Credentialing Alliance

**ORGANIZATIONAL FACILITY APPLICATION**

**Initial Credentialing**—Failure to legibly complete all sections of this Application and submit current copies of all required documentation may result in processing delays

**SUBMIT THIS FORM and if not enrolled in CAQH submit all required documents:**

TCH_PROVIDEROPERATIONS@CENTENE.COM

HNOR_PROVIDEROPERATIONS@HEALTHNET.COM

**INSTRUCTIONS**:

**PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING PROVIDING ANY ATTACHMENTS, TO PREVENT DELAYS IN PROCESSING YOUR REQUEST.**

**PLEASE NOTE**: FOR EVERY ORGANIZATION/FACILITY TYPE, A SEPARATE APPLICATION MUST BE COMPLETED.

*Action Required: If your practitioners are registered with CAQH, credentialing documents must be current and uploaded to CAQH. Please ensure that Centene Corp. is listed as an authorized plan.

**Please include with your completed/signed application the following items for each location:**

- ☐ Copy of current State License and/or business license for each location
- ☐ Copy of Medicare Certification letter (if applicable)
- ☐ Copy of Certifications and/or Accreditation Certificates (e.g. TJC,CHAP, etc)
- ☐ Copy of your CLIA Certificate (if applicable)
- ☐ Copy of your current *Professional Malpractice* Insurance Policies
- ☐ Accurate W9
- ☐ Organizational Attestation
- ☐ DEA (if applicable)
- ☐ DOO 3974 for the provider group name, TIN and group NPI (Medicaid enrollment only)
- ☐ Policy for Seclusion and Restraint, OAR 410-141-3590 (2) (cc)

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**ORGANIZATIONAL FACILITY APPLICATION**

| 1099 Registered Name (Required): | | | Tax ID#: |
|---|---|---|---|
| Organization Provider Name/DBA (if applicable): | | | |
| Lines of Business:<br>☐Medicaid ☐Medicare ☐Commercial | License # | State | Exp Date |
| Is Facility a Medicare participating provider:<br>☐YES ☐NO | Organization NPI# | | |

| **ORGANIZATION TYPE (as listed on License or Accreditation) Check all that apply:** | | |
|---|---|---|
| ☐ Acute Rehab | ☐ FQHC/RHC | ☐ Pharmacy |
| ☐ Ambulatory Surgery Center | ☐ Habilitation Providers | ☐ PT/OT/ST |
| ☐ Attendant Care Agency | ☐ Home Health | ☐ Radiology |
| ☐ Assisted Living Center | ☐ Hospice | ☐ Sleep Center |
| ☐ Assisted Living Home | ☐ Hospital | ☐ Skilled Nursing Facility |
| ☐ Behavioral Health | ☐ Intensive Outpatient Treatment (BH) | ☐ Transportation |
| ☐ Dialysis | ☐ Lab | ☐ Urgent Care |
| ☐ DME/Infusion | ☐ Medical/Dental Schools | ☐ Vision |
| ☐ Enteral | ☐ Orthotics & Prosthetics | ☐ Wound Care |
| ☐ Family Planning | ☐ Outpatient Medical Rehab Center | ☐ Other: |

| **FACILITY TYPE SPECIALTIES: Check all that apply:** | | |
|---|---|---|
| ☐Acute Inpatient Hospitals | ☐Skilled Nursing Facilities | ☐Occupational Therapy |
| ☐Cardiac Surgery Program | ☐Diagnostic Radiology | ☐Speech Therapy |
| ☐Cardiac Catheterization Services | ☐Mammography | ☐Inpatient Psychiatric Facility Services |
| ☐Critical Care Services -Intensive Care Units (ICU) | ☐Physical Therapy | ☐Outpatient Infusion/Chemotherapy |
| ☐Surgical Services (Outpatient or ASC) | | |

| **PRIMARY ADDRESS**: Physical Location where services are performed. Please complete a supplemental form for each location. | | | |
|---|---|---|---|
| Address: | City | State | Zip Code |
| Phone: | Fax: | County: | Location NPI (*Cannot be processed without a valid 10 digit NPI):* |
| Modalities: | Hours: | | |
| List Address in Directories:<br>☐Yes ☐NO | | | |

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**ORGANIZATIONAL FACILITY APPLICATION**

## SUPPLEMENT FORM FOR ADDITIONAL CERTIFICATIONS

| For each additional address, copy and complete this Supplemental form and include the appropriate certification information below. | |
|---|---|
| **Street Address:** | |
| **State:** | **Zip Code:** |
| **Phone #:** | **Fax #:** |
| ***Please provide a copy of State License and/or business license***<br>**State License #:** _____<br>**Expiration Date:** _____ | **CLIA #:**<br>**Expiration Date:** _____ |
| **NPI #:**<br>**(Application cannot be processed without a valid 10-digit NPI)** | |
| **Medicare Certified?** ☐ **Yes** ☐ **No**<br>***Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter***<br>**Medicare #:** _____ | |
| **Oregon Medicaid #:** _____ | |

The Fax number and phone number for each participating plan is listed in the table below.

If your intent is to apply for participation in a Health Plan network, please send only to the Plan(s) you are Interested in joining. NOT ALL plans provide services in every county. Please contact the Plan directly to verify that they provide services in your county and that they are accepting new providers.

If you are adding a practitioner under an existing Health Plan contract, please only send to the Plan(s) you are contracted with.

| HEALTH PLAN | PHONE | FAX/EMAIL | WEBSITE |
|---|---|---|---|
| Health Net of Oregon (HMO/PPO/Commercial) | (888) 445-8913 | (855)536-4449<br>HNOR_ProviderOperations@healthnet.com | www.healthnetoregon.com/ |
| Trillium Community Health Plan (Medicaid/ Medicare) | Lane/Linn/Douglas: (541) 485-2155<br>Washington/Multnomah/ Clackamas (877) 600-5472 | (855)536-4449<br>TCH_Provideroperations@centene.com | www.trilliumohp.com/ |

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**ORGANIZATIONAL FACILITY APPLICATION**

| **ACCREDITING AUTHORITIES:** Please indicate if this location has been reviewed by any of the accrediting authorities listed below and provide a copy of the most recent accreditation report for each location. | |
|---|---|
| ☐ Accreditation Commission for Health Care, INC. | ☐ Commission on Office Laboratory Accreditation |
| ☐ American Association for Accreditation of Ambulatory Surgery Facilities | ☐ Community Health Accreditation |
| ☐ American Association for Ambulatory Health Care | ☐ Det Norske Veritas National Integrated Accreditation for Healthcare Organizations |
| ☐ American College of Radiology | ☐ Healthcare Facilities Accreditation Program |
| ☐ American Osteopathic Association | ☐ Joint Commission |
| ☐ Commission on Accreditation of Rehabilitation Facilities | ☐ Other: |
| ☐ Not Applicable | |

| **Organizational FACILITY CONTACT/MAILING ADDRESS:** | | | |
|---|---|---|---|
| Contact Name/Title: | Phone: | Fax: | |
| Email: | Organizational Facility Website Address: | | |
| Address: | City: | State: | Zip Code: |

| **BILLING SERVICE** | | |
|---|---|---|
| Name of Service: | Contact Name: | |
| Address: | Phone: | |
| City: | State: | Zip Code: |

| **PAY TO ADDRESS** | | | |
|---|---|---|---|
| Name: | Contact: | | |
| Address: | City: | State: | Zip Code: |
| Phone: | Fax: | | |

| **CREDENTIALING CONTACT** | | | |
|---|---|---|---|
| Name: | | | |
| Address: | City: | State: | Zip Code: |
| Phone: | Fax: | Email: | |

**Organizational/Facility Assessment of Cognitive and Physical Disabilities Accommodations**

Please identify what accommodations you provide at **each of your organizational facility locations** for members with cognitive or physical disabilities. If accommodations are the same at all locations, on Practice Location Address, please state ALL. Please, complete a separate Assessment for each location if accommodations vary.

