

**Ohio Department of Health
Primary Care and Rural Health Program**



**Ohio Physician Loan Repayment Program;
Bureau of Health Professions State Loan
Repayment Program**

2010 Application Package

**Ohio Department of Health
Primary Care and Rural Health Program
246 N. High Street -6th Floor**

Columbus, Ohio 43215

Phone: 614-644-8496

Fax: 614-995-4235

Email: geri.rousculp@odh.ohio.gov

Application Instructions

The application consists of:

- a) the three-page Application, Sections I - VI;
- b) the one-page Practice Site questionnaire; and
- c) the one-page Loan Information form.

Additional copies of the application can be obtained by submitting a request to the Primary Care Program at the Ohio Department of Health (ODH) or by visiting http://www.odh.ohio.gov/odhprograms/chss/pcrh_programs/recruitment/slrp.aspx Requests can be made in writing, by telephone or by email. See page three for contact information.

In addition to the five pages described above which make up the application, the applicant must submit the following:

1. W-9 form (first page only) – **Two** copies signed in blue ink;
2. New Vendor Information Form;
3. Current resumé or CV;
4. A copy of applicant's Ohio Medical License;
5. Background and Biographical Statements (page 2, Section IV. of Application);
6. A statement from each lender showing the current loan balance, account number and lender's address (see Loan Information form);
7. A letter, addressed to the Ohio Department of Health from the applicant, authorizing the lenders to release financial information to the ODH (see Loan Information form);
8. A copy of the practice site's Sliding Fee Scale, policy and waiting room/lobby sign, if applicable (see Practice Site questionnaire);
9. The applicant's job description; and,
10. A copy of the applicant's employment contract.

Eligibility

Physicians who are practicing or finishing their residency or fellowship in the following primary care specialties, may apply:

Family Practice, General Internal Medicine, Internal Medicine/Pediatrics, General Pediatrics, Adolescent Medicine, Psychiatry, Child/Adolescent Psychiatry, Geriatric Psychiatry, Geriatrics, and Obstetrics & Gynecology.

Applicants must work full-time, defined as a minimum of 40 hours/week at an eligible site. For all physicians, except OB/Gyns, at least 32 of the 40 hours must be spent in direct patient care in an outpatient setting. OB/Gyns must spend at least 21 hours per week in direct patient care in an outpatient setting.

All sites **must be located in a federally-designated Health Professional Shortage Area (HPSA) specific to the applicant's discipline** or in a former HPSA that meets a certain physician : population ratio. To search for HPSAs, go to <http://hpsafind.hrsa.gov>.

Instructions

Application for Loan Repayment – Two Pages

I. Applicant Demographics

Complete all sections. Under Race, more than one option may be selected. For Ethnicity, mark only one. The Total Medical School Debt is the sum of all existing medical school loans.

II. Education

Respond to all four sections, including dates of attendance. If you attended more than one medical school or undergraduate program, list only the one from which you graduated.

III. Obligations

No person with an existing obligation to a state or federal government can apply unless the obligation will be fulfilled prior to the time of loan repayment contract awards. This includes existing loan repayment programs in other states, National Health Service Corps loan repayment or scholar commitments, active military obligation, or employment contracts that impose a service obligation.

IV. Background and Biographical Statements

Address all items in 1 – 6 as provided on the application. Responses shall be put on separate sheets and included with the completed application packet.

V. Professional References

List only two, including all contact information as requested. Corresponding letters of reference are not needed.

VI. Certification and Acknowledgements

The applicant signs and dates numbers 1 and 2. The Executive Director or practice site administrator signs and dates number 3.

Practice Site – One Page

Complete one page for each practice site where the applicant is, or will be, practicing. All sections must be completed in their entirety. If the site has a sliding fee scale, a copy of the scale, policy and waiting room/lobby sign must be included with the application (see #6). The person completing the Practice Site questionnaire should be the office manager, billing manager or similar staff.

Loan Information – One Page

I. Applicant Information

If the applicant has consolidated medical school loans, the original loan documents and the consolidation documents must be included.

II. Lender Information

For "Total Medical School Debt," list the sum of all existing medical school loans. In the chart, complete one line for each loan acquired. If additional room is needed,

provide the information on another sheet. A current balance statement from each lender/servicer must be attached. A letter addressed to the Ohio Department of Health, authorizing the lenders to release financial information to the Ohio Department of Health, must be included.

