Advanced Practice Provider (APP) Credentialing Packet

(Nurse Practitioners, Physician Assistants ONLY)

Pre-Hire Screening must be completed and approved (if in KHF Malpractice Program) before completing the credentialing packet.

Enclosed is the credentialing packet for Kids Health First PediatricAlliance. The following items need to be completed and preferably returned by email to credentialing@khfirst.com. If email is unavailable, documents may also be faxed (770-333-1725).

CREDENTIALING DOCUMENTS REQUIRED:

☐ Georgia Uniform Allied Healthcare Professional Credentialing Application Form, completed

☐ IRS W-9 Form, completed

☐ Supplemental Information Form contains additional data fields required for CMO participation submission

☐ Complete CV showing entire education and job history to the present **(6-month gaps must be explained)**

☐ Legible copy of current Georgia medical board license

☐ Legible copy of current DEA Certificate or physician agreement for controlled substance, if applicable

☐ Legible copy of current Malpractice Certificate for your practice (must include retro date, must be for your practice)

IMPORTANT! Providers are responsible for initiating and updating information with Medicaid. KHF does not have access to GAMMIS accounts and cannot make updates for providers.

Please retain a copy of all completed applications for your records. If you haveany questions, please contact Kathryn Glass at (770) 333–0033, Ext. 203.

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

Please contact the Hospital, Health Plan or other Healthcare Organization, hereinafter "Healthcare Entity(ies)", to which you are applying for instructions on how to proceed. The Healthcare Entity may not have adopted this form for use and/or may require a pre-application prior to submitting this form.

This Application has been designed and organized into two main parts: Part One and Part Two.

Part One is standardized for Healthcare Entity(ies), and contains identical questions that Healthcare Entities need to ask as a part of their credentialing processes. Part One is available on the Georgia Uniform Healthcare Practitioner Credentialing Application Form (UHPCAF) web site at www.georgiacredentialing.org.

Part Two for health plans is standardized and contains additional identical questions that health plans need to ask as part of their credentialing processes and, is also available at www.georgiacredentialing.org.

Part Two for hospitals contains additional, customized or more specific questions as part of their credentialing and privileging processes.

PREPARED AND ENDORSED BY MEMBERS OF:

GHA/AN ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS
GEORGIA IN-HOUSE COUNSEL ASSOCIATION
GEORGIA ASSOCIATION MEDICAL STAFF SERVICES
GEORGIA ASSOCIATION OF HEALTH PLANS

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

Prior to completing this Application, please read and observe the following:

GENERAL INSTRUCTIONS

- Please type or print legibly your responses.
- Please note that modification to the wording or format of this Application will invalidate it.
- All information requested must be FULLY and TRUTHFULLY provided.
- Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable.
- If an entire section does not apply to you, then please check the box provided at the top of the section. If a particular question does not apply to you, then write "N/A" in the answer blank. If there are multiple, repetitive answer blanks in a particular section (as, for example, in the section entitled "Professional Training"), it is not necessary to mark "N/A" in each unneeded answer blank.
- Unless *specifically permitted* by a particular question, please understand that a reference to "See CV or resume" for an answer is not appropriate.
- **If more space than is provided on this Application is needed in order to answer a question completely, use the attached Explanation Form as necessary. Make as many copies of the Explanation Form as needed to fully answer each question. Include the section and page number of the question being answered as well as your name and Social Security Number on each Explanation Form. Attach all Explanation Forms to this Application.**
- After **Part One** of the Application has been completed in its entirety but *before* you sign and date it or fill in the information on page **ii**, make a copy of the Application to retain in your files and/or computer for future use.
  In so doing, at the time of a submission to another Healthcare Entity, all you will need to do is to check to ensure that all the information remains complete, current and accurate before completing page **ii** and signing and forwarding the Application as needed.
- Any gaps of time greater than thirty (30) days from completion of professional school / training to the present date must be accounted for before your Application will be considered complete.
- Please sign and date the Application.
- Please sign and date Schedule A and Schedule B (as appropriate).
- Identify the Healthcare Entity to which you are submitting this Application and for what practice area(s) you are applying in the spaces provided on page **ii**.
- Mail the Application, Schedules, any Explanation Form(s) prepared in order to answer any question(s) completely, as well as a copy of all applicable enclosures listed on page **ii** to the Healthcare Entity.

