

Ohio Department of Job and Family Services
OHIO HOME CHOICE DEMONSTRATION PROGRAM
PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT

Submit completed signed application/agreement with required attachments to

Ohio HOME Choice Demonstration Program
 Provider Application Processing
 P.O. Box 182709
 Columbus, Ohio 43218-2709

<i>(For State Use Only)</i>

Provider Types (Check ALL that apply)

Agency Providers	Non-Agency Providers
<input type="checkbox"/> HOME Choice Agency Nursing (HCA 100) <input type="checkbox"/> HOME Choice Agency Independent Living Skills Training (HCA 200) <input type="checkbox"/> HOME Choice Agency Community Support Coach (HCA 300) <input type="checkbox"/> HOME Choice Agency Social Work/Counseling Services (HCA400) <input type="checkbox"/> HOME Choice Agency Nutritional Consultation Services (HCA 500) <input type="checkbox"/> HOME Choice Agency Communication Aids (HCA 600) <input type="checkbox"/> HOME Choice Agency Service Animals (HCA 700)	<input type="checkbox"/> HOME Choice Non-Agency RN Nursing (HCNA 101) <input type="checkbox"/> HOME Choice Non-Agency LPN Nursing (HCNA 102) <input type="checkbox"/> HOME Choice Non-Agency Community Support Coach (HCNA 301) <input type="checkbox"/> HOME Choice Non-Agency Social Work/Counseling Services (HCNA 401) <input type="checkbox"/> HOME Choice Non-Agency Nutritional Consultation Services (HCNA 501)

Provider Identification (Please print or type entries)

Individual Name (First, Middle Initial, and Last) or Agency Name			
Social Security or EIN Number *		Current or previous Medicaid Number(s) (if applicable)	
Current NPI Number**		License Number ***	License Expiration Date (mm/dd/yyyy)

*You must attach a completed and signed W-9 form. Do not use GROUP tax ID number.
 **You must attach a copy of the notice from the NPI Enumerator to verify the NPI Number.
 ***You must attach a copy of your current state board license.

Service Location of Practice/Business (Please print or type entries)

(Please complete an application for each physical location of practice or business. Non-agency providers can use home address if applicable)

Name/ Building Name/ or Department/ or In care of			
Physical Address (Number, Street, Avenue or Route) (P.O. and Drop Boxes are not acceptable)			Suite Number
City	County	State	Zip Code (Zip +4, if possible)
Telephone Number	Cell Phone Number	Email Address	

"Pay to" Address (Name & Address to which all other material is to be mailed)

Leave blank if address is the same as "Service Location of Practice/Business"

Name		
Address		Suite Number
City	State	Zip Code (Zip +4, if possible)

Mailing/Correspondence Address (Name & Address to which all other material is to be mailed)

Leave blank if address is the same as "Service Location of Practice/Business"

Name		
Address		Suite Number
City	County	State
		Zip Code (Zip +4, if possible)

Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided. List any additional names and addresses on the proper section of the sheet provided.

1. Have you or any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, agency, or professional association been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX? YES NO

Name (Who was it?)	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN
Name (Who was it?)	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN

2. Have you or any directors, officers, agents or managing employees of the institution, agency, organization, or professional association ever been indicted or convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, XX? YES NO

Name (Who was it?)	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN
Name (Who was it?)	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN

3. List names, addresses, AND SSNs for individuals, and the names, address, and Employer Identification Number (EIN) for organizations having direct or indirect ownership or a controlling interest in the entity or practice. Place an "X" in the box labeled "Related" for all listed individuals who are related to each other.

Name	Related	Address	SSN/EIN
	<input type="checkbox"/>		
Name	Related	Address	SSN/EIN
	<input type="checkbox"/>		
Name	Related	Address	SSN/EIN
	<input type="checkbox"/>		
Name	Related	Address	SSN/EIN
	<input type="checkbox"/>		

4. Type of Entity or Practice

- Sole Proprietorship (Non-agency provider) Partnership Corporation Unincorporated Association
 Professional Corporation/Association Non-profit Other (specify)

5. If the disclosing entity is a corporation, list names, addresses, and SSNs of the Directors and the name, address, and EIN of the parent corporation, if applicable.