W-9 – One Page

When completing the W-9s, use **your** name, home address and social security number. Do **not** use the practice site information or Tax ID, even if you are the owner of the practice. Sign the W-9s in blue ink. This eliminates confusion as to whether the document is an original or a copy. Complete two W-9s for inclusion with the application.

New Vendor Information Form – Two Pages

Mark the box NEW in Section 1. In Section 2, use the same legal name you put on the W-9. Use your social security number for Taxpayer ID. For Business Entity, select "Individual." Skip the question about Industry Classification. Provide your permanent home address, which matches the information provided on the W-9, in Section 3. Put your name, phone, fax and email in Section 5. Mark NA in Section 6, and Net 30 in Section 7. Section 8 is optional. Sign and date Section 9, while leaving Section 10 blank.

This form, as well as the W-9, is also available in a fillable format at <http://ohiosharedservices.ohio.gov/Vendors.aspx>

All items should be **mailed** to the following address:

Ohio Physician Loan Repayment Program
c/o Geri Rousculp
Primary Care and Rural Health Program
Ohio Department of Health
246 N. High Street – 6th Floor
Columbus, Ohio 43215

Phone 614-644-8496
Email geri.rousculp@odh.ohio.gov

The application due date (receipt or postmark) is Jan. 15, 2010.

Ohio Department of Health

2010 Application for Physician Loan Repayment

Ohio Physician Loan Repayment Program
BHP State Loan Repayment Program

I. Applicant Demographics			
Name		SS # _____ - _____ - _____	
Last:	First:	Middle:	
Home Address:			Home Phone:
City:	State:	Zip:	Home email:
Primary Practice Site Name:			Fax:
Address:		City:	Pager or Cell:
State:	Zip+4:	Current Employment Contract:	Work Phone:
		Start Date: ___/___/___	
County:		End Date: ___/___/___	Work email:
Languages Spoken: _____ _____ _____	Ethnicity: (select one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	Are you a:	Alternate email:
		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal alien <input type="checkbox"/> Neither of the above	
		Race: (check all that apply)	Reared in Ohio? If yes, provide years.
		<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes (19__ - ____) <input type="checkbox"/> No
Are you: (select one)			Medicaid Provider #:
<input type="checkbox"/> Board Certified, or <input type="checkbox"/> Board Eligible			National Provider ID:
If Resident, date available to practice: ___/___/___			Total Medical School Debt: \$

Physician Specialty: Only physicians who are Board-certified/eligible in the following primary care specialties are eligible for the state funding. Select all that apply:

- | | | | | | |
|--|--|---|--|---------------------------------|---------------------------------|
| <input type="checkbox"/> Adolescent Medicine | <input type="checkbox"/> Family Practice | <input type="checkbox"/> General IM | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> IM/Ped | <input type="checkbox"/> OB/GYN |
| <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Psych - General | <input type="checkbox"/> Psych - Child/Adolescent | <input type="checkbox"/> Psych - Geriatric | | |

II. Education

Medical School: _____	City/State: _____
Dates of Attendance: ___/___/___ through ___/___/___	Graduation: ___/___/___
Residency Program/Fellowship: _____	City/State: _____
Dates of Attendance: ___/___/___ through ___/___/___	Graduation: ___/___/___
Undergraduate College/University: _____	City/State: _____
Dates of Attendance: ___/___/___ through ___/___/___	Completion: ___/___/___

Previous **SEARCH** (Student/Resident Experiences and Rotations in Community Health) participant?

- Yes → If yes, indicate which state(s): _____
- No

V. Professional References (list 2)

1. Name: _____ Title: _____
Address: _____
Telephone: _____ Email: _____
Professional relationship to the applicant: _____
2. Name: _____ Title: _____
Address: _____
Telephone: _____ Email: _____
Professional relationship to the applicant: _____

Do not attach letters of recommendation. They will not be considered when determining loan repayment awards.

VI. Certification and Acknowledgements

1. I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that any willfully false representation is sufficient cause for rejection of this application.

Applicant's Signature Date

2. I acknowledge that I have read the Application Information and understand that if selected for a loan repayment contract, I will be bound to the practice site for a minimum of two years. I also understand that failure to uphold the requirements of a loan repayment contract could result in significant financial consequences.

