

APPLICATION PROCESS FOR IN-HOME SERVICES

1. Providers must comply with all applicable licensing standards required to deliver requisite services and include **current license** with packet.
 2. The provider will submit to SWIRCA three copies of the provider application packet and **Certificates of Insurance** verifying:
 - General aggregate liability insurance in the amount of at least \$500,000.
 - SWIRCA must be named as additional insured for General Liability on the insurance Certificate.
 - Workers' compensation with SWIRCA as a Certificate Holder.
 3. Providers should be aware that the establishment of a contractual agreement provides no guarantee of referrals for service to the agency.
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For Providers to be approved by the Indiana Medicaid Waiver Unit as **Medicaid Waiver Providers** for applicable services they can access a copy of the Medicaid Waiver application packet, by contacting Linda Wolcott, Indiana Division of Aging, at (317) 234-0373.

SOUTHWESTERN INDIANA REGIONAL COUNCIL ON AGING

SERVICE PROVIDER APPLICATION

I. INTRODUCTION

The Southwestern Indiana Regional Council on Aging (SWIRCA) welcomes your interest in becoming enrolled as a SWIRCA provider of services for the elderly and disabled. SWIRCA is a not-for-profit, private corporation incorporated in 1973 and designated in 1974 by the State of Indiana as the Area Agency on Aging for the six southwestern Indiana counties known as Area 16. These six counties include Gibson, Perry, Posey, Spencer, Vanderburgh, and Warrick.

It has been SWIRCA's mission to serve families by providing a network of services for the elderly and disabled that encourage independence and self determination; prevent inappropriate institutionalization; promote physical fitness and good health; and promote dignity and positive self esteem. These services are non-sectarian in nature and are provided without regard to race, religion, or ethnic origin. To be eligible for most services, persons must be sixty years of age or older or be disabled. Some funding sources have income eligibility requirements. Services are targeted to those with the greatest social and economic needs, especially minorities. The primary funding sources for these services include the Older Americans Act (OAA), the Social Services Block Grant (SSBG), and the Community and Home Options to Institutionalization for the Challenged and Elderly (CHOICE) received through contracts with the Indiana Family and Social Services Administration.

As the Area Agency on Aging, it is SWIRCA's responsibility to select service providers who will be authorized to serve SWIRCA's clients. Those organizations selected to become a provider of SWIRCA-funded services will become an integral part of this network. Together, we are a team united through shared values relating to our ethics, clients, our selves, and our funding sources.

The organizations that comprise this network of service will practice the highest standards of personal ethics and integrity. We will strive relentlessly to exceed our clients' expectations to assure them of receiving the highest quality of service, opportunity to maximize their independence, and to remain the decision maker for their care. We will accept our responsibility to be effective stewards of all resources so that through our performance, our funding sources will be satisfied with their investment.

This packet of material includes a Provider Application and Instructions to guide you in its completion.

For consideration, an original and two copies of this proposal must be completed and submitted to:

Southwestern Indiana Regional Council on Aging, Inc.
P.O. Box 3938, Evansville, IN 47737-3938

I. PROVIDER IDENTIFICATION

DATE: _____
Month Day Year

1. _____
Legal Name of Applicant Agency/Organization submitting Proposal (if d/b/a, please also indicate.)

2. _____
President/CEO/Owner of Agency/Organization

3. _____
Street Address of Administrative (Main) office
_____ State Zip Code

4. _____
Contact Person/Title Claims Contact Person

_____ Street Address of Local/Area Office

() Telephone () Fax

5. _____
Email address Website

6. _____
Employer Tax Identification Number

Also, complete and return a Federal W-9 form (Enclosed)

Proposed Geographic Service Area for services requested in this Application:

Warrick Vanderburgh Gibson Posey Perry Spencer

PROVIDER PROFILE

1. Type of Agency/Organization:

- Governmental Entity
- Corporation
 - For Profit
 - Not For Profit

2. Identify your organization's fiscal reporting period (budget year)

January to December

July to June

October to September

Other (Please Specify: _____)

3. In the space below, give a brief history of your organization. Include important dates and significant accomplishments.