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

(For State Use Only)

Disclosure and Ownership/Control Interest Statement (Continued)

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided. List any additional names and addresses on the proper section of the sheet provided.

6. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership, or Members of the Board of Directors.) If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number. YES NO

Name	Address	Provider (Title XIX Vendor) Number

7. Has there been a change in ownership or control within the last year? If yes, when? (mm/dd/yyyy) YES NO
If "YES", when? (mm/dd/yyyy) **IF YES, ATTACH EXPLANATION**

8. Do you anticipate any change in ownership or control within the year? If yes, when? (mm/dd/yyyy) YES NO
If "YES", when? (mm/dd/yyyy) **IF YES, ATTACH EXPLANATION**

9. Is this entity operated by a management company, or leased in whole or part by another organization? YES NO
If "YES", give date of change of operations. (mm/dd/yyyy) **IF YES, ATTACH EXPLANATION**

10. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? YES NO

11. Is this entity affiliated with a chain? (If yes, list name, address of Corporation, and EIN number.) YES NO

Name	Address	Employer Identification Number (EIN)

12. Have you or the entity ever been sanctioned by the Medicare or Medicaid Program? YES NO
If "YES", when? (mm/dd/yyyy) How long? (mm/dd/yyyy) **IF YES, ATTACH EXPLANATION**

Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN

13. Have you or any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, or Organization ever been indicted or convicted of a violation of State or Federal Law? YES NO

Name	Type of Offense and Disposition	When, give date? (mm/dd/yyyy)	SSN/EIN

(For State Use Only)

All providers must read the statements below, print name, initial, and date.

In accordance with Executive order 2007-01S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) has reviewed and understands the Ohio Ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.

Name and Title (please print)

Initial

Date

A copy of Executive Order 2007-01S can be found on our website at: <http://jfs.ohio.gov/ohp/>

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

Name and Title (please print)

Initial

Date

Ohio HOME Choice Demonstration Program Provider Agreement
[For providers of HOME Choice Demonstration Program (Money Follows the Person) Services]

This provider agreement is a contract between the Ohio Department of Job and Family Services (the Department) and the undersigned provider of HOME Choice Demonstration Program services (the Provider) in which the Provider agrees to comply with the terms of this is provider agreement, state statutes, Ohio Administrative Code rules, and agrees and certifies to:

1. Render HOME Choice Demonstration Program services in accordance with Chapter 5101:3-51 of the Administrative Code and as authorized in the HOME Choice Demonstration Program participant's (the Participant) all service plan, service plan, individual service plan or non-waiver HOME Choice service plan as appropriate, and only in the amount required by the Participant without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department in accordance with rule 5101:3-51-06 of the Administrative Code.
2. Follow all ODJFS-approved reimbursement policies and procedures established for the HOME Choice Demonstration Program, including timely submission of claims.
3. Accept the allowable reimbursement for all HOME Choice Demonstration Program services as payment-in-full and not seek reimbursement for the services from the Participant, authorized representative, any member of the family, or any other person. Follow all ODJFS-approved reimbursement policies and procedures established for the HOME Choice Fiscal Management Services (FMS), including timely submission of claims.
4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The Provider shall maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.
5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Health Care Fraud Section of the Ohio Attorney General, or their designees, any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of HOME Choice Demonstration Program payments and may result in termination from the HOME Choice Demonstration Program.
6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; additions; deletions, physical, mail-to, pay-to or email address; and phone number.
7. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-51-03 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX Services. The provider shall also comply with the criminal record check requirements set forth in Rule 5101:3-51-03 of the Administrative Code.
8. Neither the non-agency provider, nor the organization, nor any owner, director, officer, employer of the organization, or any non-agency provider retained by the organization or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title XX beneficiaries.
9. Follow the regulations and policies set forth in Chapter 5101:3-51 of the Administrative Code.
10. Provide to the Department, through the court of jurisdiction, notice of any action brought by the Provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to the Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street – 31st Floor, Columbus, Ohio 43215.
11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of HOME health care and personal care services, hospices, HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d), and Chapter 5101:3-51 of the Administrative Code.

