EI PROMISe™ Provider Enrollment Readiness Packet

This packet contains information that will help guide Early Intervention (EI) providers through the PROMISe™ Provider Enrollment Process.

Use the following links to go directly to the document you would like to view:

Provider Revalidation Enrollment Information

Early intervention services providers completing revalidation activities must submit a complete and accurate application to the following address/email:

Office of Child Development & Early Learning Early
Intervention PROMISe Enrollment
333 Market Street – Floor 6
Harrisburg, Pa 17126
Email: RA-PWOCDELEIENROLL@pa.gov

Tips for a successful revalidation enrollment

1. All provider Types should use the following link to gain access to a PROMISe Enrollment Application. Incorrect enrollment applications will be returned.
    a. http://www.dhs.pa.gov/provider/promise/enrollmentinformation/index.htm
    b. Select the application link under Provider Type 17, regardless of the type of provider revalidating.
2. The Service Location address (Question 18a) should reflect the home address of the applicant, NOT the address of the employing/contracting provider agency. Applications with mis-matched service location addresses will be returned.
    a. To check the current service location address, the applicant shall create an account on the PROMISe portal and review the data.
        i. https://promise.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider
    b. To change the service location address to reflect the applicant's home address select the link: "**I have relocated my practice and need to update my provider file:** Provider Practice Relocation Request" using the following link: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/index.htm
3. If the providers service location address is outside of PA (applicable to Provider Type 16/17/19/20/21) the following must be attached:
    a. copy of their home state therapy license
    b. proof of participation in their home state MA Program

Tips regarding common errors and omissions on revalidations applications

1. Question 2b box must be selected
2. Question 2 "Enter Provider Number" must be completed
3. Question 3: NPI must be included. The NPI confirmation letter must also be attached.

4. Question 5: Provider Types for Early Intervention include

Provider Name	Provider Type
Nursing	16
Therapy	17
Psychological	19
Audiology	20
Social Work	21
Special Instruction	51

5. Question 6: Provider Specialties for Early Intervention include

Provider Name (Type)	Provider Specialty
Nurse (16)	572
Physical Therapist (17)	176
Occupational Therapist (17)	177
Speech Therapist (17)	178
Psychologist (19)	572
Audiologist (20)	572
Social Worker (21)	216
Special Instructor (51)	529
Special Instructor-Vision (51)	517
Special Instructor-Hearing (51)	572
Special Instructor-Nutrition (51)	573
Special Instructor-Behavior (51)	575

6. Question 18l shall include the following PEP combinations

Provider Type	PEP
16	WAV 16 WAV15 WAV11
17	WAV 16 WAV15 WAV11
19	WAV 16 WAV15 WAV11
20	WAV 16 WAV15 WAV11
21	WAV 16 WAV15 WAV11
51	WAV 16 WAV11

7. Question 20: If Yes is selected, a copy of board certification MUST be attached
8. Questions 20 – 26 MUST be completed. A resume and liability documentation fulfilling the same credentialing data will also be accepted.
9. Provider Disclosure Statement (pgs. 16-18) MUST be completed.
10. Applications missing supporting documentation will be returned.
    a. NPI Attachments: https://nppes.cms.hhs.gov/NPPES/Welcome.do
    b. Provider License Attachments: http://www.licensepa.state.pa.us/

Tips for efficient processing of a revalidation application

1. Applications must be completed with BLACK ink or typed.
2. Applications must be submitted as a single sided document.
3. Applications must not be stapled.
4. Applications must be submitted in page order.
5. Revalidation applications received prior to the deadline of 3/14/16 will be processed, however may exceed the 60-90 day expected processing time. Current enrollment data is still effective and can be used for processing claims for payment.

Initial Enrollment/New Service Location Requests for Billing and Rendering Providers

Please visit the PROMISe™ website

http://www.dhs.pa.gov/provider/promise/enrollmentinformation/index.htm

Early Intervention Providers are to select the 17 application titled
"Individual Practitioner Application or Group Application" and follow the directions.

