Ohio Department of Mental Health

30 East Broad Street
Columbus, Ohio 43215-3430

Date: June 16, 2008

To: Executive Directors
Community Mental Health Agencies

From: Angie Bergefurd, Assistant Deputy Director
Ohio Department of Mental Health

Subject: Ohio Department of Job & Family Services (ODJFS) Medicaid Provider Agreement

PLEASE READ THIS DOCUMENT BEFORE YOU COMPLETE THE ENCLOSED MATERIAL

Recent changes in State Law require the Ohio Department of Job and Family Services (ODJFS) to implement three year time-limited Medicaid provider agreements for all providers participating in Ohio's Medicaid program. To comply with this requirement and to assure timely renewal of provider agreements, ODJFS will be tracking all Medicaid provider agreements and their termination dates.

In collaboration with ODJFS, the Ohio Department of Mental Health (ODMH) will be requesting, collecting and submitting all provider agreements for providers of Medicaid-covered community mental health services to ODJFS. Included with this letter is the ODJFS Medicaid provider agreement specifically for providers of community mental health services. Please complete and return this agreement to ODMH no later than **August 1, 2008** to ensure your continued participation in Ohio's Medicaid program, including your ability to be paid for Medicaid-covered community mental health services.

Each section of the application contains specific instructions for completion, therefore, please read each section carefully. Several sections require attachments to be submitted. Sections of the application that are not applicable to your provider type, which is "ODMH certified community mental health agency", have been shaded-out; please be sure to leave those areas blank. It is especially important that an authorized representative, usually the Executive Director of the agency, sign the provider agreement. Medicaid reimbursement is contingent upon a valid provider agreement being in effect when services are/were provided. In addition to the provider application and its required attachments, you must also complete and submit the Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization Form, which can be accessed on the ODJFS website using the following link: http://jfs.ohio.gov/OHP/bpo/pnms/providerDocuments/dma.pdf.

Please make sure the following forms are completed and included in your submission:

- ✓ Ohio Health Plans Provider Enrollment Application/Time Limited Agreement for Organizations (JFS 06751)
- ✓ Signed W-9 form
- ✓ Copy of the notice from the NPI Enumerator
- ✓ Copy of Department of Health and Human Services approval letter for Medicare Identification (if applicable)
- ✓ Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization form (HLS 0038)

Do not submit the agreement directly to ODJFS as it will not be accepted. Completed agreements and required attachments are to be mailed to:

Margie Herrel, Program Administrator
Ohio Department of Mental Health
30 E. Broad St., 7th Floor
Columbus, OH 43215

ODMH will be forwarding all agreements to ODJFS for their processing and ODJFS will return all approved or denied agreements to ODMH for return to the submitting provider organization. **Unsigned, incomplete or applications without required attachments will be returned as denied.**

If you have any questions, please contact Margie Herrel at 614-466-9655 or herrelm@mh.state.oh.us.

CC: ADAMH/CMH Board
Ohio Association of County Behavioral Health Authorities
Ohio Association of Child Caring Agencies
Ohio Council of Behavioral Health Care Providers
Family Services Council of Ohio
Ed Zachrich, Ohio Department of Job & Family Services

On behalf of ODJFS, Submit completed signed application/agreement with required attachments to:
Margie Herrel, Program Administrator
Ohio Department of Mental Health
30 E. Broad St., 7th Floor
Columbus, OH 43215

(For State Use Only)

Ohio Health Plans Provider Enrollment Application/Time Limited Agreement for Organizations (*Medicaid Program*)

Complete all applicable items if you plan to bill Medicaid as a sole proprietor of a business, or if you are a publicly or privately held business with more than one owner. (This does not apply to individual practitioners or practitioner groups.)

Organizational Provider Types: - Required

Mark the **ONE** appropriate type

- ☐ Ambulance (82)
- ☐ Ambulatory Surgery Center (46)
- ☐ Ambulette (83)
- ☐ Assisted Living Waiver Provider (74)
- ☐ Durable Medical Equipment (76)
- ☐ End-Stage Renal Disease Dialysis Clinic (59)
- ☐ Family Planning Clinic (54)
- ☐ Federally Qualified Health Center (12)
- ☐ General Hospital (01)
- ☐ Hearing and Speech Clinic (58)
- ☐ Home Health Agency (Medicare Cert.) (60)
- ☐ Home Health Agency (JC/CHAPS) (16)
- ☐ Hospice (44)
- ☐ Independent Diagnostic Testing Facility (IDTF) (79)
- ☐ Independent Laboratory (80)
- ☐ Medicaid School Program (28)
- ☐ Mental Health Clinic (51)
- ☐ Mental Hospital (02)
- ☐ Optician (75)
- ☐ Outpatient Health Facility (04)
- ☐ Outpatient Rehabilitation Clinic (53)
- ☐ ODADAS Certified/Licensed Treatment Program
- ☐ PACE (08)
- ☐ Pharmacy (70)
- ☐ Portable X-ray Laboratory 81)
- ☐ Primary Care Clinic (50)
- ☐ Professional Dental School Clinic (56)
- ☐ Professional Optometry School Clinic (55)
- ☐ Public Health Department Clinic (52)
- ☐ Rural Health Clinic (05)
- ☐ Targeted Case Management (85)
- ☐ Waiver Service Provider (45)
- ☐ ODMH Certified Comm Mental Hlth Agency

Provider Identification: - Required

(Print or type entries)

Organization Name

Abbreviated Organization Name (If your name exceeds 30 spaces, indicate preferred abbreviation.)