This agreement may be canceled by either party upon written notice to the other party no less than 30 days prior to the termination date.

I further certify that I am the non-agency provider who is applying for approval to provide HOME Choice Demonstration Program Services, or in the case of an organization, I am the officer, chief executive officer, or general partner of the organization that is applying for this HOME Choice Demonstration Program provider agreement. I further agree to be bound by this agreement, and certify that the information I have given on this application is true and accurate.

The HOME Choice Demonstration Program is not a Medicaid program. This agreement does not permit the Provider to furnish medical assistance services through the Ohio Medicaid Program.

This agreement is limited to the duration of the HOME Choice Demonstration Program, and will thereby end on September 30, 2012.

Name and Title <i>(Please Print)</i>	
Signature	Date

Ohio Department of Job and Family Services
OHIO HOME CHOICE DEMONSTRATION PROGRAM
PROVIDER ENROLLMENT APPLICATION ADDENDUM
Non-Agency Nutritional Consultation Services (HCNA 501)

Provider Type: Nutritional Consultation Services (Non-agency)

Name	
Phone Number	Medicaid Number

Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Home Choice Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with the Provider agreement.

- My signature below serves as verification that I meet the provider qualifications/specifications and the enrollment requirements as a HOME Choice demonstration program as set forth in Ohio Administrative Code (OAC) 5101:3-51-04 and 5101:3-51-05; **(*Please attach proof of certification by ODMR/DD or ODA)**

- I attest that I will comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-51-03;

- I attest that I am a Registered Dietitian with the Commission on Dietetic Registration and licensed by the Ohio Board of Dietetics; **(* Please attach a copy of your license.)**

- I attest I have successfully completed criminal records check within the last 30-days as set forth in OAC 5101:3-51-03 (A) (1) (b); **(*Non-agency providers must have results of the criminal background check sent directly to the Bureau of Community Services Policy.)**

- I attest that I have received and read all rules of the Administrative Code governing the HOME Choice demonstration program and the ODJFS-administered waiver (OAC 5101:3-46-04, 5101:3-47-04 or 5101:3-50-04) on which the participant is enrolled;

- I attest that I am the individual applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on the application and this addendum is true and accurate. **(*Please attach copy of your Social Security card and a copy of a valid driver's license or other government-issue photo ID.)**

Signature	Date
-----------	------

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: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	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

¹See Form 1099-MISC, Miscellaneous Income, and its instructions.
²However, 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.

*** I M P O R T A N T ***

YOU MUST READ THESE INSTRUCTIONS

Failure to comply with the requirements outlined below may result in additional expense & may impact your eligibility to provide services.

Due to changes in the Ohio laws pertaining to criminal background checks for independent providers, ODJFS can not accept background checks directly from providers, WebCheck vendors, or any entity other than the Ohio Bureau of Criminal Identification & Investigation (BCI). (Ohio Administrative Code 5101:3-45-08)

- You must have your Ohio BCI background check completed at a location that uses the electronic WebCheck fingerprinting system. Ink cards and background checks completed by other authorities are **not** acceptable. The results must be sent **directly** to ODJFS from BCI.
- **DO NOT DELAY.** Due to the increased volume of background checks processed by BCI, it now takes much longer for a background check to be processed than in prior years. In some cases, it can take 30 – 60 days or longer for us to receive the results of your background check. We must receive your background check by the due date for you to be compliant. **Get it done ASAP.**

The results of your background check must be mailed **DIRECTLY** to the Bureau of Community Services Policy from BCI to the following address:

**Ohio Department of Job and Family Services
Bureau of Community Services Policy/ Home Choice
Attn: BCI Coordinator
P.O. Box 182709 5th Floor
Columbus, OH 43218-2709**

Take this paper with you to the WebCheck location to make certain you provide them with our correct address and inform them that the results of your background check must be sent directly to ODJFS from BCI; we cannot accept results from the WebCheck vendor.*

We will **REJECT** any background check that is faxed or mailed directly from a provider, a WebCheck vendor, or any entity other than BCI.