Please send all applications to:

Office of Child Development & Early Learning
Early Intervention PROMISe Enrollment
333 Market Street – Floor 6
Harrisburg, PA 17126
Email: RA-PWOCDELEIENROLL@pa.gov

Request for Assignment of Fees Document

Request for Assignment of Fees

Individual Practitioner Name: _____

Individual Provider Number (9-Digit): _____

Please assign my fees from the following service location(s) to the listed group(s):

Individual Provider Service Location	to	Assign fees to Group Name	PROMISe 13-Digit Provider Group Number	Effective Date
1._____	to	_____		
2._____	to	_____		
3._____	to	_____		
4._____	to	_____		
5._____	to	_____		

By Signing, I am agreeing to assign my fees to the group(s) named, and service location number listed above.

_____

Date **Print or Type Provider Name**

_____

***Original* Provider Signature (Signature Stamps Not Accepted)**

****This is the contact name and phone number we will use if we have any questions about this document.**

Contact Name: _____

Phone:_____E-Mail

Address: _____

Address Change – Provider Practice Relocation Request

This form can ONLY be used for the following Provider Types:

05 – Home Health Agency*	19 - Psychologist
06 – Hospice*	20 - Audiologist
09 – CRNP**	23 - Nutritionist
14 - Podiatrist	27 – Dentist
15 - Chiropractor	31 - Physician
16 - Nurse	32 - CRNA
17 - Therapist	33 - CNM
18 - Optometrist	

*** Provider type 05 and 06 MUST provide CMS verification of address change along with this form.**

****Provider type 09 MUST provide a collaborative practice agreement reflecting change of address.**

This form **MAY** be used for the following purposes only:

1. To update your ***Service Location*** address if the practice has ***relocated*** (please refer to examples below).
   - **Example of when to use this form:** The practice was located at 200 West Mills Street. The practice closed at 200 West Mills Street completely and relocated to 35 East Main Street.
   - **Do not use this form if:** You were employed with a practice at 100 Fairfield Drive and you left this employer and are now working for a new employer at 4350 Fowler Street. If this is your situation please complete a **PROMISe™ Provider Service Location Change Request:** http://www.dhs.pa.gov/cs/groups/public/documents/form/s_001983.pdf **in addition to a New Service Location Request:** http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994
2. To change a ***Mail-To*** address for this new location.
3. To change a ***Pay-To*** address for this new location.
4. To change a ***Home Office*** address for this new location.

This form **CANNOT** be used to add or change a service location.

- To add a service location**,** complete a PROMISe™ Provider Enrollment Base Application or PROMISe™ New Service Location Application, as applicable, and any required related forms: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994 **NOTE: This form is NOT to be used to add a service location where actual recipient services are performed.**

THIS FORM CANNOT BE USED TO ADD A NEW SERVICE LOCATION OR MAKE CHANGES TO A CURRENT SERVICE LOCATION OR ADDRESS.

This form can only be used to:

- Update the Service Location address if the practice has ***RELOCATED***. **See examples on instruction sheet**.
- Change the Pay-To, Mail-To, and/or Home Office address.

Please note: You must complete a new Provider Enrollment Application or New Service Location Application, as applicable, to add a new service location where actual recipient services are provided.

Old Address:
The following address is the address listed currently for this service location:

Provider Name: _____

PROMISe™ Provider Number: _____ ___ ___ ___ ___ ___ ___ ___ ___ _____**(13 digits)**

Provider Type Number and Description:_____/ _____

Specialty Number and Description:_____/ _____

Street Address: _____

City:_____County: _____

State: Zip Code: : - _____ ___

Please **change** the above address for this service location to the address below:

New Address:
The address listed below is the address of the service location now:

Provider Name: ____

Street Address: _____

City:_____County: _____

State: Zip Code: - _____ ___

Phone No.: ( )_____Fax No.: ( )_____

Effective Change Date: / /_____

Is this address an active Rural Health Choice Clinic of FQHC? ☐ Yes ☐ No

Is this office handicap accessible? ☐ Yes ☐ No

Does the office have an official exemption from the U.S. Department of Justice excusing compliance with Title III of the Americans with Disabilities ACT (ADA)? If yes, attach a copy of the exemption to your application. ☐ Yes ☐ No

Check this block only if you wish your Medicare claims to crossover to this service location. ☐

***Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

Please complete to change the Mail-to, Pay-to, or Home Office address for the new location.