**Organizational Facility Location Address:**

_____ _____

| Accommodation | YES | NO | Comments |
|---|---|---|---|
| Provider/Staff trained to assist individuals with a cognitive disability, i.e., autism or intellectual disabilities | | | |
| Provider/Staff trained to assist individuals with a physical disability, i.e., mobility limitations or wheelchair bound | | | |
| Flexible appointment times available—sick appointments, same day appts—please specify | | | |
| Extended appointment times—before 8 am, after 5pm, Sat and/or Sunday—please specify | | | |
| Assistance available to members to fill out forms | | | |
| In-home and/or community services | | | |
| Large print materials | | | |
| Materials in electronic format | | | |
| Augmentative/Alternative communication devices | | | |
| TDD capabilities | | | |
| American Sign Language translator | | | |
| Signage with Braille and raised tactile text characters at office, elevator, stairwells and restroom doors mounted 60in from floor | | | |
| Visible & Audible alarms – emergency systems | | | |
| Dimmable Lights | | | |
| Ramps have non-slip surface material | | | |
| Railings between 30 & 38in high. On both sides. | | | |
| Paths are at least 36in wide and free of protruding objects | | | |
| Cane detectible objects on ground as a warning barrier | | | |
| Widened doorways (at least 32in clearance) | | | |
| Offset (swing-clear) hinges | | | |
| Power assisted or automatic door openers | | | |
| Door handles no higher than 48in | | | |
| Lever or loop handles vs knobs | | | |
| 5ft circle or T-shaped space for turning a wheelchair completely | | | |

| Accommodation | YES | NO | Comments |
|---|---|---|---|
| A clear floor space, 30" x 48" minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer | | | |
| Adjustable height exam table or chair (lowers to 17-19in from floor) | | | |
| Positioning and support aids, such as wedges, rolled up blankets, straps and rails | | | |
| Ceiling or floor based patient lift | | | |
| Gurneys and/or stretchers | | | |
| Wheelchair accessible scales | | | |
| Adjustable height radiologic equipment | | | |
| Handicap parking | | | |
| Handicap accessible restroom | | | |
| Access ramps | | | |
| Accessible by bus | | | |
| Accessible by Valley Metro Rail | | | |
| Accessible by Taxi or similar options i.e., Uber/Lyft | | | |
| Provider/Staff has completed cultural competence training | | | |
| Do you provide Field Clinic services?<br><br>(A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis) | | | |
| Do you provide Virtual Clinic services?<br><br>(Integrated services provided in community settings through the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings) | | | |

# DISCLOSURE QUESTIONS

| **Please answer the following questions by checking the appropriate box. If the answer to any question is "YES" please provide a complete description of the facts on a separate sheet to be attached to application.** | |
|---|---|
| 1. Has the Organizational Facility license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed? | ☐ Yes<br>☐ No |
| 2. Has the Organizational Facility been denied participation, suspended from or denied renewal from Medicare or Medicaid? | ☐ Yes<br>☐ No |
| 3. Has the Organizational Facility ever had its professional liability coverage cancelled or not renewed? | ☐ Yes<br>☐ No |
| 4. Has the Organizational Facility been denied accreditation by its selected accrediting body (e.g. TJC) or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body? | ☐ Yes<br>☐ No |

# Organizational Facility Attestation/Consent & Release Form

| Any alteration or failure to sign and date this form will result in the delay of processing this application. By signing below, I attest that I am the duly authorized representative of the Organization, that all information on the Application pertains to the above-named Organization, and that such information is current, complete and correct. |
|---|
| ORGANIZATIONAL FACILITY NAME: |
| REPRESENTATIVE NAME: |
| TITLE: |
| SIGNATURE: |
| DATE: |

Credentialing Alliance

**ORGANIZATIONAL FACILITY APPLICATION**

## SUPPLEMENT FORM FOR ADDITIONAL ADDRESSES/LOCATIONS

| For each additional address, copy and complete this Supplemental form. A Provider Assessment of Cognitive and Physical Disabilities Accommodations must be completed for each location unless accommodations are the same at each location. | |
|---|---|
| **Street Address:** | |
| **State:** | **Zip Code:** |
| **Phone #:** | **Fax #:** |
| ***Please provide a copy of State License and/or business license***<br>**State License #:** _____<br>**Expiration Date:** _____ | **CLIA #:**<br>**Expiration Date:** _____ |
| **NPI #:**<br>**(Application cannot be processed without a valid 10-digit NPI)** | |
| **Medicare Certified?** ☐ **Yes** ☐ **No**<br>***Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter***<br>**Medicare #:** _____ | |
| **Oregon Medicaid #:** _____ | |

The Fax number and phone number for each participating plan is listed in the table below.

If your intent is to apply for participation in a Health Plan network, please send only to the Plan(s) you are Interested in joining. NOT ALL plans provide services in every county. Please contact the Plan directly to verify that they provide services in your county and that they are accepting new providers.

If you are adding a practitioner under an existing Health Plan contract, please only send to the Plan(s) you are contracted with.

| HEALTH PLAN | PHONE | FAX/EMAIL | WEBSITE |
|---|---|---|---|
| Health Net of Oregon (HMO/PPO/Commercial) | (888) 445-8913 | (855)536-4449<br>HNOR_ProviderOperations@healthnet.com | www.healthnetoregon.com/ |
| Trillium Community Health Plan (Medicaid/ Medicare) | Lane/Linn/Douglas:<br>(541) 485-2155<br>Washington/Multnomah/ Clackamas<br>(877) 600-5472 | (855)536-4449<br>TCH_Provideroperations@centene.com | www.trilliumohp.com/ |

# Attestation Statement

INSTRUCTIONS: Please complete either **Section A *or* Section B** for consideration to participate in the provider network. For any "Yes" response to one or more of the questions in Section B, complete the attached Attestation Question Explanation Form.

This attestation pertains to all employed and contracted provider(s) authorized to provide or supervise care provided by _____(the "Agency").

I, _____ , the undersigned representative of Agency, on its behalf, understand and agree that as part of the credentialing process for participation in the Health Plan provider network,

**Section A**

…attest that the Agency has conducted the following on each caregiver prior to allowing each to provide care to a Health Plan member:

☐
- Criminal Background Check *and*;
- State Child Abuse Registry *and*;
- Other State Mandated Clearance Checks

**Section B**

…assure through a background check and other reasonable means the following with respect to each caregiver providing care and each attendant supervising care on behalf of the Agency:

| | | | |
|---|---|---|---|
| ☐ YES | ☐ NO | 1. | Have applicable license(s) held by caregiver(s) and/or attendant(s) been revoked, refused, restricted or voluntarily surrendered? |
| ☐ YES | ☐ NO | 2. | Have caregiver(s) and/or attendant(s) been convicted of, or pled guilty to, a felony? |
| ☐ YES | ☐ NO | 3. | Has any caregiver or attendant been terminated, suspended, barred, sanctioned or voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program? |
| ☐ YES | ☐ NO | 4. | Is/Are caregiver(s) and/or attendant(s) unable to perform the essential functions of his or her job with reasonable accommodation? |

Signature: _____

Print: _____

Title: _____

Date: _____

Tax ID: _____

# Attestation Question Explanation Form

Use this form to report any "Yes" response to one or more of the questions on the Attestation Statement. Record the question number in the first column, then your explanation in the second column. If you need additional space to explain a "Yes" response, photocopy this page as needed.

| QUESTION # | EXPLANATION: |
| --- | --- |
| | |
| | |
| | |
| | |

**Prior to completing this credentialing application, please read and observe the following:**

| **INSTRUCTIONS** |
|---|
| This form should be **typed (using a different font than the form) or legibly printed in black or blue ink**. If more space is needed than provided on the original, attach additional sheets and reference the question being answered. |

- Modification to the wording or format of the Organizational Provider Credentialing Application will invalidate the application.
- Complete the application in its entirety. Please sign and date pages 7 and 9. Mail application to:

  **Trillium Community Health Plans: TCH_ProviderOperations@centene.com**

  **Health Net of Oregon: HNOR_ProviderOperations@healthnet.com**
- Identify the health care related organization(s) to which this application is being submitted in the space provided below.