GENERAL INSTRUCTIONS - continued

A current copy of the following documents must be submitted with your Application:

- One recent passport size photograph of yourself
- State Professional License(s)
- Federal Narcotics License (DEA Registration) if applicable
- Curriculum Vitae or resume with complete professional history in chronological order (month & year)
- Diplomas and/or certificates of completion from professional school
- Specialty/Subspecialty Certification or letter from certifying body stating your status (if applicable)
- Declaration Page (Face Sheet) of Professional Liability Policy or Certificate of Insurance
- Permanent Resident Card or Visa Status (if applicable)
- Military Discharge Record (Form DD-214) (if applicable)

Name of Healthcare Entity to which you are submitting this Application:
For what type of relationship (i.e., staff membership, network participation, etc.):

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

**********PART ONE**********

If more space than is provided on this Application is needed in order to answer a question completely, please use the attached Explanation Form as necessary.

I. IDENTIFYING INFORMATION *Please provide the practitioner's full legal name.*

Last Name (include suffix; Jr., Sr., III):	First:	Middle:
Title (PhD, CRNA, PA, etc.):		
Is there any other name under which you have been known or have used (e.g. maiden name)? ☐ Yes ☐ No Name(s) and Date(s) Used:		
Home Street Address:		
City:	State:	Zip:
Home Telephone Number: ( ) -	E-Mail Address: @	Citizenship (if not USA, provide type and status of visa and enclose a copy)
Date of Birth: / /	Place of Birth:	Gender: ☐ Male ☐ Female
Social Security Number: - -	UPIN:	National Provider Identifier (NPI) (Type 1 Only):
Medicare Provider Number:	Georgia Medicaid Provider Number(s):	Other State Medicaid Provider Number:
Georgia License Number: / Expiration Date mm/yy:	DEA Registration #: / Expiration Date mm/yy:	Controlled Substance Registration # / Expiration Date (if applicable):
Marital Status (optional): ☐ Single ☐ Married ☐ Divorced ☐ Widow	Name of Spouse (if applicable) (optional):	Medical Specialty for Which Applying Primary: Secondary:

II. PRACTICE INFORMATION

A. NAME OF PRIMARY CLINICAL PRACTICE:	Type of Practice Setting: ☐ Solo ☐ Group/Single	Specialty: ☐ Group/Multi-Specialty ☐ Hospital Based ☐ Other
Primary Clinical Practice Street Address:	Start Date at Location (mm/yy): /	
City: County: State:	Zip:	
Primary Office Telephone Number: ( ) -	Primary Office Fax Number: ( ) -	Patient Appointment Telephone Number: ( ) -
Mailing Address (if different from above):		
Name of Office Manager /Administrative Contact:	Office Manager's Telephone Number: ( ) -	Office Manager's Fax Number: ( ) -
Answering Service Number: ( ) -	Pager/Beeper Number : ( ) -	Office E-Mail Address: @
Credentialing Contact and Address (if different from above):		
Credentialing Contact's Telephone Number: ( ) -	Credentialing Contact's Fax Number: ( ) -	
Federal Tax ID Number for this Practice Address:	Name Affiliated with Tax ID Number:	

II. PRACTICE INFORMATION – continued

Does Not Apply ☐

NAME OF SECONDARY CLINICAL PRACTICE:	Type of Practice Setting: ☐ Solo ☐ Group/Single	Specialty: ☐ Group/Multi-Specialty ☐ Hospital Based ☐ Other
Secondary Clinical Practice Street Address:	Start Date at Location (mm/yy): /	

City:	County:	State:	Zip:
Answering Service Number: ( ) -	Pager/Beeper Number: ( ) -	Office E-Mail Address: @	
Federal Tax ID Number for this Practice Address:	Name Affiliated with Tax ID Number:		

B. OTHER OFFICES: ***Please list any other current office locations with the above information on Explanation Form(s).***

C. BILLING ADDRESS: If different than primary clinical site address, please provide complete billing address:

Name of Office Manager/Administrative Contact:	Office Phone Number: ( ) -	Office Fax Number: ( ) -

D. INTENTION: If you are not currently in practice, please describe your intentions regarding beginning and/or reinstating your practice.