Employer Identification Number	**You must attach a signed W-9 form**

Address Information: - Required

Physical Location of Business (Applicants: If more than one location, list Primary. Required field)

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

"Pay to" Address (Name & Address to which Payment and/or Remittance Advice is to be mailed)

(If Address is not different from "Physical Location of Business" address, leave blank)

Building Name / **or** / Department / **or** / In care of		
Address		Suite Number
City	State	Zip Code (Zip + 4, if possible)

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

(If Address is not different from "Physical Location of Business" address, leave blank)

Building Name / **or** / Department / **or** / In care of		
Address (P.O. and Drop Boxes are not acceptable)		Suite Number
City	State	Zip Code (Zip + 4, if possible)

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National Provider Identifier:

If you have received your National Provider Identifier (NPI) number, please report it here:

NPI number **

If you had a previous NPI number, please report it here:

NPI number

** You must attach a copy of the notice from the NPI Enumerator to verify the National Provider Identifier Number.

Medicare Identification Information: - Required if applicable

PIN number*	PIN number*	DMERC number*

You must attach copy of CMS Approval Letter.

Clinical Laboratory Improvement Act Information - REQUIRED FOR ALL HOSPITALS AND ALL LABORATORIES

CLIA number*	CLIA number*	CLIA number*
* You must attach copy of CLIA Certificate	* You must attach copy of CLIA Certificate	* You must attach copy of CLIA Certificate

Optional Categories of Service:

Check your Provider Type, and any other Categories of Service you are licensed and/or authorized to provide.

Provider Type	Optional Category of Service
☐ Ambulance (82)	☐ Ambulette Services (38)
☐ End-Stage Renal Disease Dialysis Clinic (59)	☐ Prescribed Drugs (30) ☐ Supplies & Med Equip (32)
☐ Family Planning Clinic (54)	☐ Supplies & Med Equip (32)
☐ General Hospital (01)	☐ Ambulance Services (37) ☐ Ambulette Services (38)
☐ Mental Health Clinic(51)	☐ Supplies & Medical Equip(32)

Provider Type	Optional Category of Service
☐ Outpatient Rehabilitation Clinic (53)	☐ Supplies & Med Equip (32)
☐ Primary Care Clinic (50)	☐ Dental Services (45) ☐ Optometric Services (47) ☐ Advanced Practice Nurse (21) ☐ Supplies and Medical Equip (32) ☐ Physician Services (43) ☐ EPSDT Services (40)
☐ Professional Optometry School Clinic (55)	☐ Supplies & Med Equip (32)
☐ Public Health Department Clinic (52)	☐ Dental Services (45) ☐ Optometric Services (47) ☐ Supplies & Medical Equip (32)

Federally Qualified Health Centers, Rural Health Facilities, Outpatient Health Facilities

Providers may be enrolled as only one type of alternative payment clinic. An “alternative payment clinic” shall be defined as an FQHC, rural health clinic (RHC), or outpatient health facility (OHF). Check the appropriate box:

☐ Section 330 of Public Health Service Act grants – recipient or under a contract with the recipient
(include documentation from CMS that identifies the specific service site(s) included in the 330 public health services project)

☐ Health and Human Services Certification as a Federally Qualified Health Center
(include documentation from US secretary of health and human services confirmation letter that the service site(s) is/are considered an FQHC look-alike with respect to Medicaid coverage)

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Medicaid School Program

Ohio Department of Education Information Retrieval Number:	Information Retrieval Number*	* You must attach a copy of the Information Retrieval Number notification.

Clinics *Check the applicable Clinic Provider Type , and attach a copy of the required documentation as indicated for your Provider Type*

Ambulatory Health Care Clinics – Required

Provider Type	Required documentation (to be submitted with application)
☐ 59 - End-Stage Renal Dialysis Clinic	☐ Medicare Certification as a Dialysis Clinic ☐ Licensure by the Ohio Department of Health as a dialysis provider
☐ 54 - Family Planning Clinic	☐ Affiliation with the Planned Parenthood Federation of America (PPFA) ☐ Grant award for the provision of family planning services under Title X of the Public Health Services Act ☐ Grant award through the Ohio Department of Health for family planning services under the Child and Family Health Services program ☐ Grant award through the Ohio Department of Health's Women's Health Services, in accordance with rule 3701-68-01 of the Administrative Code
☐ 58 - Hearing and Speech Clinic	☐ Specialize in either speech language/audiology services or diagnostic imaging services
☐ 51 - Mental Health Clinic	☐ Ohio Department of Health Recognition as an Alcoholism Outpatient and After-care ☐ Services Program. ☐ Ohio Department of Mental Health Certification as an Outpatient Mental Health Facility.
☐ 53 – Outpatient Rehabilitation Clinic	☐ Medicare Certification as an Outpatient Rehabilitation Clinic OR ☐ Medicare Certification a Comprehensive Outpatient Rehabilitation Clinic
☐ 50 - Primary Care Clinic	☐ Joint Commission Accreditation ☐ Accreditation Association for Ambulatory Health Care (AAAHC) ☐ Healthcare Facilities Accreditation Program of the American Osteopathic Association ☐ Community Health Accreditation Program (CHAP) ☐ Receipt of state or federal grant funds for the provision of health services
☐ 56 – Professional Dental Dental Clinic	☐ Accreditation by the Council on Dental Education (CODA) of the American ☐ Dental Association (ADA)
☐ 55 – Professional Optometry School Clinic	☐ Accreditation by the Council on Optometry Education (ACOE) of the American ☐ Optometric Association
☐ 52 - Public Health Department Clinic	☐ Legal Status as a County Health Department, City Health Department, or Combined Health District