4. If your organization is licensed by the State of Indiana?

Please submit a current copy.

Yes No

5. Does your company carry general liability insurance in a minimum of \$500,000.00?

Yes No

Does your company carry Workmen's Compensation Insurance?

Yes No

SWIRCA must be listed as an Additional Insured for General Liability on an insurance certificate.

SWIRCA must be listed as a Certificate Holder for Workmen's Compensation on an insurance certificate..

Please enclose the proper certificate(s) of insurance with your application.

6. Circle if certified to provide Medicare, Medicaid, or Medicaid Waiver services in Indiana. If you have applied for any of the above and been denied, please indicate.

7. Are you a Certified Medicaid Waiver Provider? Yes No

If yes, list approved services. If more space is required, attach a separate sheet.

If no, have you applied to be a Medicaid Waiver Provider? Yes No

NOTE: The State of Indiana no longer requires that providers approved to provide services through CHOICE also be enrolled as a Medicaid Waiver Provider and vice versa, however, we strongly recommend doing so to expand your business.

8. Do you employ your workers?

Yes No

9. Are you an Equal Employment/Affirmative Action employer? Do you have a current Affirmative Action Plan?

Yes No

10. If accepted as a SWIRCA Service Provider, will your organization agree to clearly state in any publicity release or other public reference relative to SWIRCA-funded services that these services are provided without regard to race, age, color, religion, sex, disability, national origin or ancestry? Yes No
Attach your agency's public relations brochure, if one exists.

11. If accepted as a SWIRCA Service Provider, is your organization willing to list SWIRCA and the appropriate funding source(s) in any publicity release or other public reference, including media releases, informational pamphlets, etc. relative to these same services?
 Yes No

12. Are all your employees supervised and evaluated on a regular basis? If so, by whom and how often? (Annual performance evaluations are required.)
 Yes No
(Please refer to service standards to assure employees are in compliance with minimum criteria for service workers.)

13. Describe your organization's new employee orientation plan and your policy for annual employee continuing education/staff training. Please provide a copy of your current Staff Training Calendar.

14. How many field workers are assigned to each supervisor? _____

15. Describe your organization's procedures when your employees handle client funds.

16. Briefly describe the methods used by your organization to monitor and evaluate the quality of service provided to your clients. Attach a copy of any forms used (e.g. Client Evaluation Form.)

17. Are your services available

on holidays	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
weekends	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
evenings	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

List hours of operation:

18. Specify holidays on which your organization will be closed. Also indicate the criteria used in determining winter/emergency cancellations and what procedures are followed to inform clients of service cancellations.

19. Is your organization able to serve the elderly and those with disabilities regardless of age? Yes No
If no, which population do you serve?

20. Are your employees allowed to transport clients? Yes No
If yes, Briefly describe your policies for transporting clients:

21. Describe methods used to determine when weather emergencies or other circumstances would cause your organization to close and force cancellation of client services and how clients will be informed of cancellations. (Please provide written Agency procedures):

22. Does your agency have a disaster plan addressing emergency conditions? Yes No
If no, we require a disaster plan.. Do you agree to develop one? Yes No

23. Do your employees receive training and receive a copy of your disaster plan? Yes No
If no, do you agree to do so? Yes No

24. SWIRCA requires provider agencies to provide back up for staff unable to be at their assignments. Describe your policies regarding back up. (Please provide written agency procedures):

25. Describe how your company assists persons who have limited English proficiency:

SECTION III

Please refer to the Provider Manual Section on the SWIRCA website (www.swirca.org) for service definitions that are to be followed by all providers. In the space shown "Check here to provide" please indicate which services your agency intends to provide under CHOICE, SSBG and Title III funding. **All rates listed below are caps and are subject to state approval. Each service may be provided at a lower rate. Please indicate in the Additional Comments section the rate to be charged if lower than the cap.**