***IMPORTANT***

**Current copies of all applicable documentation requested in Section VIII, *Attachments*, must accompany this Application. Failure to complete all sections of this Application or submit all required documentation will constitute an incomplete application and will be returned to the provider without processing.**

I am applying to (please list: Hospital Staff, HMO, IPA)_____

_____

_____for

_____ (i.e., staff membership, network participation, if applicable).

**PLEASE USE A SEPARATE APPLICATION FOR MULTIPLE LOCATIONS**

## I. PROVIDER IDENTIFICATION

### A. Corporate Identification Information

Furnish the provider's legal business name (as reported to the IRS) "doing business as" name (name provider generally known by to the public), and the various operating dates and places of formal business registration and/or incorporation. All payments will be issued in the provider's legal business name in compliance with IRS regulations.

**1.** Legal Business Name as Reported to the IRS (claims will be paid to this name)

| **2.** "Doing Business As" (DBA) Name (if applicable) | County where DBA Name Registered (if applicable) |
|---|---|
| **3.** Address: | **4**. Tax Identification Number: |

### B. Current Practice Location(s)

Practice Location Name:

Practice Location Address Line 1:

Practice Location Address Line 2:

| City: | State: | Zip: | County: |
|---|---|---|---|

| Phone: ( ) | Fax: ( ) | E-mail: |
|---|---|---|

| Primary Contact Name: | Contact Title: |
|---|---|

| Phone: ( ) | Fax: ( ) | E-mail: |
|---|---|---|

Administrator (Full Name):

### C. Mailing/Correspondence Address

**This must be an address where provider can be contacted directly.**

Check here ❑ if all correspondence can be directed to the practice location in Section B.

Mailing Address Line 1:

Mailing Address Line 2:

| City: | State: | Zip: | County: |
|---|---|---|---|

**D. Type of Provider**

**Provider Type** (*check all boxes that apply)*:

- ☐ Clinical Laboratories
- ☐ Comprehensive Outpatient Rehab Facility
- ☐ Durable Medical Equipment
- ☐ End-Stage Renal Disease Services
- ☐ Federally Qualified Health Centers
- ☐ Free Standing Laboratory
- ☐ Free Standing Surgical Center
- ☐ Hospice Agency
- ☐ Hospital
- ☐ Home Health Agency
- ☐ Outpatient Diabetes Self-Management Training
- ☐ Outpatient Physical Therapy
- ☐ Portable X-Ray Suppliers
- ☐ Rural Health Clinics
- ☐ Federally Qualified Health Center
- ☐ Skilled Nursing Facility
- ☐ Speech Pathology
- ☐ Urgent Care
- ☐ Other (explain): _____

_____

**Behavioral Health Facility**

Mental Health:

- ☐ Inpatient
- ☐ Residential
- ☐ Ambulatory Setting

Substance Abuse:

- ☐ Inpatient
- ☐ Residential
- ☐ Ambulatory Setting

**E. Scope of Services**

**List all services provided at this facility:**

- ☐ Acute Care
- ☐ Emergency Department (Level I, II, III, IV, V)
- ☐ PT, OT, Speech Therapy
- ☐ Imaging Department
- ☐ Laboratory/Pathology Department
- ☐ Skilled Nursing
- ☐ Outpatient Surgery
- ☐ Hospice
- ☐ Infusion Therapy
- ☐ Home Health
- ☐ Other _____

_____

_____

**II. CERTIFICATION AND ACCREDITATION**

**A. Certification**

1. Is this provider participating in the Medicare program? ❑ Yes ❑ No ❑ Pending

   If Yes, please provide the following:
2. Date of initial Medicare certification (MM/DD/YYYY): _____
3. Date of last full CMS survey* (MM/DD/YYYY): _____ _____

*if the provider is accredited by a national accreditation organization that has been granted deeming authority by CMS, the site survey performed by the accredited organization meets this requirement.

4. Were any deficiencies identified during the last full CMS/accreditation survey? ❑ Yes ❑ No

   **If Yes,** have all deficiencies been corrected?

   ❑ Yes (please provide evidence)

   ❑ No (please provide a complete copy of the most recent survey and any or all corrective action plans)

**B. Accreditation**

**1.** Is this provider accredited by a national accreditation organization? ❑ Yes ❑ No ❑ Pending

**If Yes**, please complete the following:

| | | | |
|---|---|---|---|
| **2.** Check One: | ❑ TJC<br>❑ URAC<br>❑ DNV/NIAHO | ❑ AAAHC<br>❑ AAAASF<br>❑ CARF<br>❑ HFAP | ❑ CHAP<br>❑ CLIA<br>❑ ACHC<br>❑ COA<br>❑ _____ |

Date of initial accreditation (MM/DD/YYYY): _____

**3.** Date of last survey (MM/DD/YYYY): _____

**4.** Name of Accreditation Organization: _____

**5.** Has the accreditation organization been granted deeming authority by CMS for this provider type?

❑ Yes ❑ No

**6.** Has this provider ever been denied accreditation by any accrediting body? ❑ Yes ❑ No

**7.** **If Yes,** please provide details below.

Details:

## III. HEALTHCARE LICENSURE, REGISTRATION, CERTIFICATES, AND ID NUMBERS

| | License # | Issue Date | Expiration Date | Licensing Agency |
|---|---|---|---|---|
| State of Oregon | | | | |
| State of Washington | | | | |
| Other: | | | | |

| | | |
|---|---|---|
| Medicare Number | Medicaid Number | NPI: |
| DEA Number (if applicable) | | Expiration Date: |

If the organizational provider does not have a Medicare Number, please submit an explanation:

## IV. LIABILITY INSURANCE

This section is to be completed with information about the provider's professional liability and/or medical malpractice insurance including, but not limited to General Liability, Excess Liability, Umbrella and/or Reinsurance policies. If there is more than one carrier, copy and complete this section for each.