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Hospitals - Required

Hospital License Registry Number*	License Registry Date (mm/dd/yyyy)	Current License Registry Expiration Date* (mm/dd/yyyy)

*You must attach copy of License

Hospital Beds - **You must attach a copy of the letter from Department of Health with Your Bed Certification.**

TOTAL HOSPITAL BEDS ______

Please check all that apply and attach supporting documentation for each block checked

- ☐ Children's Hospital
- ☐ Hospital has a Distinct Part Psychiatric Unit
- ☐ Major Teaching Hospital (Submit intern to bed ratio from fiscal intermediary)
- ☐ Rural Referral Center
- ☐ For hospitals in Ohio, please specify Nursery Level (Submit documentation from Ohio Dept. of Health) ☐ Level 1 ☐ Level 2 ☐ Level 3
- ☐ Rehabilitation Hospital
- ☐ Long Term Acute Care Hospital
- ☐ Cancer Hospital
- ☐ HMO owned Hospital
- ☐ Specialty Hospital (Please Specify)__________________

If you provide Pharmacy and/or Ambulance/Ambulette services you must also complete the Pharmacy and Transportation sections of this application

National Provider Identifier: Secondary NPIs

Psychiatric Unit NPI	Rehabilitation Unit NPI

Hospital Cost Report Contact- Required

Name/Title				
Address				Suite Number
City			State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address		

Hospital Care Assurance Program (HCAP) Contact

(If contact is not different from "Hospital Cost Report Contact,", leave blank.)

Name/Title				
Address				Suite Number
City			State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address		

Upper Payment Limit (UPL) Program Contact

(If contact is not different from "Hospital Cost Report Contact,", leave blank.)

Name/Title				
Address				Suite Number
City			State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address		

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Pharmacies - Required

State Pharmacy Board License Number*

*You must attach a copy of license.

DEA Registration Number*

*You must attach a copy of Controlled Substance Registration Certificate

Name of Licensed, Registered Pharmacist (In full and actual charge of the Pharmacy)(print or type.)

Pharmacist's License Number*	Pharmacist's Signature	Date of Signature (mm/dd/yyyy)

*You must attach a copy of license.

Medical Suppliers - Required

State Vendor's License Number* **or** Orthotics / Prosthetics License Number* **or** State Tax Exemption Certificate Number*

*You must attach a copy of license. *You must attach a copy of license. *You must attach a copy of Certificate.

Do you have a Respiratory Board license? ☐ YES ☐ NO (This is required to bill for respiratory services)

State Respiratory Board License Number*	Date license was issued (mm/dd/yyyy)	Date license expires (mm/dd/yyyy)

*You must attach a copy of license. *You must attach a copy of license.

Are you dispensing hearing aids? ☐ YES ☐ NO If yes, please enter the appropriate License Number below.

Hearing Aid Dispensor License Number* **or** Audiologist License Number*

*You must attach a copy of license. *You must attach a copy of license.

Independent Diagnostic Testing Facilities - Required

Physician's Certification: *I certify that* (check one):

☐ I own or partially own the facility and employ the operating personnel.

☐ I am a part-time employee or an employee under contract whose responsibilities include checking the procedural and quality control manuals, observing the operator's or technician's performance, verifying that the equipment and personnel meet applicable federal, state, and local licensure and registration requirements, and assuring that safe operating procedures and quality control procedures are used.

Physician's Name (print)	Physician's Signature	Date of Signature (mm/dd/yyyy)

Eligible Medicaid providers of Independent Diagnostic Testing Facility services must meet the following criteria:

1. Possess a current unrevoked or unsuspended Medicare Provider Number as an Independent Diagnostic Testing Facility.
2. Be in conformity with all applicable federal, state, and local laws and regulations.
3. Provide nonradiological services under the general supervision of a physician who is certified or meets the requirements and/or training in the performance and interpretation of diagnostic testing procedures.
4. Provide radiological services under the following conditions:
   a) The services are performed under the general supervision of a licensed doctor of medicine or licensed doctor of osteopathy who is qualified by advanced training and experience in the use of x-rays as defined below:
      i) The physician is certified in radiology by the American Board of Radiology or by the American Osteopathy Board of Radiology or possesses qualifications which are equivalent to those required for such certification;
      ii) The physician is certified or meets the requirements for certification in a specialty in which the physician has become qualified by experience and/or training in the use of x-rays for diagnostic purposes.
   b) All operators of the x-ray equipment must meet the following requirements:
      i) Successful completion of a program of formal training in x-ray technology of not less than 24 months duration in a school approved by the Council on Education of the American Medical Association, or have earned a bachelor of science degree or associate degree in radiology technology from an accredited college or university.
      ii) For those whose training was completed prior to July 1, 1966, but on or after July 1, 1960, successful completion of 24 full months of training under the direct supervision of a physician who meets the definition of a qualified physician.
5. Radiology procedures are conducted in compliance with radiology safety standards which assure that the equipment and the operating procedures used minimize the radiation exposure and hazards for patients, personnel, and other persons in the immediate environment. X-ray equipment and shielding are inspected by qualified individuals at intervals not greater than every 24 months.

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Ambulance/Ambulette Transportation Services

Are you publicly owned and operated? ☐ Yes ☐ No If no, enter your ***State Medical Transportation Board Service Number**** here	Medicare Certification Number (Ambulance Provider Applicants only)*
*** You must attach a copy of the State Medical Transportation Board Certificate of Licensure**	*** You must attach a copy of the Medicare Certification**

Ambulance/Ambulette Personnel

(This page may be copied as needed to list all drivers.)