Applicant's Signature Date

3. As an administrator with _____ (practice site), I understand that the applicant, if selected for the Ohio Physician Loan Repayment Program, has a minimum two-year commitment to the above-named site. Furthermore, I acknowledge that OPLRP participants must work a total of 40 hours per week at eligible sites, of which no more than 8 can be spent in administrative duties.

Executive Director or Site Administrator Signature Date

Practice Site
Ohio Physician Loan Repayment Program
Bureau of Health Professions State Loan Repayment Program

Directions: Complete one Practice Site information page for each site where the applicant practices or will practice.

1. Clinician (applicant) Name: _____
Practice Site Name: _____
Practice Address: _____
Phone: _____ Fax: _____ E-mail: _____
2. List hours per week the clinician will practice primary care at this site: _____ hours/week
a. How many hours will be spent in administration or supervision? _____ hours/week
3. Does this practice participate in the Ohio Medicaid program? Yes No
↓
If yes, complete a, b, c, d and e.
- a. Total number of Medicaid claims paid for the most recent 12 months: _____
- b. Total number of patient visits for the same time period: _____
- c. Percent of the practice comprised of Medicaid patients: _____%
- d. Practice Site's Medicaid number: _____
- e. Does the practice accept new Medicaid patients? Yes No
4. Do you accept assignment in the Medicare program? Yes No
5. Does the practice provide services regardless of the patient's ability to pay? Yes No
If yes, include the waiting room/lobby sign indicating services are available
6. Does the practice use a sliding fee scale for patients with incomes at or below 200% of the Federal Poverty Guidelines? Yes No
If yes, include a copy, with corresponding policy, with the application
If no, explain the billing/payment policy for uninsured patients:

-
-
7. Is this practice not-for-profit? Yes No
8. This practice is (select one): Private Public or Government

9. Site Contact Person if applicant is awarded loan repayment:

Name of Contact: _____ Phone: _____ Email: _____

Printed Name of Person Completing Survey

Title

Date

Signature of Person Completing Survey

Email

Phone

Loan Information
Ohio Physician Loan Repayment Program
Bureau of Health Professions State Loan Repayment Program

Directions: Please list only the loans you are requesting to be paid, i.e. loans taken for the medical school training which enabled you to become eligible for this program. For each loan listed, attach a copy of the loan agreement and a current statement from the lender showing the account number and balance.

SECTION I: Applicant Information

Name (Last, First, MI): _____ Email: _____
 Home Address: _____
 City, State, Zip Code: _____ Telephone Number: (____) _____

Have you consolidated your loans for undergraduate costs with medical school loans or health professions training program loans?
 Yes - If yes, you must attach copies of the loan documents, which reflect the new consolidated loan.
 No

SECTION II: Lender Information

This program pays for the educational costs for a medical degree. If loans have been consolidated, a determination will be made of the proportion of the consolidation loan that will be paid for a successful applicant. Only Institutional or Government loans are eligible including Stafford, SLS, HEAL, Perkins, and others. Loans from individuals are not eligible.

Total medical school debt: \$ _____

AWARD YEAR	DISBURSEMENT DATE	HOLDER OF LOAN	ORIGINAL LOAN AMOUNT	CURRENT BALANCE	DATE OF BALANCE	PROJECTED PAYOFF DATE

Are any parts of the loan(s) listed above being paid by another organization?

No
 Yes - If yes, specify the amount being paid for applicable loans, the name of the organization, and the terms, including any obligations by the applicant.

Amount - \$ _____ Payer – _____

Terms - _____

CERTIFICATION:

I certify that the financial information given on this form is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that any false representation is sufficient cause for rejection of this application.

Signature

Date

Frequently Asked Questions

Ohio Physician Loan Repayment Program (OPLRP); Bureau of Health Professions State Loan Repayment Program (BHPr SLRP)

1. What is the purpose of a Loan Repayment Program?

These programs were created to assist communities in underserved areas who are seeking clinicians to provide primary care, dental and/or mental health services. In addition, the programs aid primary care clinicians, mental health providers and dental professionals who are dedicated to working with the medically underserved in Ohio's Health Professional Shortage Areas (HPSA). Eligible clinicians may apply for loan repayment if they choose employment at an eligible site in one of the qualified areas.