**A copy of all face sheets showing current coverage amounts and expiration dates must be attached.**

### A. Current Coverage

| | | |
|---|---|---|
| Current Carrier Name: | | Policy #: |
| Carrier Address: | | Coverage Type:<br>❑ Occurrence Based ❑ Claims Based |
| City: | State: | Zip: |
| Effective Date: | | Expiration Date: |
| Aggregate: $ | | Per Incident: $ |

| **V. CREDENTIALING PROGRAM** | | |
|---|---|---|
| Contact Name: | Contact Title: | |
| Phone: ( ) | Fax: ( ) | Email: |

Is there a formal credentialing program in place for health care professionals employed or contracted at the facility?
❑ Yes ❑ No

☐ **Credentialing procedures are performed internally**

☐ **Credentialing procedures are outsourced to: _____**

**Include a description of how the facility conducts the credentialing process and clinical staff privileging program for each practitioner employed or contracted at your facility.**

## VI. RESTR**AINT AND SECLUSION**

Attach a copy of your policy & procedure related to the use of seclusion and restraint as required under the Code of Federal Regulations (CFR), 438.100

*policy must include:

- Measures to ensure patients are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

## VII. PATIENT VISITATION - HOSPITALS ONLY

Attach a copy of your policy & procedure* regarding the visitation rights of patients as required under the Code of Federal Regulations (CFR), 482.013

*policy must include:

- Identifying any clinically necessary or reasonable restriction or limitation the hospital may need to place on such rights and
- The reasons for the clinical restriction or limitation

## VIII. EXCLUSION CERTIFICATION

I hereby certify the on-line exclusion lists for the Health and Human Services, Office of Inspector General (OIG) and Systems for Awards Management (SAM) are checked for all new hires and annually for existing employees to ensure that no excluded employees work on any jobs related to any Federal health care programs. I also hereby certify that I will remove any employee found on one of the above-referenced lists from any work related to a Federal health care program.

_____ _____

Authorized Signature for Facility Date

_____ _____

Print Name Title

## IX. ATTACHMENTS

This section is a list of documents that, if applicable, should be submitted with this completed enrollment application

Place a check next to each document (as applicable or required) from the list below that is being included with this completed application:

- ❑ Copy(s) of all Federal, State, and/or local professional licenses, certifications and/or registrations specifically required to operate as a health care facility.
- ❑ Copy(s) of all Federal, State, and/or local business licenses, certifications and/or registrations specifically required to operate as a health care facility.
- ❑ Copy(s) of all Accreditation Certificates and copy of most recent survey results.
- ❑ Copy(s) of Federal Register Final Notice documenting deeming authority to any applicable accrediting organization which exempts provider from the CMS survey process.
- ❑ Copy(s) of most recent CMS survey, including corrective action plan if deficiencies were cited and evidence from CMS that all deficiencies are remedied, if no CMS exemption provision applies.
- ❑ IRS documents confirming the tax identification number and legal business name (e.g., CP 575).
- ❑ Description of credentialing and clinical staff privileging program for health care professionals.
- ❑ Copy of your policy and procedure for Restraint and Seclusion and Patient Visitation
- ❑ Copy of your policy and procedure for Patient Visitation Rights at hospitals (applicable to hospitals)

## X. SITE REVIEW (as required)

I hereby grant permission for the Health Care Organization or its designated agent to conduct on-site and/or medical record reviews as necessary. I further agree that this provider will participate in, and support the Healthcare Organization(s) Credentialing, Quality Improvement and Utilization Review Programs.

## XI. ATTESTATION QUESTIONS

Please answer the following questions **"YES**" or "**NO**". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. Please sign and date each additional sheet. ***Modification to the wording or format will invalidate the application.***

| | | |
|---|---|---|
| **1.** | Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service? | ❑ Yes ❑ No |
| **2.** | Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service? | ❑ Yes ❑ No |
| **3.** | Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR Section 1001.101 or 1001.201? | ❑ Yes ❑ No |
| **4.** | Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? | ❑ Yes ❑ No |

| XI. ATTESTATION QUESTIONS | |
|---|---|
| **5.** Has this provider, under any current or former name or business identity, ever had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority. | ❑ Yes ❑ No |
| **6.** Has this provider, under any current or former name or business identity, ever had accreditation revoked or suspended? | ❑ Yes ❑ No |
| **7.** Has this provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program? | ❑ Yes ❑ No |
| **8.** Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number? | ❑ Yes ❑ No |
| 9. Does this provider utilize seclusion and restraints?<br>If yes, do you have policies and procedures that apply to use of seclusion and restraints?<br>If yes, please submit a copy of the Policies & Procedures with this application.<br>If yes, do you have a committee that oversees proper use of seclusion and restraints? | ❑ Yes ❑ No<br>❑ Yes ❑ No<br><br>❑ Yes ❑ No |

_____ _____

Printed Name of Authorized Representative | Signature of Authorized Representative

_____ _____

Authorized Representative's Title | Date Signed

## AUTHORIZATION AND RELEASE OF INFORMATION FORM

**By submitting this application, it is agreed and understood that:**

1. As a representative of the health care provider(s)/supplier(s) listed on this application, I understand that, as a contracted facility, the burden of producing adequate information for proper evaluation of licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions indicated in this application is upon the contracted provider or its representative.

2. I further understand and acknowledge that The Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, the provider(s)/supplier(s) agree to such investigation and to the HIPDB reporting and information as required by law as a part of the verification and credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which the provider(s)/supplier(s) have been associated and all professional liability insurers with which the provider (s)/supplier(s) have had or currently have professional liability insurance, who may have information bearing on the provider(s)/supplier(s) licensure, accreditation, Medicare certification, malpractice or sanctions to consult with The Healthcare Organization(s) or designated agent.

4. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating the provider(s)/supplier(s) application, and waive all legal claims against any representative of The Healthcare Organization(s) or its respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

5. I understand and agree that the authorizations and releases given by me herein shall be valid for three years according to The Healthcare Organization(s) cycle of recredentialing provided the provider(s)/ supplier(s) is actively pursuing or holds an active contract with The Healthcare Organization(s).

6. The provider(s)/supplier(s) agree to exhaust all available procedures and remedies as outlined in the rules, regulations, and policies, and/or contractual agreements of The Healthcare Organization(s) or its respective agent(s) before initiating judicial action.

7. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

8. I further acknowledge that failure to communicate any relevant information or to release any and all required documentation and authorizations in support of this application may be considered a request to withdraw from the credentialing process and participation with The Healthcare Organization.

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as The Healthcare Organization(s) Participating Provider or cause for summary dismissal from The Healthcare Organization(s) or be subject to applicable state or federal penalties for perjury.

Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with The Healthcare Organization(s) and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this provider by The Healthcare Organization(s) .

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

*This provider complies with all federal, state, and local handicapped access requirements as well as the standards required by the Federal Americans with Disabilities Act (ADA).

**Signature: _____ Date: _____**

**Title: _____**

**Printed Name_____**

**As the authorized representative for the following provider(s)/supplier(s), I grant permission for the release of information related to licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions for the following provider(s)/supplier(s):**

| | |
|---|---|
| **(Facility Name)** | **City, State** |
| **(Facility Name)** | **City, State,** |

Print Clear Form

HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Oregon Health Authority

# Provider Disclosure Statement of Ownership and Control, Business Transactions and Criminal Convictions

## Purpose

Federal law requires fiscal agents, managed care entities (MCEs), and other Oregon Medicaid providers, including applicants and certain bidders seeking to provide Oregon Medicaid services, to disclose all of the following: business ownership and control, business transactions, and criminal convictions. See 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3.

## Instructions

For these disclosures, the Oregon Health Authority (OHA) requires fiscal agents, MCEs, and other providers to complete this form entirely.

**Submit tax identification numbers (TINs) for all individuals or entities reported using this form.** Submit a Social Security number (SSN) for all individuals, and Employer Identification number (EIN) for all entities.

**OHA requires SSNs in order to conduct the provider screenings required by 42 CFR § 455 Subpart E.** See 42 U.S.C. § 1320a-3, 42 U.S.C. § 405 (c)(1) and OHA's Privacy Policy and Disclosure Notice *(page 1 of the Information and Instructions at the end of this form)* to learn more about this requirement.