E. CORRESPONDENCE: To what address would you like all correspondence forwarded?
☐ Primary Office ☐ Secondary Office ☐ Billing Office ☐ Home ☐ Other (Please specify)

F. LANGUAGES:
1. Please list any language other than English (including sign language) in which you are fluent:
2. Please list any language other than English (including sign language) in which a member of your staff is fluent and identify staff member:

III. CERTIFICATION

Does Not Apply ☐

Are you certified by any board in your profession? ☐ YES ☐ NO ***List all current and past board certifications.***

Name of Issuing Board	Specialty	Date Certified (mm/yy):	Date Recertified (mm/yy):	Date Recertified (mm/yy):	Expiration Date (if any) (mm/yy):
		/	/	/	/
		/	/	/	/
		/	/	/	/

Please answer the following questions. Attach Explanation Form(s), if necessary.

A.	Have you ever been examined by any certifying body, but failed to pass? If yes, please provide name and date(s):	☐ YES ☐ NO
B.	1. If you are not currently certified, have you applied for the certification examination?	☐ YES ☐ NO
	2. If you have not applied for the certification examination, do you intend to apply for the certification examination? If yes, when? Date: /	☐ YES ☐ NO
	3. If you have applied for the certification examination, have you been accepted to take the certification examination?	☐ YES ☐ NO
	4. If you have been accepted, when do you intend to take the certification examination?	Date: /
	5. If you do not intend to apply for the certification examination, please attach reason on Explanation Form(s)	
C.	If you are not currently certified, is there an expiration date for admissibility? If yes, when? Date: /	☐ YES ☐ NO
D.	Have you ever had certification revoked, limited, suspended, involuntarily relinquished, subject to stipulated or probationary conditions, received a letter of reprimand from a specialty board, or is any such action currently pending or under review? If yes, please attach Explanation Form(s).	☐ YES ☐ NO
E.	Have you ever voluntarily relinquished a certification, including any voluntary non-renewal of a time limited certification? If yes, please attach Explanation Form(s).	☐ YES ☐ NO

IV. EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE

A. UNDERGRADUATE or TECHNICAL SCHOOL

Complete School Name:	Degree(s) Received:	Graduation Date (mm/yy): /
City:	State/Country:	Course of Study or Major:

B. POST GRADUATE DEGREES

Does Not Apply ☐

Complete School Name:	Degree(s) Received:	Graduation Date (mm/yy): /
City:	State/Country:	Course of Study or Major:

C. PROFESSIONAL TRAINING

Medical / Professional School Name and Street Address:

City:	State/Country:	Zip:

From (mm/yy): /	To (mm/yy): /	Date of Completion (mm/yy): /	Degree(s) Received:

Did you complete the program? ☐ Yes ☐ No (If you did not complete the program, please attach Explanation Form(s)

Medical / Professional School Name and Street Address:

City:	State/Country:	Zip:

From (mm/yy): /	To (mm/yy): /	Date of Completion (mm/yy): /	Degree(s) Received:

Did you complete the program? ☐ Yes ☐ No (If you did not complete the program, please attach Explanation Form(s)

D. FACULTY POSITIONS *List all academic, faculty, research, assistantships or teaching positions you have held and the dates of those appointments.*

Does Not Apply ☐

Program Specialty & Institution:	Academic Rank or Title:		
Institution Name & Address:	City:	State/Country:	Zip:
From (mm/yy): /	To (mm/yy): /		
Program Specialty & Institution:	Academic Rank or Title:		
Institution Name & Address:	City:	State/Country:	Zip:
From (mm/yy): /	To (mm/yy): /		

E. MILITARY/PUBLIC HEALTH SERVICE

Does Not Apply ☐

Location of Last Duty Station:

Rank at Discharge:	Branch:	Active Duty Dates: From (mm/yy) /	Active Duty Dates: To (mm/yy) /

Honorable Discharge: ☐ Yes ☐ No If no, attach Explanation Form(s).

Are you currently in the Reserves or National Guard? ☐ Yes ☐ No

Have you ever been court-martialed? ☐ Yes ☐ No If yes, attach Explanation Form(s).

Attach a copy of DD-214 Form.

F. SPONSORSHIP INFORMATION

Does Not Apply ☐

Please name your primary sponsoring physician:

Address:

Phone Number:	Fax Number:

V. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS & CERTIFICATES

Does Not Apply ☐

Please include all ever held. If more room is needed please list on an attached Explanation Form.

