Medical Transportation Program Lodging Provider Enrollment Application

A STATE MEDICAID CONTRACTOR

V1

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Required Forms for Medical Transportation Program Enrollment

To avoid any delay of the enrollment process, use this sheet as a checklist. For assistance with completing these forms, call the TMHP MTP Contact Center at **1-800-925-9126**.

Medical Transportation Program (MTP) Providers

The following forms must be completed and returned for processing:

Lodging Provider:

- ☐ *A copy of the completed Lodging Provider Information pages*
- ☐ *A completed and signed Lodging Provider Rate Information page*
- ☐ *A signed Lodging Provider Agreement*
- ☐ *A completed and signed Provider Information Form (PIF-1)*
- ☐ *A completed and signed Principal Information Form (PIF-2)*
- ☐ *A completed and signed Disclosure of Ownership and Control Interest Statement*
- ☐ *A completed and signed IRS W–9 Form*

If Incorporated

The following forms must be completed and returned for processing:

- ☐ Corporate Board of Directors Resolution Form – *MUST BE NOTARIZED*.
- ☐ *For corporations formed prior to January 1, 2006: Articles or Certificate of Incorporation/Certificate of Authority *(required for in-state corporations; certificate can be obtained from the Office of Secretary of State)*
- ☐ *For corporations formed on or after January 1, 2006: Certificates of Formation or Certificate of Filing
- ☐ *Certificate of Good Standing

*Out-of-state providers not providing services in the state of Texas are exempt

Certificate of Good Standing

This certificate must be obtained from the Texas State Comptroller's Office. Obtain a certificate by contacting the following:

State Comptroller's Office:	Tax Assistance Section
Sales and Use Taxes:	1-800-252-5555
Franchise Tax:	1-800-252-1381
Austin Number:	1-800-252-1386

This request is free and may be made by telephone. The certificate is mailed to the requester. Callers must have the taxpayer's name, federal tax ID number, and the charter number available at the time of the request.

If your corporation has a **501(c)(3) Internal Revenue Exemption**, this certificate is not required. Indicate this exemption by signing the appropriate box on the *Disclosure of Ownership and Control Interest Statemen*t.

Get your money faster with Electronic Funds Transfer (EFT)

For faster payment with direct deposit to your account, complete and return the enclosed EFT Notification form.

NOTE: *Retain a copy of all documents for your records.*

Privacy Statement

With a few exceptions, Texas privacy laws and the *Public Information Act* entitle you to ask about the information collected on this form, to receive and review this information, and to request corrections of inaccurate information. The Health and Human Services Commission's (HHSC) procedures for requesting corrections are in Title 1 of the *Texas Administrative Code*, sections 351.17 through 351.23.

For questions concerning this notice or to request information or corrections, please contact Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at **1-800-925-9126**.

Important — Claim Filing Information

Claim Filing Information

TMHP must receive all claims for Medicaid services within the filing deadline.

When medical services are rendered to an MTP client in Texas, TMHP must receive claims within 95 days of the date of service (DOS) on the claim.

- Claims submitted by newly enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the DOS.
- A valid authorization from MTP does not guarantee payment of a claim, but it is required for payment.

Written Communication

Enrollment Applications:
Texas Medicaid & Healthcare Partnership
Attn: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

Claims:
Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555

Telephone Communication

TMHP Contact Center **1-800-925-9126**

TMHP EDI Help Desk **1-888-863-3638**

Medical Transportation Program Provider Enrollment Application

Lodging Provider Information

- **All information must be completed and contain a valid signature to be processed. If a question or answer does not apply, enter "N/A".**
- **Original signatures only; copies or stamped signatures not accepted.**
- **Use blue or black ink.**

REQUESTING ENROLLMENT AS:

☒ **Facility**

Section A — Provider of Service Information

Existing Texas Provider Identifiers (TPIs): *(List all TPIs associated with the facility enrolling)*
List API and NPI: *(if applicable)*