For questions about filling out this form, see the Information and Instructions (after page 5 of this form). Form will not be accepted if missing information such as TIN or DOB. Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to enroll or contract, or if the Provider already is enrolled, termination of its agreement or contract.

## Please check each box that explains the reason for disclosure:

☐ New enrollment ☐ Reactivated enrollment ☐ Revalidation

☐ Change in ownership ☐ Change in managing employees

| |
|---|
| Contact name: |
| Contact phone: |
| Contact email: |

## Section I. Disclosing entity information

| | |
|---|---|
| **Legal name of provider** *(individual, agency, facility or group)*: | |
| **Doing Business As (DBA):** | |
| **TIN** *(SSN for individual, EIN for entity)*: | **Service address:** |
| **National Provider Identifier (NPI):** | |

## Section II. Disclosure information

In this section, please report the following information:

**Owner (5% or more):**

List the name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. For individuals, include DOB and SSN; for corporations, include TIN.

**Subcontractor:**

List all subcontractors who are related to the disclosing entity owners as a spouse, parent, child or sibling, where the disclosing entity has a 5% or more interest in the subcontractor.

**Managing employee:**

List the name, address, DOB and SSN of any managing employee of the disclosing entity.

**Other interest:**

List the name of any other disclosing entity or fiscal agent or managed care entity in which the owner of the disclosing entity has an ownership or control interest; or of any other individual or entity with other interest. Other interest in the provider can be:

- The owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the entity;
- An officer or director of the entity, if the entity is organized as a corporation; or
- Partner in the entity, if the entity is organized as a partnership.

**Sanctions, exclusions or convictions:**

Indicate whether the individual or entity reported on this form has experienced any of the following:

- **Sanction or exclusion** from participation in Medicare or any state health care programs;
- **Conviction** for a criminal offense or assessed civil penalties related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs, or as described in sections 1128(a) and 1128(b) (1), (2) or (3) of the Social Security Act; **or**
- Transfer of their ownership or control interest to an immediate family member or a member of the person's household, in anticipation of or following any of these events.

***Provider NPI #:***

| **Disclosure # 1** | |
|---|---|
| **Person type.** *Who is this disclosure for? Check one:*<br>☐ Individual ☐ Corporation | |
| **Disclosure type.** *Check all that apply:*<br>☐ Owner (5% or more) ☐ Subcontractor<br>☐ Managing employee ☐ Other interest | |
| **Name** | **Address** *(If corporate, list primary business address and PO Box if applicable)* |
| **TIN** *(SSN for individual, EIN for corporation)* | |
| **Date of birth** | |

**Sanctions, exclusions or convictions (42 CFR §455.100)**

Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program? *Check all that apply.*

☐ Sanctioned ☐ Excluded ☐ Convicted

Describe the reason for the sanction, exclusion, or conviction:

Has this person transferred their ownership to a family or household member in anticipation of being sanctioned, excluded or convicted? ☐ Yes ☐ No

**Relationships**

Is this person related to anyone with ownership or control interest in the entity? ☐ Yes ☐ No

If yes, list the name of each person, followed by that person's relationship to the entity (e.g., spouse, parent, child, sibling). *Attach separate sheet if necessary*.

| **Name** | **Relationship** |
|---|---|
| | |
| | |
| | |

**Other ownership or control interest**

Does this person have ownership or control interest in any other entity? ☐ Yes ☐ No

If yes, list the names of the other entities. *Attach separate sheet if necessary.*

***Provider NPI #:***

| Additional Disclosures (make copies as needed) | |
|---|---|
| **Person type.** *Who is this disclosure for? Check one:*<br>☐ Individual ☐ Corporation | |
| **Disclosure type.** *Check all that apply:*<br>☐ Owner (5% or more) ☐ Subcontractor<br>☐ Managing employee ☐ Other interest | |
| **Name** | **Address** *(If corporate, list primary business address and PO Box if applicable)* |
| **TIN** *(SSN for individual, EIN for corporation)* | |
| **Date of birth** | |

**Sanctions, exclusions or convictions (42 CFR §455.100)**

Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program? *Check all that apply.*

☐ Sanctioned ☐ Excluded ☐ Convicted

Describe the reason for the sanction, exclusion, or conviction:

Has this person transferred their ownership to a family or household member in anticipation of being sanctioned, excluded or convicted? ☐ Yes ☐ No

**Relationships**

Is this person related to anyone with ownership or control interest in the entity? ☐ Yes ☐ No

If yes, list the name of each person, followed by that person's relationship to the entity (e.g., spouse, parent, child, sibling). *Attach separate sheet if necessary*.

| Name | Relationship |
|---|---|
| | |
| | |
| | |

**Other ownership or control interest**

Does this person have ownership or control interest in any other entity? ☐ Yes ☐ No

If yes, list the names of the other entities. *Attach separate sheet if necessary.*

***Provider NPI #:***

## Section III. Business transactions: Only complete at the request of CMS or OHA

During the last 12-month period, has this entity had business transactions totaling more than $25,000 with a subcontractor? ☐ Yes ☐ No

If yes, list the name, address and TIN for the subcontractor; and the owner(s) names and addresses. *Attach separate sheet if necessary.*

During the last five years, has this entity had significant business transactions with any wholly owned supplier or subcontractor? ☐ Yes ☐ No

If yes, list the name, address and TIN for the supplier or subcontractor; and the owner(s) names and addresses. *Attach separate sheet if necessary.*

## Section IV. Disclosing entity's attestation, signature, and date

I certify that the information on this form, and any attached statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that by knowingly providing false information on this form or in connection with any claim for payment from the State of Oregon, which may include federal funds, I may be liable for a false claim under the Oregon False Claims Act (ORS 180.750 to 180.785) and the federal False Claims Act (31 USC 3279 to 3733). I agree to inform OHA or its designee, in writing, within 30 days of any changes or if additional information becomes available.

Name of authorized representative

Title

Signature

Date

## 3974 Form Information and Instructions

Do not fax these pages to OHA. Only fax pages 1 through 5 of this form.

### Privacy Policy and Disclosure Notice

This privacy policy and disclosure notice explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security numbers (SSNs) and Dates of Birth, may be requested and used in connection with Provider enrollment and the administration of OHA medical assistance programs.

- Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the program.
- Any information may also be provided to the Oregon Secretary of State, the Oregon Department of Justice including the Medicaid Fraud Unit, or other state or local agencies as appropriate, the Internal Revenue Service, U.S. DHHS Centers for Medicare and Medicaid Services or Office of the Inspector General, or other authorized federal authority. Disclosures for other purposes must be authorized by law. For more information about access to information maintained by OHA, contact the Provider Services Unit.

The Authority limits its request for and use of taxpayer identification numbers, including SSNs and DOBs, to those purposes authorized by law and as described in this notice. The Oregon Consumer Identity Theft Protection Act permits OHA to collect and use SSNs to the extent authorized by federal or state law.

Providers must submit the provider's SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, whichever is required for tax reporting purposes on an IRS Form 1099.

Billing providers must submit the performing provider's SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, in connection with payments made to or on behalf of the performing provider.

Providing this number is mandatory to be eligible to enroll as a provider with the Authority, pursuant to 42 CFR 433.37, the federal tax laws at 26 USC 6041, and OAR 407-120-0320,410-120- 1260(9)(a)(B)(i)(V) and 410-141-0120 for purposes of the administration of tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities.

Taxpayer identification numbers for the provider, and individuals or entities other than the provider, are also subject to mandatory disclosure for purposes of the Disclosure of Ownership and Control Interest Statement, as authorized by OAR 407-120-0320(5)(A)(c), 410-120-1260, 410-120-1510(M), 410-120-1380(1)(M) and OAR 410-141-0120.