Ambulance providers: All drivers must have EMT certification (include a copy of EMT card for each driver with the application)
A copy of each driver's driving record from the Bureau of Motor Vehicles to be submitted with the application.
Ambulette providers:
Each driver and each attendant must have a current card as proof of successful completion of the "American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certification
Each card must be signed and a copy of each driver's card, front and back, must be included with the application
OR EMT certification for each driver/attendant (include a copy of each driver's/attendant's EMT card with the application)

List the driver/attendant information below. Be sure to include the appropriate certification cards with the application for each driver/attendant. Please print or type all responses.

Driver/Attendant's Name	**EMT Card Number** Required for Ambulance Drivers	**American Red Cross Basic/ Community First Aid and CPR**	**EMT Expiration Date or Completed Date of American Red Cross Basic/ Community First Aid Training/CPR (mm/dd/yyyy)**
		First Aid:	EMT expiration date or First Aid completion date
Driver Attendant		CPR:	CPR completion date
		First Aid:	EMT expiration date or First Aid completion date
Driver Attendant		CPR:	CPR completion date
		First Aid:	EMT expiration date or First Aid completion date
Driver Attendant		CPR:	CPR completion date
		First Aid:	EMT expiration date or First Aid completion date
Driver Attendant		CPR:	CPR completion date
		First Aid:	EMT expiration date or First Aid completion date
Driver Attendant		CPR:	CPR completion date
		First Aid:	EMT expiration date or First Aid completion date
Driver Attendant		CPR:	CPR completion date

(For State Use Only)

Requirements for Ambulette Vehicle Providers
Documents to be included with the application

You must include, with your application, copies of documents for each item listed on this page. In addition, all ambulette vehicle providers must have documented proof on file of compliance with the following requirements, to be available upon request from the Department of Job and Family Services.

Check each block to certify compliance and include required documentation

- ☐ Currently, the ambulette service is operating ______ vehicles. The provider maintains a valid current vehicle license registration with the Ohio Bureau of Motor Vehicles for each vehicle.
  Include a copy of the vehicle registration for each vehicle.
- ☐ Each vehicle displays the company logo, insignia, or name on both sides and rear of the vehicle.
  Include photos of each vehicle for verification.
- ☐ The provider maintains liability insurance coverage in the amount of not less than five hundred thousand dollars per occurrence and not less than five hundred thousand dollars in the aggregate, for any cause for which the provider would be liable. Include proof of insurance.
- ☐ The provider maintains bodily injury and property damage insurance with solvent and responsible insurers licensed to do business in this state for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any ambulette vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from any one accident. Include proof of insurance.
- ☐ Each driver and attendant must submit himself or herself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been indicted, convicted, or pleaded guilty to violation cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the revised code shall not provide services to medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply.
  Include a copy of the BCI criminal background check results.
- ☐ Each driver and each attendant has current cards issued as proof of successful completion of the "American Red Cross" (or equivalent) basic or community course in first aid and CPR. Each card must be signed on the back by the driver or attendant who completed the course.
  Include a copy of each card for each driver and attendant with the application.
- ☐ Each driver must have a copy of his or her driving record provided from the Bureau of Motor Vehicles. The date of the driving record submitted at the time of the application must be no more than fourteen days prior to the date of application for employment. Persons with six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulette driver.
  Include a copy of each driver's driving record with the application.
- ☐ The qualifications of each driver and each attendant must comply with local, state, and federal laws and regulations, including a valid driver's license and be eighteen years or older.
  Include a copy of a valid driver's license for each driver.

(For State Use Only)

Requirements for Ambulette Vehicle Providers

All ambulette providers must certify that they operate vehicles that meet the following standards and have documentation to verify compliance that is available upon request.

Check each block to certify compliance

☐	Each vehicle is specifically designed to transport one or more patients sitting in wheelchairs and has fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement. In addition, the vehicle is equipped with restraints to secure the patient in the wheelchair.
☐	Each vehicle has a minimum ceiling to floor height of fifty-six inches.
☐	Each vehicle is equipped with a communication system capable of two-way communication.
☐	Each vehicle is equipped with a stable access ramp or hydraulic lift.
☐	The provider must conduct daily inspection and testing of the hydraulic lift or access ramp.
☐	Each vehicle is equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit.
☐	Each vehicle has provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.
☐	The provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum wheelchair restraints, wheelchair lifts, lights, windshield wipers/washers, emergency equipment, mirrors, and brakes.
☐	The provider maintains on file evidence that at least an annual vehicle inspection was completed by the Ohio State Highway Patrol Safety Inspection Unit, or a certified mechanic and each vehicle has been determined to be in good working condition.
☐	Each ambulette driver and each attendant has an identification card available to the patient identifying his or her complete name and company affiliation.
☐	The provider maintains on file a signed statement from a licensed physician for each driver and attendant declaring that they do not have physical, including vision and hearing, or mental limitation likely to interfere with safe driving, passenger assistance, or emergency activity and does not have a communicable disease that could jeopardize the health or welfare of patients being transported.
☐	Each ambulette driver has undergone testing for alcohol and controlled substances in accordance with 49 CFR 382.
☐	Each ambulette and each attendant has completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.

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Disclosure and Ownership/Control Interest Statement

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

1. A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, agency, or practice that have been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ **YES** ☐ **NO**

Name	When? Give date (mm/dd/yyyy)	SSN/EIN
Name	When? Give date (mm/dd/yyyy)	SSN/EIN

1. B. Are there any directors, officers, agents, or managing employees of the institution, agency, organization, or practice who have ever been indicted or convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

☐ **YES** ☐ **NO**

Name	When? Give date (mm/dd/yyyy)	SSN/EIN
Name	When? Give date (mm/dd/yyyy)	SSN/EIN

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

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

2. B. Type of Entity or Practice: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated Associations ☐ Other (specify)____

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

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

2. D. Have you ever been issued an Ohio Medicaid 7-digit Provider Number?

☐ **YES** ☐ **NO** If, YES, you must list them in the boxes below.