Change the Current: Mail-To ☐ Pay –To ☐ Home Office ☐ Effective Change Date:_____/_____/_____
Street Address: _____
City:_____Email: _____
State: Zip Code: - Phone No.: (_____)_____

Change the Current: Mail-To ☐ Pay –To ☐ Home Office ☐ Effective Change Date:_____/_____/_____
Street Address: _____
City:_____Email: _____
State: Zip Code: - Phone No.: (_____)_____

Change the Current: Mail-To ☐ Pay –To ☐ Home Office ☐ Effective Change Date:_____/_____/_____
Street Address: _____
City:_____Email: _____
State: Zip Code: - Phone No.: (_____)_____

Verify your **IRS Address** below: **Note**: This is the address where your **1099 tax document** will be sent.

Street:_____Room/Suite: _____

City:_____State:_____Zip: _ _ _ _ _-_ _ _ _

Email: _____

Contact Name/Phone number: In case we have questions concerning this form.

Name:_____Phone Number: _____

Please **sign and date** form below:

Date **Print or Type Provider Name**

Original Provider Signature (Signature Stamps Not Accepted)

If additional changes are required, copy page 2 and 3 or attach sheet(s) using identical format.

Please return to: Bureau of Fee-for-Service Programs
Division of Operations – Provider Enrollment Section
P.O. Box 8045
Harrisburg, PA 17105-8045

Terminate Fee Assignment Provider Service Location Change Request

Instructions For PROMISe™ Provider Service Location Change Request

This form can be used for the following purposes only:

1. To ***close*** an existing service location.
2. To change a ***Mail-To*** address for an existing service location.
3. To change a ***Pay-To*** address for an existing service location.
4. To change a ***Home Office*** address for an existing service location.
5. To change an ***IRS*** address for an existing service location.
6. To change an ***e-mail*** address for an existing service location.
7. To ***terminate association (fee assignment)*** with a Provider Group by an individual.
8. To ***add or terminate participation*** with a Provider Eligibility Program (PEP).

This form **CANNOT** be used to add a service location.

- To add a service location**,** complete a PROMISe™ Provider Enrollment Individual Application or Provider Enrollment Base Application and any required related forms. **This form is NOT to be used to add a service location where actual recipient services are performed.**

THIS FORM CANNOT BE USED TO ADD A NEW SERVICE LOCATION ADDRESS.

This form can only be used to:

- Change where the mailings, e-mails and payments are to be sent for an existing service location.
- Close an existing Service Location, Pay-To, Mail-To, and/or Home Office address.
- If closing a service location currently paying to itself, change the pay-to address for outstanding payments if needed.

Please note: You must complete a new Provider Enrollment Application to add a new service location where actual recipient services are provided.

Please **CLOSE** the following service location on my provider file:

Provider Name: _____

PROMISe™ Provider Number: _____ ___ ___ ___ ___ ___ ___ ___ ___ ___ _____**(13 digits)**

Provider Type Number and Description:_____/ _____

Specialty Number and Description:_____/ _____

Effective Close Date:_____/_____/_____

Street Address: _____

City:_____County: _____

State:_____ Zip Code:_____-_____Phone No.: (_____)_____

Please **change** the following address for a **previously established** service location: **(Mail-To, Pay-To, Home Office, IRS or E-mail Address only. You cannot add or change a service location address using this form.)**

Provider Name: _____

PROMISe™ Provider Number: _____ ___ ___ ___ ___ ___ ___ ___ ___ ___ _____**(13 digits)**

Change the Current: Mail-To ☐, Pay-To ☐, Home Office ☐, IRS ☐ Effective Change Date: / / __

Provider Type Number and Description:_____/ _____

Specialty Number and Description:_____/ _____

E-mail Address: _____

Street Address: _____

City:_____County: _____

State: Zip Code: - Phone No.: ( )_____

Note: Please remember to **sign and date** on the bottom of page 3.