2. Where are the Health Professional Shortage Areas?

Ohio has many Health Professional Shortage Areas (HPSAs) in rural and urban areas. All quadrants of the state include HPSAs. To determine if an area (county, group of census tracts, special population or facility) is a HPSA, go to <http://hpsafind.hrsa.gov/>

3. Who is eligible to apply for the Ohio Physician Loan Repayment Program?

Primary care physicians who have completed residency and are practicing in Ohio or are pursuing an opportunity in Ohio can apply. Allopathic (MD) and Osteopathic (DO) physicians specializing in Family Medicine, General Pediatrics, Adolescent Medicine, General Internal Medicine, Internal Medicine/Pediatrics, Geriatrics, Obstetrics/Gynecology, General Psychiatry, Child/Adolescent Psychiatry and Geriatric Psychiatry are considered primary care physicians.

4. Are practice sites required to meet other specific criteria?

Yes. All loan repayment programs require that sites accept Medicaid, assignment for Medicare and serve all patients regardless of ability to pay. Other requirements may apply, depending on the program. For example, the BHPr SLRP requires that sites be non-profit and use a sliding fee scale for patients in households at or below 200 percent of the current federal poverty level.

Sites must assure that those selected for loan repayment work full-time, defined as a minimum of 40 hours per week at the site. For primary care physicians, up to eight hours can be spent for hospitalization coverage and practice administration. OB-GYNs are allowed additional hospital hours.

5. What are the Loan Repayment benefits?

Selected applicants may receive up to \$25,000 per year for an initial two-year contract. Those retaining eligibility and wishing to continue with the program may receive up to \$35,000 in years three and four. For those who meet the criteria for BHPr SLRP, the payments could be tax exempt.

6. How long is the commitment?

The first contract is for two years. Those continuing in their practice, and who meet contractual obligations, may renew the contracts for additional two, one-year terms. Thus, the minimum commitment is for two years and the maximum participation is four years.

7. What happens if I receive loan repayment but then change my mind or relocate before the contract is up?

A failure to complete the terms of the contract results in the clinician reimbursing the State of Ohio a sum equal to \$7,500 for each month remaining in the length of the contract, plus interest, or other amount as stipulated in the contract.

If a participant in OPLRP must leave the practice site due to unavoidable and unforeseen circumstances, the Ohio Department of health will work with the physician to find a similar practice site. Physicians in OPLRP may not initiate transfers without the expressed approval of their existing site and the Ohio Department of Health.

8. How are the loan payments made?

Payments are made directly to the holders of the loan(s) in the amounts requested by the participant, up to the maximum amount stated in the contract. Participants submit invoices to the Ohio Department of Health to initiate payments.

9. When are payments made?

The first payment is usually made within the third or fourth month of the contract. Subsequent payment is made approximately one year later.

10. Are there other obligations by the clinician or the site?

Six-month reports, providing the number of patients and patient visits by payer type (Private Insurance, Medicaid, Medicare, Sliding Fee Scale Discount, Self Pay Full Fee, No Payment, and Other), are required. Numbers are reported for the site and for the participating physician.

11. What forms must be completed as part of the application process?

The complete application consists of the following five forms which are provided by the Ohio Department of Health:

1. Application (3 pages)
2. Practice Site (1 page)
3. Loan Information (1 page)
4. W-9 (first page only, to be signed in blue ink – submit 2)
5. Vendor Information Form

In addition, the applicant must include:

- a. a current resume or CV;
- b. a copy of one's Ohio medical license;
- c. background and biographical narrative;
- d. a statement from each lender showing the loan balance, account number and lender's address;
- e. a letter from the applicant authorizing the lenders to release financial information to the ODH;
- f. a copy of the practice site's sliding fee scale, policy and waiting room/lobby sign, if applicable.
- g. the applicant's job description
- h. a copy of the applicant's employment contract

12. When are the applications due?

Applications and all required attachments must be received or postmarked on or before Jan. 15th 2010. Faxed applications will not be accepted.

13. When are the applicants notified?

Selected applicants are informed during the following spring, usually in April or May. Those not receiving loan repayment are informed after all decisions about funding have been made and the selected applicants have the opportunity to accept or decline the contract.

14. Is an applicant who currently receives loan repayment from the National Health Service Corps eligible to apply?

Applicants must have no current commitments to the National Health Service Corps or certain other federal loan programs at the time the State's loan repayment contract would begin, if selected. Applicants may apply to both programs, but cannot accept contract offers of loan repayment from both programs.

