☐	F.RDA F.RDL

SPECIALTY SERVICES (NATIONAL)	# OF UNITS	AGE 0-12	AGE 13-17	AGE 18-64	AGE 65+	PROGRAM CODE
CPEP		☐	☐	☐	☐	P.CPE
CRISIS/EVALUATION INER		☐	☐	☐	☐	F.CRE
ECT		☐	☐	☐	☐	P.ECT
HARM REDUCTION		☐	☐	☐	☐	F.HRC
SDE (STATE DESIGNATED ENTITY)		☐	☐	☐	☐	F.SDE
SPECIAL CONNECTIONS SERVICES		☐	☐	☐	☐	
TRANSCRANIAL MAGNETIC STIMULATION TMS		☐	☐	☐	☐	P.TMS
TRANSPORTATION SERVICES		☐	☐	☐	☐	P.TET
OTHER PSYCH, SUB USE SERVICE:_		☐	☐	☐	☐	

If you indicated the facility is providing services for Inpatient Detox and or Inpatient Substance, Use Rehab, answer the below questions.

1) Inpatient Detox: Does the facility provide emergency medical services on-site to treat severe, unstable conditions related to withdrawal? Yes☐ No☐
2) Inpatient Substance Use Rehab: Does the facility provide emergency psychiatric/medical services on-site or by contract? Yes☐ No☐

If your site has multiple NPI numbers, please complete the following box to provide us with all NPIs that apply to your facility/clinic:

Additional NPIs	Additional Medicaid IDs	Level of Care

ATTESTATION STATEMENT:

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

Name:_____ Title:_____

Signature:_____ Date:_____

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

FACILITY SITE VISIT ATTESTATION

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

Primary Location:

_____

Street City State Zip

Satellite Locations: (attach additional sheet if necessary)

_____

Street City State Zip

_____

Street City State Zip

_____

Street City State Zip

Attestation Statement:

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

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

_____ _____ _____/_____/_____Date

Signature of Applicant Title

_____

Name (Please Print)

Directions:

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

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

Definitions:

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

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

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

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

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

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

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

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

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

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

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

I. Identifying Information

____
Name of Person Completing Form

____
Phone Number of Person Completing Form

____
Provider's Name

Provider Entity Information:

____
Name of Entity

____
Entity DBA (If Different from Entity Name)

____
Entity Tax ID

____
Entity NPI Number

____
Practice Address Line 1

____
Practice Address Line 2

____
City

____
State

______
ZIP

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

A. Master List:

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

OWNER NAME	OWNER DOB			OWNER SSN	% OF OWNERSHIP	Non-Profit
						Yes ☐ No ☐
OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP		

OWNER NAME	OWNER DOB			OWNER SSN	% OF OWNERSHIP	Non-Profit
						Yes ☐ No ☐
OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP		

OWNER NAME	OWNER DOB			OWNER SSN	% OF OWNERSHIP	Non-Profit
						Yes ☐ No ☐
OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP		

OWNER NAME	OWNER DOB			OWNER SSN	% OF OWNERSHIP	Non-Profit
						Yes ☐ No ☐
OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP		

B. Specific Questions

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

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

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

NAME OF OTHER PROVIDER ENTITY	ADDRESS	CITY	STATE	ZIP	TAX ID

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

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

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

WHEN WERE YOU DEBARRED	LENGTH OF DEBARMENT	REASON FOR DEBARMENT

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

PRACTICING STATE WHEN TERMINATED	REASON FOR TERMINATION	DATE OF TERMINATION

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

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

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

NAME OF SUBCONTRACTOR	ADDRESS	CITY	STATE	ZIP	TAX ID

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

NAME	ADDRESS	CITY	STATE	ZIP	TAX ID	% OF OWNERSHIP	TITLE

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

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

III. BUSINESS TRANSACTIONS

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

NAME	ADDRESS	CITY	STATE	ZIP

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

NAME	ADDRESS	CITY	STATE	ZIP	NPI	TAX ID

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

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

IV. Signature

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

_____ Name of Entity Owner

_____ Signature of Entity Owner

_____ Title

_____ Date

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

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

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

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

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

Other (see instructions) [a]

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

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Social security number

			–			–				

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

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

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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), 1098-T

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).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 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 section 1446 withholding on your share of partnership income.

In the cases below, the following person must give 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:
• In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the 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 trust; and
• In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

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, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

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 his or her 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 his or her 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 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include 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 Part II instructions on page 3 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 under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 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 no longer are 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, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **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. 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 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** 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.

d. **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. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity 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, "Business name/disregarded entity name." 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, you may enter it on line 2.

Line 3

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

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in 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 in 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 possession, 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 possession

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

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 Income, 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) written or printed 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 possession, 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.

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 individual taxpayer identification number (ITIN). Enter it in the social security number box. 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. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 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 1-800-772-1213. 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/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "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, generally you will 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.

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 items 1, 4, or 5 below indicate 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), 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)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. 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]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 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:	
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other taxexempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. 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
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (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 and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. 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.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

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 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 credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system 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 1-877-777-4778 or TTY/TDD 1-800-829-4059.

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 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov 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 possessions for use in administering their laws. The information also may 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, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.
(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.
If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.
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. 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, and
4. 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?* on page 2 for further information.