Type and Status:	Number:	State/Country:	Expiration Date (mm/yy):
Year Obtained:	Year Relinquished:	Reason:	
Type and Status:	Number:	State/Country:	Expiration Date (mm/yy):
Year Obtained:	Year Relinquished:	Reason:	

VI. CURRENT HOSPITAL AND OTHER FACILITY AFFILIATIONS

Please list in reverse chronological order with the current affiliation(s) first: *(A) current hospital affiliations, (B) hospital applications in process, (C) previous hospital affiliations and (D) other current facility affiliations (which includes surgery centers, dialysis centers, nursing homes and other health care related facilities).* ***Do not list residencies, internships or fellowships. Please list all employment in Section VII.***

A. CURRENT HOSPITAL AFFILIATIONS

Does Not Apply ☐

Primary Facility Name:	Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.): Appointment Date (mm/yy):	
Facility Name:	Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.): Appointment Date (mm/yy):	

B. OTHER FACILITY AFFILIATIONS *Please list all current affiliations with other facilities.*

Does Not Apply ☐

Facility Name:	Complete Address:
From (mm/yy): To (mm/yy):	
Reason for Leaving:	

VII. PROFESSIONAL PRACTICE / WORK HISTORY

Does Not Apply ☐

A curriculum vitae or resume is not sufficient for a complete answer to these questions.

Please list in reverse chronological order all work and professional and practice history activities not detailed under Section II, IV or VI. Include any previous office addresses and any military experience. **Explain below any gaps greater than thirty (30) days.**

Name of Current Practice / Employer:	
Contact Name:	Complete Address:
Telephone Number: ( ) -	
From (mm/yy): To (mm/yy):	
Name of Previous Practice / Employer:	
Contact Name:	Complete Address:
Telephone Number: ( ) -	
From (mm/yy): To (mm/yy):	
Name of Previous Practice / Employer:	
Contact Name:	Complete Address:
Telephone Number: ( ) -	
From (mm/yy): To (mm/yy):	

VIII. PROFESSIONAL PRACTICE / WORK HISTORY - continued

If your training, practice, military or work experience has been interrupted for more than thirty (30) days by, for example, illness, injury or family medical leave, then please explain below any such gap since completing medical school.	Does Not Apply ☐

Explanation of Interruption:	From (mm/yy):	To (mm/yy):
	/	/
	/	/
	/	/

IX. PROFESSIONAL REFERENCES

Please list three (3) references, from licensed professional peers who through recent observations have personal knowledge of and are directly familiar with your professional competence, conduct and work. Do not include relatives. At least one reference must be a practitioner in your same professional discipline. **(Please refer to Part Two of this Application for any additional specific reference requirements.)**

Name of Reference:		Complete Address:
Specialty:		
Dates of Association: / - /		
Telephone Number: ( ) -	Fax Number: ( ) -	
Name of Reference:		Complete Address:
Specialty:		
Dates of Association: / - /		
Telephone Number: ( ) -	Fax Number: ( ) -	
Name of Reference:		Complete Address:
Specialty:		
Dates of Association: / - /		
Telephone Number: ( ) -	Fax Number: ( ) -	

X. PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence

Name of Local Contact (e.g. Insurance Agent or Broker):		Mailing Address:
Contact Telephone Number: ( ) -		
Per claim limit of liability: $	Aggregate amount: $	

Effective Date (mm/yy):	Expiration Date (mm/yy):	Retroactive Date, if applicable (mm/yy):
/	/	/

If you have changed your coverage <u>within the last ten years</u>, did you purchase tail and/or nose (prior occurrence/acts) coverage? ☐ Yes ☐ No

If yes, please provide details/supporting data. If no, please explain why not on an Explanation Form of the Application.

NOTE: IF YOU ARE COVERED BY A MEDICAL PROFESSIONAL LIABILITY INSURANCE PROGRAM THAT IS A CLAIMS MADE POLICY, YOU ARE REQUIRED TO SHOW EVIDENCE OF PURCHASE OF CURRENT REPORTING ENDORSEMENT COVERAGE (TAIL COVERAGE) OR PRIOR OCCURRENCE/ACTS COVERAGE TO COVER PREVIOUS YEARS OF PRACTICE.