Group/Facility Name: *(complete as it appears in legal documents)*	
Provider business e-mail: *(if applicable)*	**Provider website address:** *(if applicable)*
Telephone number:	
Physical address: You must give a street address. PO boxes will not be accepted. Number Street Suite City State ZIP	
Accounting/billing address: *(optional)* Number Street Suite City State ZIP	
Physical address FAX number:	**Accounting/billing address FAX number:** *(optional)*
Doing Business As (DBA): *(If applicable, must match Name section of the completed W-9 Form)*	
Toll-Free Reservations Telephone No.:	**Telecommunications Device for the Deaf (TDD) No.:**
Federal ID (FEI) No.:	

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Lodging Provider Information

Physical Description of Facility:

Type of Property: (check one box only) ☐ Hotel ☐ Motel ☐ All-Suite ☐ Bed and Breakfast

Total number of sleeping rooms: _____ Total number of floors: _____

Sleeping room door access: (check both, if applicable) ☐ Inside ☐ Outside

Location of Facility:

Enter **only miles** to local major medical facility, not street directions. (Example: Your facility is located 10 miles from the nearest local major medical facility.)

Full Name of *nearest* local major medical facility: **Distance** from your facility:

_____ _____ miles

Full Name of *secondary* local major medical facility: **Distance** from your facility:

_____ _____ miles

Services and Amenities Offered:

Americans with Disabilities Act (ADA) of 1990 is amended in Volume 42 of the United States Code, Services for Travelers with Disabilities Requirements.

Was your Facility constructed or renovated after 1994? ☐ Yes ☐ No

If yes, were plans filed with Texas Department of Licensing & Regulation? ☐ Yes ☐ No

If yes, was a certificate of compliance issued? ☐ Yes ☐ No

Amenities (check all that apply to your Facility)

- ☐ Non-Smoking Rooms
- ☐ Complimentary Breakfast Included (select only one)
  - ☐ Continental
  - ☐ Full
  - ☐ Buffet
- ☐ Free Parking
- ☐ Complimentary Airport Transportation
- ☐ Complimentary Local Transportation
- ☐ Free Local Phone Calls
- ☐ FAX Services Available
- ☐ Wheelchair Accessible
- ☐ Laundry Facility
- ☐ Refrigerators Available
- ☐ High-Speed Internet Available
- ☐ Copy Service Available
- ☐ Computer/Printer Available
- ☐ Electronic Room Key System
- ☐ 24-Hour Security
- ☐ Trained Dogs Accepted
- ☐ Full Kitchenettes Available
- ☐ Microwave in Room

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Lodging Provider Rate Information

Contract Rates:

Lodging rates must be approved by HHSC/MTP before TMHP can complete enrollment.

In order to enroll with TMHP, rates must be approved by HHSC/MTP and will be valid for a period of one year. After one year of enrollment, providers may submit a request for rate change to HHSC/MTP for possible consideration. HHSC does not guarantee a minimum number of stays at any enrolled establishment. Rates must be quoted at the required percentage discount off your standard single room rate. Below is a scale of required minimum discount percentages allowed.

NOTE: Rates cannot be limited to specific days of the week or change on a seasonal basis.

Single Room Required Minimum Discount	Standard/Rack Rate Off Standard/Rack Rate
$70.00 – or higher	25% or more
$55.00 – $69.99	20% or more
$40.00 - $54.99	15% or more
$30.00 - $39.99	10% or more
$29.99 or less	5% or more

Rates quoted for this contract are for clients. Lodging facilities shall not charge TMHP more than the State Rate.

Observing the above scale, please indicate below the rates you wish to submit to MTP for approval. These rates must include any and all fees imposed by the facility that are conditions of stay (phone, maid services, energy charges, etc.).

Each facility must provide covered lodging services to eligible clients in the same manner, to the same extent, and of the same quality as services provided to other facility guests. Services made available to other guests must be made available to clients. The facility must not charge the client, parent, or guardian for MTP-eligible services.

MTP Contract Rates:

Single Occupancy Room (1 person):	$.	Executive/Concierge:	$.
Double Occupancy Room (2 persons):	$.	King Bedroom Rate:	$.
One Bedroom Suite:	$.	Additional Person Charge: (3 or more persons)	$.
Two Bedroom Suite:	$.		