15. Where are completed applications sent?

Ohio Physician Loan Repayment Program
Attn: Geri Rousculp
Primary Care and Rural Health
Ohio Department of Health
246 N. High Street - 6th Floor
Columbus, Ohio 43215

16. Who do I contact for more information?

Phone – 614-644-8496
Email - geri.rousculp@odh.ohio.gov



Request for Taxpayer Identification Number and Certification

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

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

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

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

Social security number
or
Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

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

Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

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

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

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

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

Penalties

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

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

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

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

Specific Instructions

Name

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

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

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

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

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

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

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

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

Exempt Payee

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

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

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.

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.

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.

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.



VENDOR INFORMATION FORM

All applicable parts of the form must be completed by the vendor and returned to Ohio Shared Services signed.

SECTION 1 – PLEASE SPECIFY TYPE OF ACTION

- NEW (W-9 OR W-8ECI FORM ATTACHED) ADDITIONAL ADDRESS (PROVIDE COPY OF INVOICE OR LETTER)
 CHANGE OF ADDRESS (PROVIDE ADDRESS TO BE REPLACED IN THE COMMENTS BOX ON NEXT PAGE)
 CHANGE OF TIN (NEW W-9 AND LETTER OF EXPLANATION OF CHANGE ATTACHED)
 CHANGE OF NAME (NEW W-9 AND LETTER OF EXPLANATION OF CHANGE ATTACHED)
 CHANGE OF PAYTERMS CHANGE OF CONTACT CHANGE OF PO DISPATCH METHOD

SECTION 2 – PLEASE PROVIDE VENDOR INFORMATION

LEGAL BUSINESS NAME: (MUST MATCH W-9 OR W-8ECI FORM)

BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

TAXPAYER ID # (TIN):

BUSINESS ENTITY: NOTE: IF SOLE PROPRIETOR, THE INDIVIDUAL'S NAME MUST APPEAR IN LEGAL BUSINESS NAME

- CORPORATION PARTNERSHIP SOLE PROPRIETOR
 NON PROFIT INDIVIDUAL
 OTHER (PLEASE EXPLAIN)

INDUSTRY CLASSIFICATION:

STANDARD INDUSTRIAL CLASSIFICATION (SIC) CODE

NORTH AMERICAN INDUSTRY CLASSIFICATION SYSTEM (NAICS) CODE

SECTION 3 – PLEASE PROVIDE COMPLETE ADDRESS

ADDRESS:

COUNTY:

CITY:

STATE:

ZIP CODE:

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SECTION 4 – REMIT TO ADDRESS (IF DIFFERENT THAN ABOVE)

ADDRESS:

CITY: <input type="text"/>	STATE: <input type="text"/>	ZIP CODE: <input type="text"/>
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SECTION 5 – CONTACT INFORMATION AND PERSON TO RECEIVE PURCHASE ORDER

NAME:

WEB SITE:

PHONE: <input type="text"/>	FAX: <input type="text"/>	E-MAIL: <input type="text"/>
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SECTION 6 – IS YOUR BUSINESS CURRENTLY CERTIFIED AS? (PLEASE CHECK)

MBE (MINORITY BUSINESS ENTERPRISE) EDGE (ENCOURAGING DIVERSITY, GROWTH, & EQUITY) N/A

SECTION 7 – PAYMENT TERMS (PLEASE CHECK ONE, OTHERWISE NET 30 WILL BE APPLIED BY DEFAULT)

2/10 NET 30 NET 30 NET 45 NET 60 NET 90

SECTION 8 – PURCHASE ORDER DISTRIBUTION-OTHER THAN USPS MAIL (INPUT E-MAIL ADDRESS OR FAX # BELOW)

E-MAIL:

FAX:

SECTION 9 – PLEASE SIGN & DATE

SIGNATURE: <input type="text"/>	DATE: <input type="text"/>
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SECTION 10 – AGENCY CONTACT INFORMATION

AGENCY NAME:

PHONE NUMBER: <input type="text"/>	E-MAIL: <input type="text"/>
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COMMENTS:

<p>SUBMIT FORM TO:</p> <p>Mail: Ohio Shared Services 4310 E. Fifth Ave. Columbus, OH 43219</p> <p>Fax number: (614) 485-1039</p> <p>E-mail: vendor@ohio.gov</p>	<p>QUESTIONS? PLEASE CONTACT:</p> <p>Phone: 1 (877) OHIO - SS1 (1-877-644-6771) 1 (614) 338-4781</p> <p>E-mail: vendor@ohio.gov</p>
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