*If the WebCheck vendor refuses to enter that the results are to be forwarded to a "P.O. Box," contact the Bureau of Community Services Policy at (614) 466-6742 to receive a physical mailing address.

Criminal Background Check Instructions IMPORTANT INFORMATION ~ PLEASE READ

In accordance with Ohio Administrative Code (OAC) 5101:3-45-08, all independent Medicaid providers must complete an a criminal background check. Failure to complete the annual criminal background check in accordance with the OAC can lead to termination of your provider number.

This is important—do not delay.

The results of your background check **must be sent directly** to the Ohio Department of Job and Family Services (ODJFS) by the Bureau of Criminal Identification and Investigation (BCI) to the address below. **We must receive the results from BCI. You are not compliant with the requirement until we receive your results directly from BCI.**

ANY BACKGROUND CHECK NOT RECEIVED FROM BCI WILL BE REJECTED. We will NOT accept background checks mailed or faxed from providers, WebCheck vendors, or any entity other than BCI.

You must provide the mailing address below to the WebCheck location when you have your background check performed. BCI must send your background check results directly to us at:

**Ohio Department of Job and Family Services
Bureau of Community Services Policy/ Home Choice
Attn: BCI Coordinator
P.O. Box 182709 5th Floor
Columbus, OH 43218-2709**

- **Background checks completed prior 30 days from the date of the Home Choice application are not acceptable.**
- **DO NOT DELAY.** Due to an increase in the number of background checks processed by BCI, it now takes **much longer** for a background check to be processed than in prior years (can take 30+ days or longer).
- You must have your Ohio BCI background check completed at a location that uses the electronic WebCheck fingerprinting system. Ink cards and background checks completed by other authorities are **not acceptable**.
- You may obtain a listing of Ohio WebCheck locations on the Ohio Attorney General's website and selecting the WebCheck link @: <http://www.ag.state.oh.us/> or by contacting BCI at **(877) 224-0043 or (740) 845-2000.**

- If you had a background check processed by BCI less than twelve months ago, you may **contact BCI at (877) 224-0043** to request an updated background check. There is an \$8 fee charged for this request. Be advised, this type of request can take at least 30 days or more to process.
- **Do not send this request to ODJFS. It will be returned to you.**
- No confirmation will be sent to you once you comply with this requirement. You may contact ODJFS at **(614) 466-6742** to confirm receipt of your background check.
- We cannot provide copies of background checks. Contact BCI if you need a copy.
- You are responsible for all fees related to the criminal background check process.
- Failure to submit your background check by the deadline will result in action to deny your provider agreement for HOME Choice.
- **FBI Requirement:** If you have not lived in Ohio for at least the last five years, currently live outside the state of Ohio, or are a multi-state offender, you are required to submit an FBI criminal background check in addition to the Ohio BCI background check.
- Failure to comply with the requirements may result in additional expense & may impact your eligibility to provide services.
- There are **no** exceptions to this requirement.
- **No** extensions will be granted.
- **If you have any questions about this process or if you do not understand the requirements, you are encouraged to contact the Bureau of Community Services Policy at (614) 466-6742 before taking action.**

STOP ...Did you complete all necessary steps? You need to answer “Yes” to each of these questions to have a complete application.

Provider Checklist for Non-Agency Nutritional Consultation Applications for Home Choice

Did you include a copy of your license to practice as a dietician?

Did you include proof of your certification by ODMR/DD or ODA?

Did you include a copy of your W-9?

Did you provide a copy of your NPI Enumerator notice, if you have a NPI number?

Did you include a copy of your Provider Enrollment Application?

Did you include a copy of the provider addendum?

Did you read and sign all necessary forms and boxes?

Did you include your include a copy of your valid Driver’s license or other government issued photo ID?

Did you include a copy of your Social Security card?

Did you do a background check as instructed?

Did you send all of the above items in an envelope to:

Ohio HOME Choice Demonstration Program
Provider Application Processing
P.O. Box 182709
Columbus, Ohio 43218-2709

For questions, please contact: Provider Enrollment-Home Choice at (614) 466-6742.
Please know that incomplete applications will be returned to the applicant. Thank you!