X. PROFESSIONAL LIABILITY INSURANCE - continued

Please list all previous professional liability carriers within the past ten (10) years (including any carriers during medical training if within the ten year period). Does Not Apply ☐

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence
Name of Local Contact:		Mailing Address:
Contact Telephone Number: ( ) -		
Per claim limit of liability: $	Aggregate amount: $	
Effective Date (mm/yy): /	Retroactive Date, if applicable (mm/yy): /	Expiration Date (mm/yy): /

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence
Name of Local Contact:		Mailing Address:
Contact Telephone Number: ( ) -		
Per claim limit of liability: $	Aggregate amount: $	
Effective Date (mm/yy): /	Retroactive Date, if applicable (mm/yy): /	Expiration Date (mm/yy): /

Professional Insurance History: Please answer each of the following questions in full. ***If the answer to any question is "YES", or requires further information*****, please give a full explanation of the specific details on an Explanation Form and attach to the Application.**

1.	Has your professional liability insurance coverage ever been terminated or not renewed by action of the insurance company? ☐ Yes ☐ No If yes, please provide date, name of company(s), and basis for termination or non-renewal.
2.	Have you ever been denied coverage? ☐ Yes ☐ No. If yes, please provide details.
3.	Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? ☐ Yes ☐ No If yes, please identify procedures and provide details.

Professional Claims History: ***(If the answer to any of these questions is "Yes," please complete a separate Professional Liability Claims Information Form for each. A Professional Liability Claims Information Form has been provided as Schedule B to this Application. Please make additional copies as necessary.)***

1.	Have there *ever been* any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you? ☐ Yes ☐ No
2.	Are any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you *currently pending*? ☐ Yes ☐ No
3.	Are you aware of any formal demand for payment or similar claim submitted to your insurer that did not result in a lawsuit or other proceeding alleging professional liability? ☐ Yes ☐ No

XI. HEALTH STATUS

Please answer each of the following questions in full.

1.	Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application? ***If the answer to this question is "YES," please give full explanation of the specific details on an Explanation Form and attach to the Application.*** (**Note**: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current participation in aftercare programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)	☐ Yes ☐ No
2.	**Are you able to perform** all the essential functions of the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation? If reasonable accommodation is required, please specify such on **an attached Explanation Form.**	☐ Yes ☐ No

XII. ATTESTATION QUESTIONS

This section to be completed by the Practitioner. Modification to the wording or format of these Attestation Questions will invalidate the Application.

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 an Explanation Form and attach to the Application.

For the purpose of the following questions, the term "adverse action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial, or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment. "Adverse action" also means, with respect to professional licensure registration or certification, any previously successful or currently pending challenges to such licensure, registration or certification including any voluntary or involuntary restriction, suspension, revocation, denial, surrender, non-renewal, public or private reprimand, probation, consent order, reduction, withdrawal, limitation, relinquishment, or failure to proceed with an application for such licensure, registration or certification.

A.	To your knowledge, have you ever been the subject of an investigation or **adverse action** (or is an investigation or **adverse action** currently pending) by:	
	• a hospital or other healthcare facility (e.g. surgical center, nursing home, renal dialysis facility, etc.)?	☐ Yes ☐ No
	• an education facility or program (medical school, residency, internship, etc.)?	☐ Yes ☐ No
	• a professional organization or society?	☐ Yes ☐ No
	• a professional licensing body (in any jurisdiction for any profession)?	☐ Yes ☐ No
	• a private, federal, or state agency regarding your participation in a third party payment program (Medicare, Medicaid, HMO, PPO, PHO, PSHCC, network, system, managed care organization, etc.)?	☐ Yes ☐ No
	• a state or federal agency (DEA, etc.) regarding your prescription of controlled substances?	☐ Yes ☐ No
B.	To your knowledge, have you ever been the subject of any report(s) to a state or federal data bank or state licensing or disciplining entity?	☐ Yes ☐ No
C.	Has your application for clinical privileges or medical staff membership or change in staff category at any hospital or healthcare facility ever been denied in whole or in part or is any such action pending?	☐ Yes ☐ No
D.	Have you ever resigned from a hospital or other health care facility medical staff to avoid disciplinary action, investigation or while under investigation or is such an investigation pending?	☐ Yes ☐ No
E.	Have you ever been suspended, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in any *federal or state* health insurance program (for example, Medicare or Medicaid)?	☐ Yes ☐ No
F.	Have you ever been suspended, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in any *private* health insurance program?	☐ Yes ☐ No
G.	Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to any patient?	☐ Yes ☐ No
H.	Have you ever been convicted of or entered a plea for any criminal offense (excluding parking tickets)?	☐ Yes ☐ No
I.	Are any criminal charges currently pending against you?	☐ Yes ☐ No
J.	Have you ever been arrested for or charged with a crime involving children?	☐ Yes ☐ No
K.	Have you ever been arrested for or charged with a sexual offense?	☐ Yes ☐ No
L.	Have you ever been arrested for or charged with a crime involving moral turpitude?	☐ Yes ☐ No
M.	Are you currently using illegal drugs or legal drugs in an illegal manner?	☐ Yes ☐ No