7-digit Provider Number	7-digit Provider Number	7-digit Provider Number	7-digit Provider Number

(For State Use Only)

2.E. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership, or Members of the Board of Directors.) If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number.

☐ **YES** ☐ **NO**

Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number

3.A. Has there been a change in ownership or control within the last year? If yes, when? (mm/dd/yyyy)

☐ **YES** ☐ **NO** **ATTACH EXPLANATION**

B. Do you anticipate any change in ownership or control within the year? If yes, when? (mm/dd/yyyy)

☐ **YES** ☐ **NO** **ATTACH EXPLANATION**

4. Is this entity operated by a management company, or leased in whole or part by another organization? If yes, give date of change in operations.(mm/dd/yyyy)

☐ **YES** ☐ **NO**

5. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?

☐ **YES** ☐ **NO**

6. Is this entity chain affiliated? (If yes, list name, address of Corporation, and EIN number.)

☐ **YES** ☐ **NO**

Name	Address	EIN

7. Are there any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, Organization, or Practice who have ever been indicted or convicted of a violation of State or Federal Law?

☐ **YES** ☐ **NO**

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

Hospitals, only:

8. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?

☐ **YES** ☐ **NO** If yes, give year of change. Current Beds Prior Beds

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Disclosure statement: Additional Names, Addresses, and Numbers by section.

Section: **1.A.**

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

Section: **1.B.**

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

Section: **2.A.**

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

Section: **2.C.**

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

Removal of this, or any page, invalidates this application

(For State Use Only)

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

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

Authorized Representative Name and Title (please print) :

____

Authorized Representative Initial: _______________ Date: _______________

A copy of Executive Order 2007-01S can be found at: http://www.dot.state.oh.us/clc/governor.asp

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

Authorized Representative Name and Title (please print) :

____

Authorized Representative Initial: _______________ Date: _______________

For all Ambulatory Health Care Clinics Only:

All Ambulatory Health Care Clinics must provide documentation indicating the facility:
* Is Free Standing – no administrative, organizational, financial, or other connection with a hospital or long term care facility;
* Furnishes outpatient (non-institutional) health care by or under the direction of a physician or dentist;
* Has a fixed location or specifically designed mobile unit;
* Does not provide overnight accdommodations;
* Is not eligible as a Medicaid provider as a professional association of physicians, dentists, optometrists, opticians, podiatrists, or limited practitioners such as physical therapists, psychologists, or chiropractors endolled as a Medicare provider.

(*For State Use Only*)

OHIO MEDICAID PROVIDER AGREEMENT

(For all providers except Medicaid Managed Care Plans and Long-Term Care Facilities)

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

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service.

2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.

3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.

4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.

5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid fraud control unit or their designees any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid or Disability Assistance Medical payments and may result in termination from the Medicaid and Disability Assistance Medical programs.

6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address;

7. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-1-17.3 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX services.

8. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any independent contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title X beneficiaries.

9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.

10. Provide to ODJFS, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".

11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d).

This provider agreement may be canceled by either party upon 30 days written notice prior to termination date.

I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

Certain provider agreements may be made retroactive (up to 12 months) to encompass dates on which the provider furnished covered services to a Medicaid consumer and the service has not been billed to Medicaid. **If you meet this provision, please check this box**. ☐
A failure to check this box shall be taken by ODJFS to mean that you waive your rights to a retroactive period of up to 12 months prior to the date ODJFS approves your application.

Authorized Representative Name and Title (please print) : ______________________________

Authorized Repersentative Signature: ______________________________ Date: ____________ (mm/dd/yyyy)

For State Use Only

Signature of Authorized Agent: ______________________________ Date: ____________ (mm/dd/yyyy)

(For State Use Only)

For State Use Only

Date Received(**1**)	Date Received(**2**)	Date Received(**3**)	Date Received(**4**)
Date Returned(**1**)	Date Returned(**2**)	Date Returned(**3**)	Date Returned(**4**)

Date Processed	Effective Date	Provider Number
Operator's Number		

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

Request for Taxpayer Identification Number and Certification

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

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

Name (as shown on your income tax return)

Business name, if different from above

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

☐ Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

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

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

Social security number

or

Employer identification number

Part II **Certification**

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

Purpose of Form

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

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

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

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

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

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

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

Penalties

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

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

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

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

Specific Instructions

Name

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

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

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

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

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

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

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

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

Exempt Payee

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

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

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

The following payees are exempt from backup withholding:

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

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

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

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

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

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

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

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

10. A real estate investment trust,

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

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

13. A financial institution,

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

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

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

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

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

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

Part I. Taxpayer Identification Number (TIN)

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

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

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

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

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

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

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

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

Part II. Certification

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

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

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

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

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

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

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

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

What Name and Number To Give the Requester

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

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

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

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

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

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

Secure Your Tax Records from Identity Theft

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

To reduce your risk:

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

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

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

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

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

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

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

Privacy Act Notice

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

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

Bob Taft
Governor

Barbara Riley
Director

30 East Broad Street · Columbus, Ohio 43215-3414
jfs.ohio.gov

July, 2006

Declaration Regarding Material Assistance /Non-assistance to a Terrorist Organization (DMA)

Dear Provider:

Attached you will find two documents, the first is a form entitled Declaration Regarding Material Assistance /Nonassistance to a Terrorist Organization (DMA), HLS 0038 2/06, "Government Business and Funding Contracts". The DMA form was developed as a result of Ohio Senate Bill 9, signed into law by Governor Bob Taft on January 11, 2006. Sections 2909.32, 2909.33, and 2909.34 of the Ohio Revised Code defined and created the DMA. The DMA form must be completed by applicants to certify that they have not provided "material assistance" , including "material support and resources", to a terrorist organization included on the U.S. Department of State Terrorist Exclusion List (TEL), in order to do business with or receive funding from the state. If the Applicant is a company, affiliated group or organization, this form must also be completed by any person who holds, owns, or otherwise has a controlling interest in the Applicant. The second document is the U. S. State Department's Terrorist Exclusion List (TEL). This document contains a list of foreign organizations known to support and/or engage in acts of terrorism. The TEL is maintained by the United State's Department of State.

The definition of "material support or resources" is found on the HLS form. Answering yes, or the failure to answer "no", to any of the questions on the form serves as a disclosure that material assistance to an identified organization has been provided.

Ohio Medicaid providers, and certain persons who hold, own, or otherwise have a controlling interest in the provider, doing business with the State of Ohio, are required to complete the HLS 0038 form and return it to the department along with their completed Ohio Medicaid Provider Application/Agreement.

Please mail or fax the completed form to:
Provider Enrollment Unit
PO Box 1461
Columbus, Ohio 43216-1461
Fax: 614-995-5904

If you should have questions concerning the completion of the Declaration Regarding Material Assistance /Nonassistance to a Terrorist Organization (DMA)), HLS 0038 2/06,"Government Business and Funding Contracts", please contact the Ohio Department of Public Safety Division of Homeland Security at

http://www.homelandsecurity.ohio.gov/dma.asp

Ohio Department of Public Safety
Division of Homeland Security
http://www.homelandsecurity.ohio.gov

GOVERNMENT BUSINESS AND FUNDING CONTRACTS

In accordance with section 2909.33 of the Ohio Revised Code

DECLARATION REGARDING MATERIAL ASSISTANCE/NONASSISTANCE TO A TERRORIST ORGANIZATION

This form serves as a declaration of the provision of material assistance to a terrorist organization or organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List (see the Ohio Homeland Security Division website for a reference copy of the Terrorist Exclusion List).

Any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided. Failure to disclose the provision of material assistance to such an organization or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree.

For the purposes of this declaration, "material support or resources" means currency, payment instruments, other financial securities, funds, transfer of funds, and financial services that are in excess of one hundred dollars, as well as communications, lodging, training, safe houses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials.

LAST NAME		FIRST NAME	MIDDLE INITIAL
HOME ADDRESS			
CITY	STATE	ZIP	COUNTY
HOME PHONE		WORK PHONE	

COMPLETE THIS SECTION ONLY IF YOU ARE A COMPANY, BUSINESS OR ORGANIZATION

BUSINESS/ORGANIZATION NAME			
BUSINESS ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE NUMBER			

DECLARATION

In accordance with division (A)(2)(b) of section 2909.32 of the Ohio Revised Code

For each question, indicate either "yes," or "no" in the space provided. Responses must be truthful to the best of your knowledge.

1. Are you a member of an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ Yes ☐ No

2. Have you used any position of prominence you have with any country to persuade others to support an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ Yes ☐ No

3. Have you knowingly solicited funds or other things of value for an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ Yes ☐ No

4. Have you solicited any individual for membership in an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ Yes ☐ No

5. Have you committed an act that you know, or reasonably should have known, affords "material support or resources" to an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ Yes ☐ No

6. Have you hired or compensated a person you knew to be a member of an organization on the U.S. Department of State Terrorist Exclusion List, or a person you knew to be engaged in planning, assisting, or carrying out an act of terrorism?
   ☐ Yes ☐ No

In the event of a denial of a government contract or government funding due to a positive indication that material assistance has been provided to a terrorist organization, or an organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List, a review of the denial may be requested. The request must be sent to the Ohio Department of Public Safety's Division of Homeland Security. The request forms and instructions for filing can be found on the Ohio Homeland Security Division website.

CERTIFICATION

I hereby certify that the answers I have made to all of the questions on this declaration are true to the best of my knowledge. I understand that if this declaration is not completed in its entirety, it will not be processed and I will be automatically disqualified. I understand that I am responsible for the correctness of this declaration. I understand that failure to disclose the provision of material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List, or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree. I understand that any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided by myself or my organization. If I am signing this on behalf of a company, business or organization, I hereby acknowledge that I have the authority to make this certification on behalf of the company, business or organization referenced on page 1 of this declaration.