Failure to submit the requested taxpayer identification number(s) may result in a denial of enrollment as a provider and issuance of the provider number, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from OHA or for encounter purposes.

## Definitions

Definitions for the terms that are used in this form are provided here for your convenience.

### A. The source of these definitions is 42 CFR § 455.101:

**Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider.

**Disclosing entity** means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

**Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

**Group of practitioners** means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

**Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

**Managed Care Entity (MCE)** means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs[1], as defined by 42 CFR §455.101.

**Managing employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. This includes:

- An officer or director of the disclosing entity, if the entity is organized as a corporation;
- Partner in the disclosing entity, if the entity is organized as a partnership.

**Other disclosing entity** means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes

(a) any hospital, nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
(b) any Medicare intermediary or carrier; and
(c) any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

[1] The following terms are defined in 42 CFR 438.2.

- Health Insuring Organization (HIO)
- Prepaid Inpatient Health Plan (PIHP)
- Managed Care Organization (MCO)
- Primary Care Case Manager (PCCM)
- Prepaid Ambulatory Health Plan (PAHP)

**Ownership** interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

**Person with an ownership or control interest** means a person or corporation that:

(a) has an ownership interest totaling five percent or more in a disclosing entity;
(b) has an indirect ownership interest equal to five percent or more in a disclosing entity;
(c) has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity;
(d) owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity;
(e) is an officer or director of a disclosing entity that is organized as a corporation; or
(f) is a partner in a disclosing entity that is organized as a partnership.

**Significant business transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five percent of a provider's total operating expenses.

**Subcontractor means**

(a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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

**Wholly owned supplier** means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

**Relationships to excluded, penalized, or convicted persons in accordance with 42 CFR §1002.3**

The following terms are as defined in 42 CFR §1001.2:

- **Immediate family member** means 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** means, 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.

## Instructions for determination of ownership or control percentages

Instructions for determining ownership or control percentages are reproduced here for your convenience. The source of these definitions is 42 CFR § 455.102.

### A. Indirect ownership interest

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

### Person with an ownership or control interest.

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

## Instructions for disclosing entity's signature

Signature and date stamps, or the signature of anyone other than the provider/fiscal agent, applicant, bidder, or in the case of a legal entity, person legally authorized to sign on behalf of the entity are not acceptable.

Print Save Reset

HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Oregon Health Authority

# Provider Enrollment Agreement

The Oregon Health Authority (OHA) administers Oregon's medical assistance program for individuals eligible for Medicaid, the Children's Health Insurance Program (CHIP), and other federally funded medical programs, called the Oregon Health Plan (OHP). To comply with Federal law 42 CFR 455 Subpart E, OHA is required to enroll eligible providers into the Oregon Medicaid Program, pursuant to Oregon Administrative Rule 943-120 and 410-120, as a condition of delivering health services to OHP members.

All providers including non-payable (non-billing), payable (billing), individuals and organizations must fill out and sign this Agreement and all other required documents to receive an OHP provider number from OHA. An OHP provider number must be issued before a claim or encounter for delivered health services or goods is sent to OHA for payment.

The type of providers enrolled by OHA are defined in OAR 410-120-1260 and include billing agents, managed care entities (MCEs) and other providers who order, refer or prescribe services or goods.

| Provider name | Date |
|---|---|
| Provider service location for this Agreement | National Provider Identifier (NPI) |

## Scope of Agreement

This Provider Enrollment Agreement sets forth the rights, responsibilities, terms and conditions governing provider participation in the Oregon Medicaid program. Per OAR 410-120-1260(17), the provision of health care services or items to OHP clients is a voluntary action on the part of the provider. Providers are not required to serve all Division clients seeking service.

**To be eligible for enrollment, a provider must:**

A. Complete and submit an Enrollment Application
B. Agree to and sign this Provider Enrollment Agreement (Agreement)
C. Complete, sign and submit a Medicaid Provider Disclosure Statement (organizations and billing providers only)

D. Be an eligible provider and meet the conditions in (OAR) 410-120-1260 and any rules directly related to the provider's service category and OHA program in effect on the date of enrollment, and,
E. Meet all the applicable state and/or federal licensure or certification requirements to assure OHA provider meets minimum qualifications to perform services under this Agreement. This includes maintaining a professional license or certification in good standing and compliance with all program rules and rules related to providers service category.
F. Pass all mandatory screening and validation steps.
G. This Agreement becomes effective the date approved by OHA for date requested on initial application.
H. For revalidation and any other circumstances, this Agreement becomes effective the date signed by Provider.
I. Failure to comply with the terms of this Agreement or any applicable CFR or OAR may result in termination, sanction(s) or payment recovery, subject to Provider appeal rights, pursuant to OHA rules.

## Governance

Oregon's Medicaid program is authorized and governed by:

- Title XIX of the Social Security Act
- Title XXI of the Social Security Act
- Chapter IV and V of Title 42 of the Code of Federal Regulations (CFR);
- Oregon Revised Statue (ORS) 414;

This Agreement is governed by federal law pertaining to the Medicaid program and the laws of Oregon that include: OAR Chapters 410, 943 and any OAR applicable to provider's service category, e.g. Mental Health.

OHA's administrative rules are posted and available at all times on OHA's website and Oregon's Secretary of State (SOS) website. Federal regulations are posted and available at all times on Electronic Code of Federal Regulations (eCFR) and Federal Register websites. It is the provider's responsibility to become familiar with and abide by these rules.

## Assurances

As an OHP provider, hereafter known as "Provider," and as a condition of payment for goods or services under this Agreement, you agree to:

**Comply with applicable laws**

A. Comply fully with all federal, state and local laws, rules, regulations, and statements of OHA policy applicable to the care, services, equipment or supplies including but not limited to OAR 410-120-1380, and this Agreement. Failure to comply with the terms of this Agreement or OHA

rules may result in sanction(s) and/or payment recovery, which may also result in termination pursuant to federal regulation, OHA rule, and any contract(s) between the Provider and OHA.

B. Provider shall at all times be qualified, professionally competent and actively licensed where required by law to perform work under this Agreement.

## Disclosure

**Provider understands and agrees that:**

A. The information in the enrollment form(s) and all supporting documentation is true, accurate and complete. Information disclosed by a Provider is subject to verification. OHA will use this information for administration of the Oregon Medicaid program.

B. Loss, suspension or restriction of licensure, or certification, may result in immediate disenrollment.

C. Any deliberate omission, misrepresentation or falsification of information in enrollment form(s) or in any communication supplying information to OHA may be prosecuted under state or federal law.

D. All providers that request to enroll or are already enrolled are subject to additional screening by OHA at any time. Additional screening includes, but is not limited to, pre and post enrollment site visits and fingerprint and criminal background check.

E. Provider is not excluded or otherwise prohibited from participating in Medicare or any state Medicaid or CHIP programs. Provider has not been convicted of a criminal offense related to Medicare, Medicaid, CHIP or any federal agency or program.

F. Provider is not listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal procurement or Non-procurement Programs" currently found at https://www.sam.gov/portal/public/SAM/. Provider will not use public funds to support, in whole or in part, the employment of individuals in any capacity having contact with Medicaid eligible individuals who have been convicted of a crime as identified under ORS 443.004(3), are on the Office of Inspector General (OIG) list of excluded individuals or entities, on the System Award Management (SAM) exclusion list, or the Data Exchange (DEX).