Please terminate my association/fee assignment with the following Group:

☐ Delete this provider from the provider group. Specify the Group provider number:

__ __ __ __ __ __ __ __ __ __ __ __ __ **(Must be a 13 digit number or will be returned)**

Group Name: _____

Individual Provider Name: _____

Individual Provider Number: _____ ___ ___ ___ ___ ___ ___ ___ ___ _____ **(13 digits)**

Provider Type Number and Description: _____/ _____

Specialty Number and Description: _____/ _____

Effective date of withdrawal from Group participation: _/____/_____

Please add or end date my participation with the following Provider Eligibility Program (PEP).

☐ Add a Provider Eligibility Program (PEP) for this provider.

☐ End-date the Provider Eligibility Program (PEP) for this provider.

Provider Eligibility Program (PEP) Name: _____

Provider Name: _____

PROMISe™ Provider Number: _____ ___ ___ ___ ___ ___ ___ ___ ___ _____ **(13 digits)**

Provider Type Number and Description: _____/ _____

Specialty Number and Description: _____/ ____ Effective **begin** date:

_____/_____/_____ when **adding** a PEP or

Effective **end** date: _____/_____/_____ when **closing** a PEP.

_____ _____

Date Print or Type Provider Name

_____

Original Provider Signature (Signature Stamps Not Accepted)

If additional changes are required, copy page 2 and 3 or attach sheet(s) using identical format.

Please return to: Bureau of Fee-for-Service Programs

Division of Operations – Provider Enrollment Section

P.O. Box 8045

Harrisburg, PA 17105-8045

Examples of Acceptable Documentation to Verify IRS Numbers

The following documents are acceptable as verification of the FEIN/SSN number:

NOTE: Only the applicable portions of the documents have been included.

- **IRS Form CP575**

Keep this part for your records. CP 575 C (Rev. 1-

Return this part with any correspondence so we may identify your account. Please correct any errors in your name or address.

CP 575 C

Your Telephone Number ( ) -

Best Time to Call

DATE OF THIS NOTICE: 04-19-96
EMPLOYER IDENTIFICATION NUMBER: 12-3456789
FORM: SS-4

INTERNAL REVENUE SERVICE
KANSAS CITY MO 64999

JOE M. SMITH
1421 MAIN STREET
NOWHERE, IN 41414

- **Form 8109 – Federal Tax Deposit Coupon**

Mark the "X" in this box only if there is a change to Employer Identification Number (EIN) or Name.

See instructions on page 1.