X ______________________________ ______________________________

Signature Date

OHIO DEPARTMENT OF PUBLIC SAFETY
Division of Homeland Security

Terrorist Exclusion List

As of July 20, 2006

U.S. Department of State List of Designated Foreign Terrorist Organizations

1. Abu Nidal Organization (ANO)
2. Abu Sayyaf Group
3. Al-Aqsa Martyrs Brigade
4. Ansar al-Islam
5. Armed Islamic Group (GIA)
6. Asbat al-Ansar
7. Aum Shinrikyo
8. Basque Fatherland and Liberty (ETA)
9. Communist Party of the Philippines/New People's Army (CPP/NPA)
10. Continuity Irish Republican Army
11. Gama'a al-Islamiyya (Islamic Group)
12. HAMAS (Islamic Resistance Movement)
13. Harakat ul-Mujahidin (HUM)
14. Hizballah (Party of God)
15. Islamic Jihad Group
16. Islamic Movement of Uzbekistan (IMU)
17. Jaish-e-Mohammed (JEM) (Army of Mohammed)
18. Jemaah Islamiya organization (JI)
19. al-Jihad (Egyptian Islamic Jihad)
20. Kahane Chai (Kach)
21. Kongra-Gel (KGK, formerly Kurdistan Workers' Party, PKK, KADEK)
22. Lashkar-e Tayyiba (LT) (Army of the Righteous)
23. Lashkar i Jhangvi
24. Liberation Tigers of Tamil Eelam (LTTE)
25. Libyan Islamic Fighting Group (LIFG)
26. Moroccan Islamic Combatant Group (GICM)
27. Mujahedin-e Khalq Organization (MEK)
28. National Liberation Army (ELN)
29. Palestine Liberation Front (PLF)
30. Palestinian Islamic Jihad (PIJ)
31. Popular Front for the Liberation of Palestine (PFLF)
32. PFLP-General Command (PFLP-GC)
33. al-Qa'ida
34. Real IRA
35. Revolutionary Armed Forces of Colombia (FARC)
36. Revolutionary Nuclei (formerly ELA)
37. Revolutionary Organization 17 November
38. Revolutionary People's Liberation Party/Front (DHKP/C)
39. Salafist Group for Call and Combat (GSPC)
40. Shining Path (Sendero Luminoso, SL)
41. Tanzim Qa'idat al-Jihad fi Bilad al-Rafidayn (QJBR) (al-Qaida in Iraq) (formerly Jama'at al-Tawhid wa'al-Jihad, JTJ, al-Zarqawi Network)
42. United Self-Defense Forces of Colombia (AUC)

OHIO DEPARTMENT OF PUBLIC SAFETY
Division of Homeland Security

U.S. Department of State Terrorist Exclusion List

1. Afghan Support Committee (a.k.a. Ahya ul Turas; a.k.a. Jamiat Ayat-ur-Rhas al Islamia; a.k.a. Jamiat Ihya ul Turath al Islamia; a.k.a. Lajnat el Masa Eidatul Afghania)
2. Al Taqwa Trade, Property and Industry Company Ltd. (f.k.a. Al Taqwa Trade, Property and Industry; f.k.a. Al Taqwa Trade, Property and Industry Establishment; f.k.a. Himmat Establishment; a.k.a. Waldenberg, AG)
3. Al-Hamati Sweets Bakeries
4. Al-Ittihad al-Islami (AIAI)
5. Al-Manar
6. Al-Ma'unah
7. Al-Nur Honey Center
8. Al-Rashid Trust
9. Al-Shifa Honey Press for Industry and Commerce
10. Al-Wafa al-Igatha al-Islamia (a.k.a. Wafa Humanitarian Organization; a.k.a. Al Wafa; a.k.a. Al Wafa Organization)
11. Alex Boncayao Brigade (ABB)
12. Anarchist Faction for Overthrow
13. Army for the Liberation of Rwanda (ALIR) (a.k.a. Interahamwe, Former Armed Forces (EX-FAR))
14. Asbat al-Ansar
15. Babbar Khalsa International
16. Bank Al Taqwa Ltd. (a.k.a. Al Taqwa Bank; a.k.a. Bank Al Taqwa)
17. Black Star
18. Communist Party of Nepal (Maoist) (a.k.a. CPN(M); a.k.a. the United Revolutionary People's Council, a.k.a. the People's Liberation Army of Nepal)
19. Continuity Irish Republican Army (CIRA) (a.k.a. Continuity Army Council)
20. Darkazanli Company
21. Dhamat Houmet Daawa Salafia (a.k.a. Group Protectors of Salafist Preaching; a.k.a. Houmat Ed Daawa Es Salifiya; a.k.a. Katibat El Ahoual; a.k.a. Protectors of the Salafist Predication; a.k.a. El-Ahoual Battalion; a.k.a. Katibat El Ahouel; a.k.a. Houmate Ed-Daawa Es-Salafia; a.k.a. the Horror Squadron; a.k.a. Djamaat Houmat Eddawa Essalafia; a.k.a. Djamaatt Houmat Ed Daawa Es Salafiya; a.k.a. Salafist Call Protectors; a.k.a. Djamaat Houmat Ed Daawa Es Salafiya; a.k.a. Houmate el Da'awaa es-Salafiyya; a.k.a. Protectors of the Salafist Call; a.k.a. Houmat ed-Daaoua es-Salafia; a.k.a. Group of Supporters of the Salafiste Trend; a.k.a. Group of Supporters of the Salafist Trend)
22. Eastern Turkistan Islamic Movement (a.k.a. Eastern Turkistan Islamic Party; a.k.a. ETIM; a.k.a. ETIP)
23. First of October Antifascist Resistance Group (GRAPO) (a.k.a. Grupo de Resistencia Anti-Fascista Premero De Octubre)
24. Harakat ul Jihad i Islami (HUJI)
25. International Sikh Youth Federation
26. Islamic Army of Aden
27. Islamic Renewal and Reform Organization
28. Jamiat al-Ta'awun al-Islamiyya
29. Jamiat ul-Mujahideen (JUM)
30. Japanese Red Army (JRA)
31. Jaysh-e-Mohammed
32. Jayshullah
33. Jerusalem Warriors
34. Lashkar-e-Tayyiba (LET) (a.k.a. Army of the Righteous)
35. Libyan Islamic Fighting Group
36. Loyalist Volunteer Force (LVF)
37. Makhtab al-Khidmat
38. Moroccan Islamic Combatant Group (a.k.a. GICM; a.k.a. Groupe Islamique Combattant Marocain)