## Services

**Provider understands and agrees that:**

A. The Provider agrees that all health care, services, equipment or supplies billed to Medicaid must be medically necessary, a covered service as defined in OAR Chapter 410, and provided in accordance with all applicable provisions of statutes, rules and federal regulations governing the reimbursement of services or items under OHP in effect on the date of service. Rules for OHP services are listed in OAR 410-120-1160 and defined in OAR Chapter 410 and Chapter 309. Provider further agrees to:

   a. Provide services within the parameters permitted by the Provider's license or certification and agrees to bill only for the services performed within the specialty or specialties designated in the Provider application on file OAR 410-120-1260. The

services of goods must have been actually provided to the OHP member by the Provider prior to submitting a claim or encounter to OHA.

b. Provide all services under this Agreement as an independent contractor. Provider is not an "officer," "employee" or "agent" of OHA, as the term is used in ORS 30.265.

B. Provider is responsible for verification of client OHP eligibility and benefit coverage and following applicable prior authorization requirements before rendering services as required in OHA Rules and described in OAR 410-120-1140.

## Recordkeeping and access to records

**Provider understands and agrees to:**

A. Keep such records as are necessary to fully disclose the specific care, services, equipment or supplies provided to OHP members for which reimbursement is claimed, at the time it is provided, in compliance with the applicable OHA rules and federal regulations in effect on the date of service. Provider is responsible for the completeness, accuracy and secure storage of financial and clinical records and all other documentation of the specific care, services, equipment or supplies for which the provider has requested payment as required by OAR 410-120-1360 and any program specific rules in OAR Chapter 410 and Chapter 309.

B. Provide upon request by either OHA, the Program Integrity Audit Unit (PIAU), the Office of Payment Accuracy and Recovery (OPAR), the Oregon Secretary of State's Office, Federal Government, and the Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU), or any duly authorized representatives, immediate access to review and make copies of any and all records relied on by Provider in support of care, services, equipment or supplies billed to the Oregon medical assistance program. The term "immediate access" means access to records at the time the written request is presented to the Provider.

## Communication

**Provider understands and agrees that:**

Any communication or notices from the Provider shall be given in writing via personal delivery, fax, email or regular mail, postage prepaid to OHA. Provider must notify OHA of any changes to Provider’s information such as, address, name, licensure, within 30 days of the date of the change.

Provider enrollment forms should be faxed with an EDMS Coversheet to 503-378-3074.

Email communications should be sent to Provider.Enrollment@dhsoha.state.or.us.

General information regarding Provider’s enrollment record should be faxed to 503-947-1177.

## Confidentiality

**Provider understands and agrees to:**

Comply with the Health Insurance Portability and Accountability Act (HIPAA) §262 and 264 of Public Law 104-191, 42 USC §1320d, and federal regulations at 45 CFR Parts 160 and 164, and as amended. The Provider specifically acknowledges their obligation to comply with 45 CFR Section 164.506, regarding use and disclosure of information to carry out treatment, payment or health care operations. Provider agrees to comply with requirements for identifying, addressing and reporting an incident or breach, regardless of whether the incident or breach was accidental or otherwise.

## Security

**Provider understands and agrees that:**

The Provider represents and warrants that the Provider will establish and maintain privacy and security standards and practices that respect and safeguard the privacy and security of all information related to OHA and the agency's employees, equipment, providers, systems and service recipients, regardless of media. Provider shall ensure the proper handling, storage and disposal of all information accessed, created, obtained, reproduced, or stored by the Provider and its authorized users using privacy and security standards that meet or exceed standards set by laws, rules, and regulations in (HIPAA) §262 and 264 of Public Law 104-191, 42 USC §1320d, OAR Ch 943, the Oregon Consumer Identity Theft Protection Act, ORS 646A.600 through 646A.628, and Oregon's Statewide Information Security Standards, applicable to the information exchanged by the Provider and OHA or received by the Provider as a servicer of this Agreement. Provider shall ensure proper disposal of equipment and information assets when authorized use ends, consistent with Provider's record retention obligations and obligations regarding information assets under this Agreement.

## Accurate billing

**Provider understands and agrees that:**

A. All claims or encounters submitted to OHA must be certified by signature of the Provider or designee, including electronic signatures on a claim form or transmittal document, that the care, service, equipment or supplies claimed were actually provided, medically appropriate, documented at the time they were provided, documented using required diagnosis (ICD-10-CM) and procedure codes (HIPAA), and were provided in accordance with professionally recognized standards of health care, OAR 410-120-1280 through 1340 and this Agreement.
B. The Provider or its contracted agency, including billing providers, shall not submit or cause to be submitted:
    a. Any false claim for payment;
    b. Any claim altered in such a way as to result in a payment for service that has already been paid;
    c. Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed with the exceptions described in OAR

410-120-1280. If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to OHA. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate TPL Explanation Code; or

d. Any claim for furnishing specific care, items, or services that has not been provided.

C. The Provider is responsible for the accuracy of claims submitted, and the use of a billing entity does not change the Provider's responsibility for the claims or encounters submitted on Provider's behalf. OHA may recover any overpayment(s) that OHA made to Provider, by withholding future payment(s) or other processes as authorized by law or Agreement. If Provider fails to correct billing practices after written notice by OHA of non-compliance with state rules will be liable for up to triple the amount of identified overpayment(s).

## Payment

**Provider understands and agrees that:**

A. Provider will accept OHA's payment as complete remuneration the amount paid in accordance with the reimbursement rate for services covered under OHP, except where payment by the client is authorized in the OARs. Payment will only be made to the enrolled provider who actually performs the service or to the Provider's enrolled billing provider for covered services rendered to eligible clients, OAR 410-120-1340.

B. OHA has sufficient funds currently available and authorized to make payments under this Agreement within OHA's biennial budget. Provider further understands and agrees that payment for services performed after the current biennium is contingent on OHA receiving from the Oregon Legislature appropriations or other expenditure authority sufficient to allow OHA, in its reasonable administrative discretion, to continue to make payments.

C. Provider must not bill OHP members for any services unless authorized by Oregon Administrative Rule.

D. Any overpayment made to Provider by OHA may be recouped by OHA as authorized by law including, but not limited to withholding of future payment to Provider. Provider's failure to perform the work specific in the Agreement or to meet the performance standards established in this Agreement, may result in consequences that include, but are not limited to reducing or withholding payment; requiring Provider to perform at Provider's expense additional work necessary to meet performance standards; and pursuing any available remedies for default including termination of this Agreement.

E. Provider is not an officer, employee or agent of OHA and shall not be deemed for any purpose an employee of the State of Oregon. The Provider shall perform all work as an independent contractor, as defined in ORS 670.600, and is responsible for determining the appropriate means and manner of performance. Provider is responsible for all federal and state taxes applicable to compensation paid to Provider under this Agreement and, unless Provider is subject to backup withholdings, OHA may withhold from such compensation any amounts to cover Provider's federal or state tax obligations. Provider has no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State

of Oregon or federal agency would prohibit Provider's work under this Agreement. Provider certifies it is not currently employed by the federal government.

F. OHA and Provider are the only parties to this Agreement and are the only parties entitled to enforce its terms. The parties agree that Provider's performance under this Agreement is solely for the benefit of OHA to accomplish its statutory mission. Nothing in this Agreement gives or shall be construed to give or provide any benefit or right, whether directly or indirectly to third persons that are any greater than the rights and benefits enjoyed by the general public.

G. As a condition of payment, Provider must meet and maintain compliance with the Provider enrollment and payment rules OAR chapter 410, division 120; 42 CFR 455.400 through 455.470, as applicable; and 42 CFR 455.100 through 455.106.