Signature of Authorized Lodging Representative:	Date of Signature:

Medical Transportation Program Provider Enrollment Application

Lodging Provider Agreement

Lodging Provider Agreement

Medical Transportation Program (MTP) services are authorized under federal and state law. Services for Medicaid were established under 42 United States Code §1396a; 42 Code of Federal Regulations §431.53. Program rules are found under Texas Administrative Code (TAC), Title 1 Part 15 Chapter 380 for MTP and Transportation for Indigent Cancer Patients and Title 25 Part 1 Chapter 38 for Children with Special Health Care Needs (CSHCN) Services Program.

Terms and Conditions

1. Any attempt by the facility to bill or recover money from clients beyond the conditions stated in this agreement is in noncompliance with these rules and constitutes a violation of the agreement between HHSC and the facility for participation in MTP.
2. Warrants may be held by the State Comptroller when there is a tax liability and/or restitutions due on payments to the facility. It will be the responsibility of the facility to resolve these issues with the Comptroller of Public Accounts (CPA).
3. Payment will NOT be made for lodging services when the MTP client does not show (no show). The facility shall guarantee the reservation, up to 7:00 p.m., unless contacted by the client, notifying of a late arrival.
4. The facility understands there is no guarantee on the amount of business under this agreement.

By signing below and accepting payment under this Agreement, the facility agrees that the HHSC Medicaid Provider Agreement and the CSHCN Services Program Provider Agreement have been read and are accepted, as they apply to MTP. These agreements can be found on the TMHP website at www.tmhp.com/mtp. In addition, the facility agrees to furnish any and all disclosures regarding business transactions requested by HHSC or HHS in accordance with 42 CFR §455.105.

Term of the Agreement

I certify that the information listed in this enrollment application is accurate and valid through the current State Fiscal Year. I understand that failure to honor state-established rates, policies, and procedures, including all services offered; submission of inaccurate information; or deficiencies in service levels, could result in cancellation of this enrollment by HHSC/MTP. I further certify that to the best of my knowledge and belief, the facility described herein is in compliance with: a) the ADA; and b) the Texas Health and Safety Code, Title 9, Chapter 792.

NOTE: A failure to certify or a false statement on any of these will disqualify the facility from being listed as an MTP-eligible facility.

Name of Facility:	
Authorized Lodging Representative: Signature of General Manager/Owner ONLY	**Date of Signature:**
Authorized Lodging Representative: Printed	**Representative Title:**
Telephone Number:	**E-mail Address:**

Provider Information Form (PIF-1)

Each Provider must complete this Provider Information Form (PIF-1), before enrollment. A provider is any person or legal entity that meets the definition below.

Each Provider must also complete a Principal Information Form (PIF-2), for each person who is a Principal of the Provider (see the PIF-2 form for a complete definition of every person who is considered to be a Principal of the Provider).

All questions on this form must be answered by or on behalf of the Provider, by ALL provider types (all spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Provider).

The Provider or provider's duly authorized representative must personally review this completed form and certify to the validity and completeness of the information provided by signing the HHSC Medicaid Provider Agreement or other State Health-Care Program Agreement.

"Provider" - Any person or legal entity, including a managed care organization and their subcontractors, furnishing Medicaid services under a State Health-Care Program provider agreement or contract in force with a State Health-Care Program, and who has a provider number issued by the Commission or their designee to:

1. provide medical assistance under contract or provider agreement with HHSC, DSHS or its designee; or
2. provide third party billing services under a contract or provider agreement with HHSC, DSHS or its designee

A "Third-Party Biller" is a type of "Provider" under the above definition and is a person, business, or entity that submits claims on behalf of an enrolled health care provider, but is not the health care provider or an employee of the health care provider. For these purposes, an employee is a person for which the health care provider completes an IRS Form W-2 showing annual income paid to the employee.

Last, First, Middle Initial OR Group/Company name:	**Maiden name:**
List any other alias, name, or form of your name ever used:	**National Provider Identifier (NPI):** *(10-digit)*

Primary Taxonomy Code: *(10-digit)*
Secondary Taxonomy Code: *(10-digit – the provider may indicate up to 15 taxonomy codes; attach additional pages if needed)*
Non-Texas-enrolled Taxonomy Code: *(these codes are informational and describe services the provider performs but for which the provider does not currently bill Texas Medicaid)*

For additional names or addresses, attach pages as necessary.