Current Rates updated 07/01/09

Check here to provide	Service Code	Service Component Title	Rate	Unit of Measure	Additional Comments
	AD1	Level 1-Adult Day Service	\$3.00	0.25 HR	
	AD2	Level 2-Adult Day Service	\$3.00	0.25 HR	
	AD3	Level 3-Adult Day Service	\$3.00	0.25 HR	
	ADST	Transport-Adult Day Service	\$11.00	TRIP	
	*ATCH	Specialized Medical Equipment-INSTALL	\$0.01	Unit	Complete Attachment B and include charges
	ATCM	Specialized Medical Equipment-MAI	\$0.01	Unit	
	ATTC	Attendant Care	\$4.95	0.25 HR	
	BMAN	Behavior Management	\$17.03	0.25 HR	

Check here to provide	Service Code	Service Component Title	Rate	Unit of Measure	Additional Comments
	*DURM	Durable Medical Equipment	\$.01	Unit	Complete Attachment B and include charges
	EMOI	Environmental Modification-INST	\$.01	Unit	
	EMOM	Environmental Modification-MAI	\$.01	Unit	
	HCP	Handy Chore	\$.01	1 Unit	
	HMK	Homemaker	\$3.71	0.25 HR	
	HOHE	Home Health Aide	\$5.02	0.25 HR	
	OCTH	Occupational Therapy	\$13.01	0.25 HR	
	*OTH	Other Needed Services	\$.01	0.25 HR	Complete Attachment B and include charges
	PHTH	Physical Therapy	\$13.92	0.25	
	PRSI	Per Rsp System-INSTALL	\$35.00	1 Unit	
	PRSM	Per Rsp System-Monthly	\$35.00	1 Unit	

Check here to provide	Service Code	Service Component Title	Rate	Unit of Measure	Additional Comments
	RATT	Respite Attendant	\$4.95	0.25 HR	
	RHHA	Respite-HM Health Aide	\$5.02	0.25 HR	
	RHMK	Respite-Homemaker	\$3.71	0.25 HR	
	RNUR	Respite-Nursing	\$9.74	0.25 HR	
	SKNU	Respite Nursing	\$9.74	0.25 HR	
	SPTH	Speech Therapy	\$15.15	0.25 HR	
	*SUPP	Home Health Supplies	\$.01	Unit	Complete Attachment B and include charges
	VMOD	Vehicle Modification	\$.01	Unit	

IV. GENERAL ASSURANCES

The Provider Organization must maintain documentation to substantiate all of the following assurance items. Such documentation will be subject to SWIRCA, State, or Federal review for adequacy and completeness.

A. General Administration

1. Compliance with Requirements

The Provider Organization agrees to administer the program(s) in accordance with SWIRCA, the Older Americans Act, the State Plan, and all applicable Title III and SSBG regulations, policies, and procedures established by the Bureau of Aging and In-Home Services of the Indiana Family and Social Services Administration.

2. General Administrative and Fiscal Requirements

The Provider Organization utilizes such methods of administration as are necessary for the proper and efficient administration of the Program(s). The Provider Organization's uniform administrative requirements and cost principles are in compliance with the relevant provisions of 45 CFR Part 74 except where these provisions are superseded by statute or program regulation.

3. Training of Staff

The Provider Organization offers a program of appropriate training for all proposed service positions and volunteers.

4. Management of Funds

The Provider Organization maintains sufficient fiscal control and accounting procedures to assure proper disbursement of and accounting for Federal and State funds received under this application.

5. Compliance with Confidentiality Regulations

The Provider Organization has implemented such regulations, standards, and procedures as are necessary to meet the requirements on safeguarding confidential information under relevant program regulations.

6. Reporting Requirements

The Provider Organization agrees to furnish such reports and evaluations to SWIRCA and the Bureau of Aging and In-Home Services of the Indiana Family and Social Services Administration as may be specified.

7. Standards for Service Providers

The Provider Organization will operate fully in conformance with all applicable Federal, State, and local fire, health, safety, and sanitation and other standards prescribed in law or regulations. The Provider Organization agrees that where the State or Local public jurisdictions require licensure for the provision of services, such licensure shall be obtained.

8. Amendments to Provider Application

The Provider Organization will conform with applicable program regulations, policies & procedures as amendments are made superseding current requirements.

9. Drug-Free Workplace Certification

The Provider Organization agrees to comply with all applicable State regulations/requirements in a good faith effort to provide a drug-free workplace for its employees.