## Discrimination

**Provider understands and agrees to:**

A. Comply with Titles VI and VII of the 1964 Civil Rights Act and Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act.

B. Not discriminate against minorities, women or emerging small business enterprises certified under ORS 200.055 in obtaining any required subcontracts.

C. Provide services to Medicaid-eligible individuals without regard to race, religion, national origin, sex, age, marital status, sexual orientation or disability (as defined under the Americans with Disabilities Act). Medicaid services must reasonably accommodate the cultural, language and other special needs of the member.

## Compliance with applicable laws

**Provider understands and agrees that:**

A. Provider shall comply and require all subcontractors to comply with federal, state and local laws and regulations, executive orders and ordinances applicable to items and services under this Agreement, including but not limited to OAR 407-120-0325, as they are amended from time to time. Without limiting the generality of the prior sentence, the Provider expressly agrees to comply and require all subcontractors to comply with all of the laws, regulations and executive orders listed under OAR 410-120-1380 to the extent they are applicable to the items and services provided under this Agreement.

B. Provider agrees that if any term or provision of this Agreement is declared by a court to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected and the right and obligations of the parties shall be construed and enforced as if the Agreement did not contain the particular term or provision held to be invalid.

## Duration and termination of Agreement

**Provider understands and agrees that:**

A. This Agreement shall remain in effect for no more than five years from the effective date. OHA may terminate this Agreement at any time by written notice to the Provider by certified mail, return receipt requested, subject to any specific provider sanction requirements in OHA rules or Agreement(s) between OHA and the Provider.

B. OHA will terminate or suspend this Agreement if:
   a. The Provider or a person with 5 percent or greater direct or indirect ownership interest in the Provider, its agent or managing employee fails to submit timely, complete and accurate information, or cooperate with any screening requirements, unless OHA determines it is not in the best interests of the Medicaid program;
   b. Any person with a 5 percent or greater direct or indirect ownership interest in the Provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid or title XXI program in the last 10 years, unless OHA determines it is not in the best interests of the Medicaid program;
   c. The Provider is terminated under title XVIII of the Social Security Act or under the Medicaid program or Children's Health Insurance Plan (CHIP) program of any state;
   d. The Provider or any person with a 5 percent or greater, direct or indirect, ownership interest in the Provider fails to submit sets of fingerprints in a form and manner to be determined by OHA within 30 days of a Centers for Medicare and Medicaid Services (CMS) or a OHA request, unless OHA determines it is not in the best interests of the Medicaid program;
   e. The Provider fails to permit access to Provider locations for any site visits under 42 CFR 455.432, unless OHA determines it is not in the best interests of the Medicaid program;
   f. CMS or OHA determines that the Provider has falsified any information provided on the application or if CMS or OHA cannot verify the identity of the Provider applicant.
   g. OHA fails to receive funding, appropriations, limitations or other expenditure authority at levels that OHA or the specific program determines to be sufficient to pay for the services or items covered under this Agreement;
   h. Federal or state laws, regulations or guidelines are modified, or interpreted by OHA in a manner that either providing the services or items under the Agreement is prohibited or OHA is prohibited from paying for such services or items from the planned funding source;
   i. OHA issues a final order revoking this Agreement based on a sanction under termination terms and conditions established in program-specific rules or policies, if required;
   j. The Provider no longer holds a required license, certificate or other authority to qualify as a Provider. The termination will be effective on the date the license, certificate or other authority is no longer valid;
   k. The Provider fails to meet one or more of the requirements governing participation as a OHA enrolled Provider. In addition to termination or suspension of the

Agreement the Provider number may be immediately suspended in accordance with OAR 407-120-0360;

I. Provider commits any material breach or default of any covenant, warranty, or obligation under this Agreement, fails to perform the work under this Agreement or fails to pursue the work as to endanger Provider's performance under this Agreement in accordance with its terms;

C. Provider may terminate this Agreement at any time, subject to specific Provider termination requirements in OHA rules, OHA program-specific rules or federal regulations by submitting a written notice, in person, or by certified mail listing a specific termination effective date. The request must be in writing and signed by the provider. The notice shall specify the OHA-assigned provider number to be terminated and the effective date of termination. Termination of this Agreement does not relieve the Provider of any obligations for covered services or items provided for the dates of services during which the Agreement was in effect.

## Insurance requirements

**Required insurance:** During the term of this Agreement, Provider shall possess any and all insurance required within the program rules based on Provider type and any business requirements set forth by the Department of Consumer and Business Services at Providers cost and expense. The insurance may include, but is not limited to, general liability, professional liability, malpractice, workers compensation, employer's liability, excess/umbrella insurance, tail coverage, etc. Provider must retain any and all certificate(s) and proof of insurance, notice of change or cancellation, insurance reviews, state acceptance or other actions on the providers insurance.

Upon request, Provider will provide to OHA not more than thirty (30) days of any change, reduction, suspension, cancellation or termination of Provider's insurance coverage required by this section.

OHA may exempt Provider from these requirements for any reason, including but not limited to the inability of Provider to procure such insurance.

## Indemnification

Provider shall defend (subject to ORS Chapter 180), save, hold harmless, and indemnify the State of Oregon and OHA and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever, including attorney fees, resulting from, arising out of, or relating to the activities or omissions of Provider or its officers, employees, subcontractors, or agents under this agreement.

**Provider**: I have read the foregoing Agreement, understand it and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and conditions of this Agreement constitute grounds for termination of this Agreement and may be grounds for other sanctions as provided by statute, administrative rule, or this Agreement.

## Provider or authorized signature

I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Oregon Medicaid Program and/or prosecution for Medicaid fraud. I certify that I have read and understand the federal and state laws rules and regulations as cited in this Agreement. I agree to abide by the Oregon Medicaid Program terms and conditions listed in this document and aforementioned regulations.

| Print name of Provider or authorized official | Title of authorized official *(if applicable)* |
|---|---|
| Signature of Provider or authorized official | Date |

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

# Request for Taxpayer Identification Number and Certification

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

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

Name (as shown on your income tax return)

Business name, if different from above

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

☐ Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

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

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

**Social security number**

**or**

**Employer identification number**

## 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).

**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,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (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 not subject to backup withholding, give the requester the appropriate completed Form W-8.

**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, 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 the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

## 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

## Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

**Other entities.** Enter your business name as shown on required federal tax documents on the "Name" line. 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 the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

## Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

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 possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

| IF the payment is for . . . | THEN the payment is exempt for . . . |
|---|---|
| Interest and dividend payments | All exempt payees except for 9 |
| Broker transactions | Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker |
| Barter exchange transactions and patronage dividends | Exempt payees 1 through 5 |
| Payments over $600 required to be reported and direct sales over $5,000[1] | Generally, exempt payees 1 through 7[2] |

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

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

## 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 page 2), 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 Social Security Administration 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 *www.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, 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 domestic 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, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

**Signature requirements.** Complete the certification as indicated in 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 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] |
| **For this type of account:** | **Give name and EIN of:** |
| 6. Disregarded entity not owned by an individual | The owner |
| 7. A valid trust, estate, or pension trust | Legal entity [4] |
| 8. Corporate or LLC electing corporate status on Form 8832 | The corporation |
| 9. Association, club, religious, charitable, educational, or other tax-exempt organization | The organization |
| 10. Partnership or multi-member LLC | The partnership |
| 11. A broker or registered nominee | The broker or nominee |
| 12. 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 |

[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 second 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 1.

**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, social security number (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.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

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 personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.consumer.gov/idtheft* or 1-877-IDTHEFT(438-4338).

Visit the IRS website at *www.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 who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax 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. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.