Physical address: Number	Street	Suite	City	State	ZIP
Accounting/billing address: Number	Street	Suite	City	State	ZIP

If your accounting address is different than your physical address, indicate your relationship to the accounting address:

☐ Third Party Biller ☐ Management Company ☐ Employer ☐ Self ☐ Other *(explain below)*

If you chose **Other**, *please explain:*

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Professional Licensing or Certification Board, Professional License Number and State: *(if applicable)*	**Initial issue date:** MM/DD/YYYY	**Expiration date:** MM/DD/YYYY
Pharmacist Immunization Certification or CCNA Certification:	**Issue date:** MM/DD/YYYY	**Expiration date:** MM/DD/YYYY

Social Security Number:	**Federal Tax ID number:**
Specialty of practice: *(i.e., pediatrics, general practice, etc.)*	**Medicare intermediary:** *(if applicable)*
Medicare provider number: *(if applicable)*	**Medicare effective date:** MM/DD/YYYY *(if applicable)*

Driver's license number:	**State:**	**Driver's license expiration date:** MM/DD/YYYY

Date of birth: MM/DD/YYYY		**Gender:**	☐ Male ☐ Female

CLIA Number: *(attach a copy of the CLIA certification, if applicable)*
Hospitals providing laboratory services, and independent laboratories (including those located in physician's offices), must answer all CLIA certification questions. The CLIA rules and regulations are available on the CMS website at www.cms.gov.

CLIA address: *(list the address listed on the CLIA Certificate, if applicable)*

Number	Street	Suite	City	State	ZIP

Previous Physical address:

Number	Street	Suite	City	State	ZIP

Previous Accounting address:

Number	Street	Suite	City	State	ZIP

Do you plan to use a Third Party Biller to submit your health-care claims?

☐ Yes ☐ No *If* **Yes**, *provide the following information about the billing agent.*

Billing agent name:	**Address:**
Federal Tax ID number:	
Contact person name:	**Telephone number:**

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
4.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
5.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action. **Have you ever been sanctioned (as defined above) in any state or federal program?**	☐ Yes ☐ No
If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*	
Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☐ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☐ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	☐ Yes ☐ No
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action? *(You may be subject to a license or certification verification/status check with your licensing or certification board.)*	☐ Yes ☐ No
If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*	
"Convicted" means that: **(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:** **(1) There is a post-trial motion or an appeal pending, or** **(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;** **(b) A Federal, State or local court has made a finding of guilt against an individual or entity;** **(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or** **(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.** **Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?** *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☐ No
If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*	
Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☐ Yes ☐ No
If **No**, *of what country are you a citizen?* *If you answered* **No** *above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	

Principal Information Form (PIF-2)

Required for any person or entity not seeking a Provider Identifier but meets the definition of a "Principal" or "Subcontractor" as defined below.

A separate copy of this Principal Information Form (PIF-2) must be completed in full for each Principal or Subcontractor of the Provider, before enrollment.

A **Principal** of the Provider is defined as follows:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations

A **Subcontractor** of the Provider is defined as follows:

- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies

All spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Principal or Subcontractor.

The Provider or provider's duly authorized representative must personally review each copy of this completed form and certify to the validity and completeness of the information provided by signing the HHSC Medicaid Provider Agreement.

Check principal or subcontractor: ☐ Principal ☐ Subcontractor	
Name – Last, First, Middle Initial:	**Maiden name:**
List any other alias, name, or form of your name ever used:	

For additional names or addresses, attach pages as necessary.