XIII. ATTESTATION AND SIGNATURE

By signing this Application, I certify, agree, understand and acknowledge the following:

1.	The information in this entire Application, including all subparts and attachments, is complete, current, correct, and not misleading.
2.	Any misstatements or omissions (whether intentional or unintentional) on this Application may constitute cause for denial of my Application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement.
3.	A photocopy of this Application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4.	I have reviewed the information in this Application on the most recent date indicated below and it continues to be true and complete.
5.	While this Application is being processed, I agree to update the information originally provided in this Application should there be any change in the information.
6.	No action will be taken on this Application until it is complete and all outstanding questions with respect to the Application have been resolved.
7.	This attestation statement and Application must be signed no more than 180 days prior to the credentialing decision date.

Signature:

Printed Name: **Date:**

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

EXPLANATION FORM
Please make as many copies of this page as needed to fully respond to each question. For each response/explanation, please provide your name and Social Security Number, together with the corresponding page and section number from the Application.

NAME:	**SS#:**

Section #	Page #

Schedule A

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:

1. As an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), managed care organization, network, medical society, professional association, medical school faculty position, or other healthcare delivery entity or system (hereinafter referred to as a "Healthcare Entity")* indicated on this Application, I have the burden of producing adequate information for proper evaluation of this Application.

2. I also understand that I have the continuing responsibility to resolve any questions, concerns or doubts regarding any and all information in this Application. If I fail to produce this information, then I understand that the Healthcare Entity will not be required to evaluate or act upon this Application. I also agree to provide updated information as may be required or requested by the Healthcare Entity or its authorized representatives or designated agents.

3. The Healthcare Entity and its authorized representatives or designated agents will investigate the information in this Application. I consent and agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Entity as a part of the verification and credentialing process.

4. I specifically authorize the Healthcare Entity and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, utilization practices, professional licensure or certification, and any other matter related to my qualifications or matters addressed in this Application (my "Qualifications").

5. I authorize all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, companies, agencies, licensing authorities, boards, plans, organizations, Healthcare Entities or others with which I have been associated as well as all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my Qualifications to consult with the Healthcare Entity and its authorized representatives and designated agents and to report, release, exchange and share information and documents with the Healthcare Entity, for the purpose of evaluating this Application and my Qualifications.

6. I consent to and authorize the inspection of records and documents (including medical records and peer review information) that may be material to an evaluation of this Application and my Qualifications and my ability to carry out the clinical privileges/services/participation I have requested. I authorize each and every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for the evaluation of this Application. I also agree to appear for interviews, if required or requested by the Healthcare Entity, in regard to this Application.

7. I further consent to and authorize the release by the Healthcare Entity to other Healthcare Entities and interested persons on request of information the Healthcare Entity may have concerning me (including but not limited to peer review information which is provided to another Healthcare Entity for peer review purposes), as long as in each instance such release of information is done in good faith and without malice. I hereby release from all liability the Healthcare Entity and its authorized representatives or designated agents from any claim for damages of whatever nature for any release of information made in good faith by the Healthcare Entity or its representatives or agents.

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:

8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my Application and Qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this Application and my Qualifications.

9. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession. I also agree to provide for continuous care for my patients.

10. Any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Georgia law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.

11. I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application. This Authorization and Release shall apply in connection with the evaluation and processing of this Application as well as in connection with any periodic reappraisals and evaluations undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.

Signature:	
Printed Name:	**Date:**

I grant permission for the release of the credentials information contained in this Application to the following Healthcare Entity(ies):

Schedule B

Claim ____ of ____

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM

The following information is necessary to complete the credentialing verification process and will be kept confidential. Please print or type answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. For initial credentialing, please complete a separate form for each claim; for recredentialing, just complete forms for the last ten (10) years. One case per sheet *(please photocopy if additional sheets are needed).*

PROVIDER'S NAME: *(Required even if N/A)*		**Does Not Apply** ☐ *Note: Signature Required even if checked.*

Name of Patient Involved	Age	Month and Year of Occurrence *(Event precipitating claim)*	Month and Year of Lawsuit	Insurance Carrier at Time
		/	/	

What is/was your status?	List other defendants:
☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	

What was the patient's outcome?