10. Political Activity

The Provider Organization agrees to comply with State regulations prohibiting any political or voter activity with any funding provided by the State. Provider Organization further agrees to comply with applicable provisions of the Hatch Act (5 U.S.C. SS 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

11. Lobbying Activities

The Provider Organization agrees that no federally appropriated funds will be paid, by or on behalf of Provider Organization, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, grant, loan, cooperative agreement or extension, continuation, renewal, amendment or modification of the same. Should Provider Agency use funds other than federally appropriated funds for the purpose of influencing or attempting to influence an officer or employee of any agency, member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with this program, Provider Agency agrees to complete and submit "Standard Form-LLL," "Disclosure Form to Report Lobbying."

12. Conflict of Interest

The Provider Organization assures there is an absence of conflict of interest within the agency and the agency has in place a mechanism to identify and remove conflicts of interest.

13. Prioritization of Legal Assistance

For providers of Legal Assistance, provider assures that priority will be given to legal assistance related to income, health care, long term care, nutrition, housing and utilities, protective services, defense of guardianship, abuse, neglect and age discrimination.

14. Special Dietary Needs

Nutrition providers assure project(s) will reasonably accommodate participants with special dietary needs (42CFR 307(a)(13)(G)).

15. Senior Center Activities

Providers of Title III-B Senior Center Activities assures special efforts will be made to provide multi-generational activities.

16. Public Purpose of Services

The Provider Organization will maintain the integrity and public purpose of services.

17. Accuracy of Provider Information

All information provided in this proposal about the Provider Organization is complete and accurate.

18. Disclosure of Expenditures

Provider Organization agrees to disclose all sources and expenditures of funds covered in this proposal to SWIRCA and/or the Indiana Division on Aging, or to the Director of the Indiana Division on Aging upon request.

19. Determination of Title III Service Recipients

When determining who will be served with Title III services, Provider Organization will not give preference to any individual as a result of a contract or commercial relationship that is not to implement Title III.

20. Access to Title III Services by Native Americans

Provider Organization will pursue activities that increase access to Title III services by Native Americans and other minorities.

B. Equal Opportunity and Civil Rights

1. Equal Employment Opportunity

The Provider Organization has an equal employment opportunity policy, implemented through an affirmative action plan for all aspects of personnel administration as specified in 45 CFR Part 70.4. Personnel policies include hiring, firing, and grievance procedures.

2. Non-Discrimination on the Basis of Disability

All recipients of funds from SWIRCA are required to operate each funded service so that, when viewed in its entirety, the service is readily accessible to and useable by handicapped persons.

3. Civil Rights Compliance

The Provider Organization has developed and is implementing Policies to ensure that benefits and services funded pursuant to this application are provided in a non-discriminatory manner as required by Title VI of the Civil Rights Act of 1964, as amended.

C. Provision of Services

1. Needs Assessment

The Title III Provider Organization has a reasonable and objective method for determining the needs of all eligible residents of all geographic areas covered by this Application where said services are not required to be initiated by SWIRCA's Case Management Department.

2. Priorities

The Title III Provider Organization has a reasonable and objective method for establishing priorities for service and such methods are in compliance with the applicable statute where such services are not required to be initiated by SWIRCA's Case Management Department.

3. Eligibility

The Title III Provider Organization agrees to serve only those individuals and groups eligible under the provision of the applicable statute.

4. Coordination and Maximum Utilization of Services

The Provider Organization agrees to coordinate and utilize available services and resources with other appropriate public and private agencies and organizations.

5. Religious Activity

The Provider Organization agrees that services provided with funding obtained through this application shall be non-sectarian in nature and that religious activities shall not be included in any funded activities. The Provider Organization agrees that religious beliefs will not be forced on program participants or program employees.

6. Non-Discrimination

The Provider Organization agrees to comply with all applicable non-discrimination statutes and regulations to ensure that no person shall on grounds of race, age, color, religion, sex, disability, national origin or ancestry be excluded from participating in or denied the benefit of services.

Signature of Authorized Official of Provider Organization:

Date: _____

Type or Print Name and Title: _____

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.

Social security number
or
Employer identification number

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

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 ▶
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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.