Physical address: Number	Street	Suite	City	State	ZIP
Accounting/billing address: Number	Street	Suite	City	State	ZIP

If your accounting address is different than your physical address, indicate your relationship to the accounting address:

☐ Billing agent ☐ Management company ☐ Employer ☐ Self ☐ Other *(explain below)*

If you chose **Other**, *please explain:*

Professional Licensing or Certification Board, Professional License Number and State: *(if applicable)*	**Initial issue date:** MM/DD/YYYY	**Expiration date:** MM/DD/YYYY
Pharmacist Immunization Certification or CCNA Certification:	**Issue date:** MM/DD/YYYY	**Expiration date:** MM/DD/YYYY

Social Security Number:	**Federal Tax ID number:**
Specialty of practice: *(i.e., pediatrics, general practice, etc.)*	**Medicare intermediary:** *(if applicable)*
Medicare provider number: *(if applicable)*	**Medicare effective date:** MM/DD/YYYY *(if applicable)*

Driver's license number:	**State:**	**Driver's license expiration date:** MM/DD/YYYY

Date of birth: MM/DD/YYYY		**Gender:**	☐ Male ☐ Female

Previous Physical address: Number Street Suite City State ZIP
Previous Accounting address: Number Street Suite City State ZIP

Your title in the provider organization for which enrollment is being sought:
Your duties to the provider organization: *(attach additional sheets if necessary)*
Your relationship to the provider organization. Relationship types include Accountant, Aunt/Uncle/Cousin, Acquaintance, Agency, Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Ex-Spouse/Ex-Domestic Partner, Friend, Grandparent, Government Official , In-Law/Ex-In-Law, Individual (Contracted), Individual (Fiscal Agent), Limited Partner, Managing Employee, Non-Limited Partner, Nurse, Official, Owner (Direct), Owner (Indirect) Parent, Recruiter, Representative, Shareholder, Sibling, Son/Daughter, Spouse/Domestic Partner, Subcontractor, or Unknown: *(attach additional sheets if necessary)*
List all TPIs, provider names, and physical locations under which you have billed or in which your were a principal. Include current and previous TPIs : *(attach additional sheets if necessary)*

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
4.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
5.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action. **Have you ever been sanctioned (as defined above) in any state or federal program?**	☐ Yes ☐ No

If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*

Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☐ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☐ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	☐ Yes ☐ No
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action? *(You may be subject to a license or certification verification/status check with your licensing or certification board.)*	☐ Yes ☐ No

If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*

"Convicted" means that: **(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:** **(1) There is a post-trial motion or an appeal pending, or** **(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;** **(b) A Federal, State or local court has made a finding of guilt against an individual or entity;** **(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or** **(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.** **Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?** *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☐ No

If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*

Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☐ No

If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*

Are you a citizen of the United States?	☐ Yes ☐ No

If **No**, *of what country are you a citizen?*

If you answered **No** *above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*

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Disclosure of Ownership and Control Interest Statement

Instructions

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section referencing the item number to be continued. If additional space is needed, use an attached sheet.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. NO instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

ITEM I – Identifying Information

(a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, and name of trade or corporation.

ITEM II – Self–explanatory.

ITEM III – Entity

List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if “A” owns 25 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, “A’s” interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

*All individuals listed on section IIIa must submit a PIF-2

ITEMS IV through VII – Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For items IV through VII, if the **Yes** box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

ITEM IV – Ownership

(a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

ITEM V – Management

If the answer is **Yes**, list name or the management firm and employer identification number (EIN) or the leasing organization. A management company is defined as any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

ITEM VI – Staffing

If the answer is **Yes**, identify which has changed (Administrator, Medical Director or Director of Nursing) and the date the change was made. Be sure to include name of the new administrator, Director of Nursing or Medical Director, as appropriate.

ITEM VII – Affiliation

A chain affiliate is any freestanding health-care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more freestanding health-care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital–based home health agencies are not considered to be chain affiliates.

ITEM VIII – Capacity

If the answer is **Yes**, list the actual number of beds in the facility now and the previous number.

Rev. 10/22/09

Disclosure of Ownership and Control Interest Statement

This form is required for all individuals, groups, and facilities (exclude performing providers).