How were you alleged to have caused harm or injury to this patient?

Please provide specifics in reference to the adverse event:

What is/was your role in this event?

CURRENT STATUS

☐ Still pending (as of) Date: /		Who is handling the defense of the case?	
☐ Trial date set - awaiting trial		Trial Date: /	
☐ Dismissed		Date of Dismissal: /	
☐ Defense Verdict		Date of Defense Verdict: /	
☐ Settled out of court	Date: /	Total Amount of Settlement: $	Amount Paid by You: $
☐ Judgment	Date: /	Total Amount of Judgment: $	Amount Paid by You: $

This Professional Liability Claims Information Form is required on all claims/lawsuits that are reported by your malpractice insurance carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete (even if N/A) to the best of my knowledge.

Signature: (Required)		**Date:**	

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

**********PART TWO**********

GEORGIA ASSOCIATION OF HEALTH PLANS

I. Personal Identification

Last Name (include suffix; Jr., Sr., III):	First:	Middle:
Are you eligible to work in the United States?		☐ Yes ☐ No

II. Practice Location Information

Physician group name/practice name to appear in directory (if applicable):

Group/Corporate name as it appears on W-9, if different from Physician group/practice name:

III. License and Other Identification Information

National Provider Identifier (NPI) when available.

Are you a Participating Medicare Provider?	☐ Yes ☐ No
Are you a Participating Medicaid Provider?	☐ Yes ☐ No

IV. Professional/Medical Specialty Information - Primary Specialty:

Based on your contracted agreement do you wish to be listed in the directory under your primary specialty? ☐ Yes ☐ No	Specify: ☐ HMO ☐ PPO ☐ POS

V. Professional/Medical Specialty Information - Secondary Specialty:

Based on your contracted agreement do you wish to be listed in the directory under your secondary specialty? ☐ Yes ☐ No	Specify: ☐ HMO ☐ PPO ☐ POS

VI. Professional/Medical Specialty Information - Additional Specialty:

Based on your contracted agreement do you wish to be listed in the directory under an additional specialty? ☐ Yes ☐ No	Specify: ☐ HMO ☐ PPO ☐ POS

Additional areas of professional/practice interest or focus:

VII. Hospital/Affiliations

Do you have hospital privileges?	☐ Yes ☐ No

Primary hospital where you have privileges:

Name:	Address:
Contact:	Phone #: ( ) -
Are privileges temporary?	☐ Yes ☐ No

Other hospital(s) where you have privileges: ***(Use additional sheets if necessary.)*** N/A ☐

Name:	Address:
Contact:	Phone #: ( ) -
Are privileges temporary?	☐ Yes ☐ No

VIII. Work History

Are you currently on active military duty or on military reserve?	☐ Yes ☐ No

IX. Other Practice Information *Instructions: Please complete this section for each practice location. Additional copies of this section can be found at the end of this form.*

Site Address:		Type of service provided:	☐ primary care specialist ☐ non-primary care specialist
List the names of colleagues providing regular coverage, their specialties and coverage arrangements:			
After hours, back office phone number for health plan business use only:			
Office business hours, hours that patients are seen:			
Evening or weekend hours:			
Do you want to list site in the directory?			☐ Yes ☐ No
Do you make 24-hour/7 day a week phone coverage available? If Yes, Indicate type of coverage arrangements.			☐ Yes ☐ No
BILLING INFORMATION:			
E-mail for billing contact: @		Department name if hospital based:	
Who check should be payable to:		Billing representative's name:	
Practice limitations: (patient ages, sex)			
Availability of interpreters (specify languages):			
Do you provide handicap accessibility for each of the following areas:			
Building ☐ Yes ☐ No	Parking ☐ Yes ☐ No	Restroom ☐ Yes ☐ No	
Is the site accessible by public transportation? ☐ Yes ☐ No		If yes, indicate types of transportation.	
Does your site provide childcare services? (for each site)			☐ Yes ☐ No
Does your site have other services for the disabled (Test Telephony – TTY, American Sign Language – ASL, or other)?			☐ Yes ☐ No
Does your office qualify as a minority business enterprise?			☐ Yes ☐ No
Do you or someone in your office have the following additional certifications? (show expiration dates.)			
BLS (Basic Life Support)	☐ Yes ☐ No	Expiration date: /	
ACLS (Advanced Cardiac Life Support)	☐ Yes ☐ No	Expiration date: /	
ALSO (Advance Life Support in OB)	☐ Yes ☐ No	Expiration date: /	
PALS (Pediatric Advanced Life Support) Classification	☐ Yes ☐ No	Expiration date: /	
ATLS (Advanced Trauma Life Support) Certified	☐ Yes ☐ No	Expiration date: /	
NALS (Neonatal Advanced Life Support)	☐ Yes ☐ No	Expiration date: /	
NRS (Neonatal Resuscitation Program) Classification	☐ Yes ☐ No	Expiration date: /	
CPR classification	☐ Yes ☐ No	Expiration date: /	
Other (Please list on an Explanation Form(s))			
Additional office services provided:			