39. Nada Management Organization (f.k.a. Al Taqwa Management Organization SA)
40. New People's Army (NPA)
41. Orange Volunteers (OV)
42. People Against Gangsterism and Drugs (PAGAD)
43. Red Brigades-Combatant Communist Party (BR-PCC)
44. Red Hand Defenders (RHD)
45. Revival of Islamic Heritage Society (Pakistan and Afghanistan offices -- Kuwait office not designated) (a.k.a. Jamia Ihya ul Turath; a.k.a. Jamiat Ihia Al- Turath Al-Islamiya; a.k.a. Revival of Islamic Society Heritage on the African Continent)
46. Revolutionary Proletarian Nucleus
47. Revolutionary United Front (RUF)
48. Salafist Group for Call and Combat (GSPC)
49. The Allied Democratic Forces (ADF)
50. The Islamic International Brigade (a.k.a. International Battalion, a.k.a. Islamic Peacekeeping International Brigade, a.k.a. Peacekeeping Battalion, a.k.a. The International Brigade, a.k.a. The Islamic Peacekeeping Army, a.k.a. The Islamic Peacekeeping Brigade)
51. The Lord's Resistance Army (LRA)
52. The Pentagon Gang
53. The Riyadus-Salikhin Reconnaissance and Sabotage Battalion of Chechen Martyrs (a.k.a. Riyadus-Salikhin Reconnaissance and Sabotage Battalion, a.k.a. Riyadh-as-Saliheen, a.k.a. the Sabotage and Military Surveillance Group of the Riyadh al-Salihin Martyrs, a.k.a. Riyadus Salikhin Reconnaissance and Sabotage Battalion of Shahids (Martyrs))
54. The Special Purpose Islamic Regiment (a.k.a. the Islamic Special Purpose Regiment, a.k.a. the al-Jihad-Fisi-Sabililah Special Islamic Regiment, a.k.a. Islamic Regiment of Special Meaning)
55. Tunisian Combat Group (a.k.a. GCT, a.k.a. Groupe Combattant Tunisien, a.k.a. Jama'a Combattante Tunisien, a.k.a. JCT; a.k.a. Tunisian Combatant Group)
56. Turkish Hizballah
57. Ulster Defense Association (a.k.a. Ulster Freedom Fighters)
58. Ummah Tameer E-Nau (UTN) (a.k.a. Foundation for Construction; a.k.a. Nation Building; a.k.a. Reconstruction Foundation; a.k.a. Reconstruction of the Islamic Community; a.k.a. Reconstruction of the Muslim Ummah; a.k.a. Ummah Tameer I-Nau; a.k.a. Ummah Tameer E-Nau; a.k.a. Ummah Tameer-I-Pau)
59. Youssef M. Nada & Co. Gesellschaft M.B.H.

U.S. Treasury Department's Designated Charities and Potential Fundraising Front Organizations for FTOs

1. Makhtab al-Khidamat / Al Kifah (formerly U.S.-based, Pakistan)
2. Al Rashid Trust (Pakistan)
3. WAFA Humanitarian Organization (Pakistan, Saudi Arabia, Kuwait, United Arab Emirates)
4. Rabita Trust (Pakistan)
5. Ummah Tameer E-Nau (Pakistan)
6. Revival of Islamic Heritage Society - Pakistan and Afghanistan Branches (Kuwait, Afghanistan, Pakistan)
7. Afghan Support Committee (Afghanistan, Pakistan)
8. Al Haramain Foundation (Indonesia, Kenya, Pakistan, Tanzania, Bosnia, Somalia, Bangladesh, Afghanistan, Albania, Ethiopia, Netherlands, Comoros Islands, and United States branches)
9. Aid Organization of the Ulema (Pakistan)
10. Global Relief Foundation (United States)

11. Benevolence International Foundation (United States):
12. Benevolence International Fund (Canada)
13. Bosanska Idealna Futura (Bosnia)
14. Stichting Benevolence International Nederland (Netherlands)
15. Lajnat al Daawa al Islamiyya (Kuwait, Pakistan, Afghanistan)
16. Al Akhtar Trust (Pakistan)
17. Taibah International (Bosnia)
18. Al Haramain & Al Masjed Al Aqsa Charity Foundation (Bosnia)
19. Al Furqan (Bosnia)
20. Islamic African Relief Agency (IARA) / Islamic Relief Agency (ISRA) (Sudan, United States and 40 other branches throughout the world)
21. The Holy Land Foundation for Relief and Development (United States)
22. Al Aqsa Foundation (United States, Europe, Pakistan, Yemen, South Africa)
23. Commité de Bienfaisance et de Secours aux Palestiniens (France)
24. Association de Secours Palestinien (Switzerland)
25. Interpal (Palestinian Relief & Development Fund) (United Kingdom)
26. Palestinian Association in Austria (Austria)
27. Sanibil Association for Relief and Development (Lebanon)
28. Elehssan Society (Palestinian territories)
29. Aleph (Aum Shinrikyo/Aum Supreme Truth)
30. Rabbi Meir David Kahane Memorial Fund (Kahane Chai and Kach)
    American Friends of the United Yeshiva (Kahane Chai and Kach)
    American Friends of Yeshivat Rav Meir (Kahane Chai and Kach)
    Friends of the Jewish Idea Yeshiva (Kahane Chai and Kach)
31. Irish Republican Prisoners Welfare Association (Real IRA)
32. Socorro Popular Del Peru/People's Aid of Peru (Sendero Luminoso/Shining Path)