I.	Identifying information		
(a)	**Legal Name:** *(according to the IRS)*	**DBA:**	**Telephone number:**
	Physical Address: Number Street Suite City State ZIP		

II.	Answer the following questions by checking **Yes** or **No**. *If any of the questions are answered Yes, list names and addresses of individuals or corporations under Remarks on the Disclosure of Ownership and Control Interest Statement form. Identify each item number to be continued.*	
(a)	**Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?**	☐ Yes ☐ No
(b)	**Does this provider have any current employees in the position of manager, accountant, auditor, or in a similar capacity and who were previously employed by this provider's fiscal intermediary or carrier within the last 12 months?** *(Medicare providers only)*	☐ Yes ☐ No

III.	Entity		
(a)	**In addition to the owners identified in Section B of the Texas Medicaid Enrollment Application, list the name of every other person or entity with ownership of a controlling interest in the applicant entity (whether such ownership of the controlling interest is direct or indirect). In the case of persons, provide the person's full name and address. In the case of entities, provide the entity's name and federal tax identification number.** *See Instructions for Completing the Disclosure of Ownership and Control Interest Statement. List any additional names and addresses under Remarks on the Disclosure of Ownership and Control Interest Statement. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.*		
	Name:	**Address:**	**Federal Tax ID Number:**
(b)	**Type of Entity:** *(select only one - must match entity on W-9)*		
	☐ Sole proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated ☐ Association ☐ Other *(specify)* _____		
(c)	**If the disclosing entity is a corporation, list names, addresses of the directors and EINs for corporations in remarks.** *(attach additional pages if needed)*		
	Remarks:		

IV.	Ownership	
(a)	**Has there been a change in ownership or control within the last year?**	☐ Yes ☐ No
	If **Yes**, *give date:*	
(b)	**Do you anticipate any change of ownership or control within the year?**	☐ Yes ☐ No
	If **Yes**, *give date:*	
(c)	**Do you anticipate filing for bankruptcy within the year?** *(see provider agreement for additional information)*	☐ Yes ☐ No
	If **Yes**, *give date:*	

Rev. 10/22/09

Disclosure of Ownership and Control Interest Statement

This form is required for all individuals, groups, and facilities (exclude performing providers).

V.	Management	
	Does the provider identified in Section I. above comprise or include a facility that is operated by a management company, or a facility that is leased in whole or in part by another organization?	☐ Yes ☐ No
	If **Yes**, *give date of change in operations:*	

VI.	Staffing	
(a)	**Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?**	☐ Yes ☐ No

VII.	Affiliation	
(a)	**Is the provider identified in Section I. above chain affiliated?**	☐ Yes ☐ No
	If **Yes**, *provide the name, address, and Federal Tax ID number of the chain's corporate/home office:* Name Address Federal Tax ID	

VIII.	Capacity	
(a)	**Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years?** *(For Hospitals only)*	☐ Yes ☐ No
	If **Yes**, *give:* **Year of change:** **Current Beds:** **Prior Beds:**	

Please Note: When claiming "Corporation" providers must complete and return the following forms:

- Corporate Board of Directors Resolution Form must be completed with signature and notary stamp or seal
- Certificate of Formation or Certificate of Filing or Certificate of Authority
- Letter of Good Standing from the Texas State Comptroller's Office. It is a requirement of H.B. 175. A certificate can be obtained by contacting:

State Comptroller's Office — Tax Assistance Section

Sales and Use Taxes:	1-800-252-5555
Franchise Tax:	1-800-252-1381
Austin Number:	1-800-252-1386

There is no charge for this request. The request may be made by telephone, and the certificate will be mailed to the requestor. Callers must have the taxpayer's name, federal tax ID number, and charter number available at the time of the request. If the corporation has a 501(c)(3) Internal Revenue Exemption, Letter of Good Standing is not required. Indicate this by signing below:

Do you have a 501(c)(3) Internal Revenue Exemption?	☐ Yes ☐ No

Entity Name:	**Name:** *(printed/typed)*
Signature: *(if 501(c)(3) exempt)*	**Date:**

Corporate Board of Directors Resolution

THE FOLLOWING FORM IS FOR CORPORATIONS ONLY,
AS INDICATED ON THE DISCLOSURE OF OWNERSHIP, QUESTION III (B).

State Of _____

County Of _____

On The _____ Day Of _____, 20_____, at a meeting of The Board Of Directors Of _____, A Corporation, held in the city of _____, in_____ county.