Laboratory services provided	☐ Yes ☐ No	Flexible sigmoidoscopy	☐ Yes ☐ No
Radiology Service	☐ Yes ☐ No	Tympanometry/audiometry screening	☐ Yes ☐ No
EKGs	☐ Yes ☐ No	Asthma treatment	☐ Yes ☐ No
Care of minor lacerations	☐ Yes ☐ No	Osteopathic manipulation	☐ Yes ☐ No
Pulmonary function	☐ Yes ☐ No	IV hydration/treatment	☐ Yes ☐ No
Allergy injections, allergy skin testing	☐ Yes ☐ No	Cardiac stress tests	☐ Yes ☐ No
Office gynecology (routine pelvic/pap)	☐ Yes ☐ No	Physical therapy	☐ Yes ☐ No
Drawing blood	☐ Yes ☐ No	Additional office procedures provided	☐ Yes ☐ No
Age appropriate immunizations	☐ Yes ☐ No	Surgical procedures	☐ Yes ☐ No
Is anesthesia administered in your office?	☐ Yes ☐ No	If yes, what category of anesthesia do you use?	
Specify the class or category:		Who administers it?	

X. Required Attachments or Supplemental Information – Hard Copy or Scanned

Copy of state controlled dangerous substance (CDS) certificate (if applicable).
Copy(ies) of W-9 for verification of each tax identification number used.
Copy of workers compensation certificate of coverage, if applicable.

Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, preceptorship, or other clinical education program? ☐ Yes ☐ No

XI. Attestation and Signature – Part II *By signing this application, I certify, agree, understand and acknowledge the following:*

1.	The information in this entire application is complete, current, correct, and not misleading
2.	Any misstatements or omissions (whether intentional or unintentional) on this application may constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement.
3.	A photocopy of this application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4.	I have reviewed the information in this application on the most recent date indicated below and it continues to be true and complete.
5.	While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.
6.	No action will be taken on this application until it is complete and all outstanding questions with respect to the application have been resolved.
7.	This attestation statement and application must be signed no more than 180 days prior to the credentialing decision date..

Signature:

Printed Name: **Date:**

NQCA Illegal Drug Usage Questionnaire

Provider Name _____

Are you currently using illegal drugs that could affect your ability to practice medicine?
(NQCA Required question: CR3, Element C, Factor 2)

YES _____

NO _____

Provider Signature _____

Date _____

NCQA Race, Ethnicity, Language

Completion by the practitioner is optional.
(NCQA Required question: CR3, Element C, Factor 6)

Race _____

Ethnicity _____

Languages(s) Spoken _____

No provider or group will be denied an invitation to participate, or have any contract terminated, on the basis of age, sex, race, creed, color, national origin, religion, marital status, sexual orientation, disability, or type of procedure or patient (e.g. Medicaid) in which the practitioner specializes. (KHF Policy CR1C)

Supplemental Information

Start Date _____

Part Time or Full Time _____

Taxonomy Code _____

Group NPI _____

EMR Name _____

Telemedicine: Yes ☐ or No ☐

CAQH _____
(Please ensure the CAQH is fully complete and attested within the last 6 months.)

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▸ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See **Specific Instructions** on page 3.

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

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

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

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

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▸ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▸

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* 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 amno longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding becauseyou 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 for Part II, later.

Sign Here **Signature of U.S. person** ▸ **Date** ▸

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

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

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

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

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

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

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

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

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

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

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

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

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)11—

A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

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

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

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one ormore established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards,and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)J—A

bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, 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 *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), 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) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. 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
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.