With A Quorum Of The Directors Present, The Following Business Was Conducted:

It was duly moved and seconded that the following resolution be adopted: Be it resolved that the board of directors of the above corporation do hereby authorize

_____

and his/her successors in office to negotiate, on terms and conditions that he/she may deem advisable, a contract or contracts with the Texas Health and Human Services Commission, and to execute said contract or contracts on behalf of the corporation, and further we do hereby give him/her the power and authority to do all things necessary to implement, maintain, amend, or renew said contract.

The above resolution was passed by a majority of those present and voting in accordance with the by–laws and Articles of Incorporation.

I certify that the above constitutes a true and correct copy of a part of the minutes of a meeting of the board of directors of

_____,

held on the _____ day of _____, 20_____.

_____
Signature of Secretary

Subscribed and Sworn Before Me, _____, a Notary Public for the County of _____, on the _____ day of _____, 20____.

Notary Stamp/Seal

Notary Public, County of _____

State of _____

Signature _____

MESSAGE TO NOTARY:

COMPLETE ALL OF THE BLANKS IN THIS NOTARY STATEMENT.

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

Request for Taxpayer Identification Number and Certification

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

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

Name (as shown on your income tax return)

Business name, if different from above

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

☐ Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

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

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

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

General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

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

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

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

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

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

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

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

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Cat. No. 10231X Form **W-9** (Rev. 10-2007)

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

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

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

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

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

2. The treaty article addressing the income.

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

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

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

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

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

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

Payments you receive will be subject to backup withholding if:

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

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

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

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

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

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

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

Penalties

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

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

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

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

Specific Instructions

Name

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

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

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

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

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

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

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

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

Exempt Payee

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

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

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

The following payees are exempt from backup withholding:

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

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

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

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

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

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

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

10. A real estate investment trust,

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

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

13. A financial institution,

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

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

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

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

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

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

Part I. Taxpayer Identification Number (TIN)

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

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

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

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

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

Part II. Certification

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

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

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

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

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

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

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

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

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

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

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

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

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

Secure Your Tax Records from Identity Theft

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

To reduce your risk:

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

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

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

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

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

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.consumer.gov/idtheft* or 1-877-IDTHEFT(438-4338).

Visit the IRS website at *www.irs.gov* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Electronic Funds Transfer (EFT) Notification

Electronic Funds Transfer (EFT) is a payment method used to deposit funds directly into a provider's bank account. These funds can be credited to either checking or savings accounts, if the provider's bank accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks by ensuring funds are directly deposited into a specified account.

The following items are specific to EFT:

- Pre-notification to your bank occurs on the weekly cycle following the completion of enrollment in EFT.
- Future deposits are received electronically after pre-notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated R&S reports are cross-referenced by both the provider identifiers (i.e., NPI, TPI, API) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Thursday.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

> Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Contact your financial institution regarding posting time if funds are not available on the release date.
>
> However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution, who in turn should work out the best way to serve their customer's needs.
>
> In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. ***You must return a voided check or signed letter from your bank on bank letterhead with the agreement to the TMHP address indicated on the form.***

Call the **TMHP Contact Center** at **1-800-925-9126** if you need assistance.

Electronic Funds Transfer (EFT) Notification

NOTE: *Complete all sections below and* ***attach a voided check or a signed letter from your bank on bank letterhead.***

Type of authorization: ☐ New ☐ Change			
Provider name:		**Billing TPI:** *(9-digit)*	
National Provider Identifier (NPI)/Atypical Provider Identifier (API):		**Primary taxonomy code:**	
List any additional TPIs that use the same provider information:			
TPI:	**TPI:**	**TPI:**	**TPI:**
TPI:	**TPI:**	**TPI:**	**TPI:**
Provider accounting address: Number Street Suite City State ZIP			
Provider phone number:			
Bank name:		**Bank phone number:**	
ABA/Transit number:		**Account number:**	
Bank address:		**Account type:** *(check one)*	
		☐ Checking ☐ Savings	

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

Authorized signature:	**Date:**
Title:	**E-mail address:** *(if applicable)*
Contact name:	**Contact phone number:**

Return this form to:
Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

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