BANK NAME/ DATE STAMP

EIN 12-3456789

JOE M. SMITH
1421 MAIN STREET
NOWHERE, IN 41414

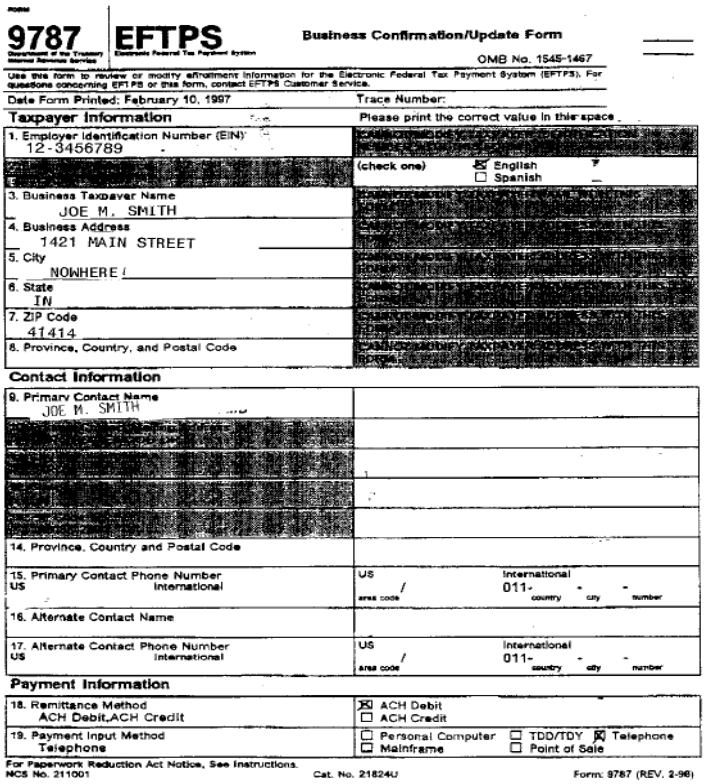
Telephone number ( )

Federal Tax Deposit Coupon
Form 8109 (Rev. 10-96)

941	945	1st Quarter
990-C	1120	2nd Quarter
943	990-T	3rd Quarter
720	990-PF	4th Quarter
CT-1	1042	
940		

FOR BANK USE IN MICR ENCODING

- **Form 9787 Electronic Federal Tax Payment System**



9787 EFTPS — Business Confirmation/Update Form

OMB No. 1545-1467

Use this form to review or modify enrollment information for the Electronic Federal Tax Payment System (EFTPS). For questions concerning EFTPS or this form, contact EFTPS Customer Service.

Date Form Printed: February 10, 1997 — Trace Number:

Taxpayer Information — Please print the correct value in this space.

1. Employer Identification Number (EIN): 12-3456789	
[redacted]	(check one) ☒ English ☐ Spanish
3. Business Taxpayer Name: JOE M. SMITH	
4. Business Address: 1421 MAIN STREET	
5. City: NOWHERE	
6. State: IN	
7. ZIP Code: 41414	
8. Province, Country, and Postal Code	

Contact Information

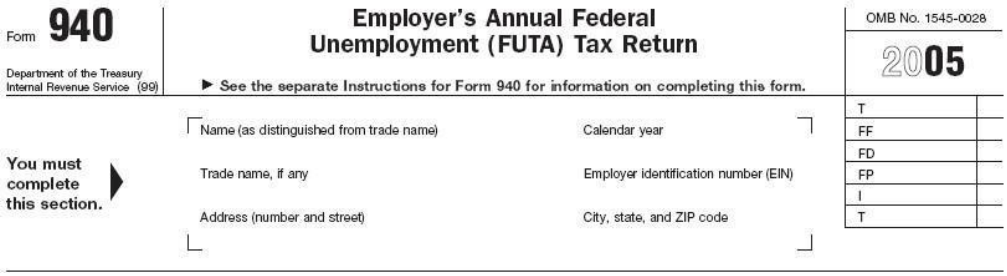
9. Primary Contact Name: JOE M. SMITH	
[redacted]	
14. Province, Country and Postal Code	
15. Primary Contact Phone Number — US / International	US: / (area code) — International: 011- - - (country city number)
16. Alternate Contact Name	
17. Alternate Contact Phone Number — US / International	US: / (area code) — International: 011- - - (country city number)

Payment Information

18. Remittance Method: ACH Debit,ACH Credit	☒ ACH Debit ☐ ACH Credit
19. Payment Input Method: Telephone	☐ Personal Computer ☐ TDD/TDY ☒ Telephone ☐ Mainframe ☐ Point of Sale

For Paperwork Reduction Act Notice, See Instructions. NCS No. 211001 — Cat. No. 21824U — Form: 9787 (REV. 2-96)

- **940 Social Security Tax Form**



Form **940** — Department of the Treasury, Internal Revenue Service (99)

Employer's Annual Federal Unemployment (FUTA) Tax Return

▶ See the separate Instructions for Form 940 for information on completing this form.

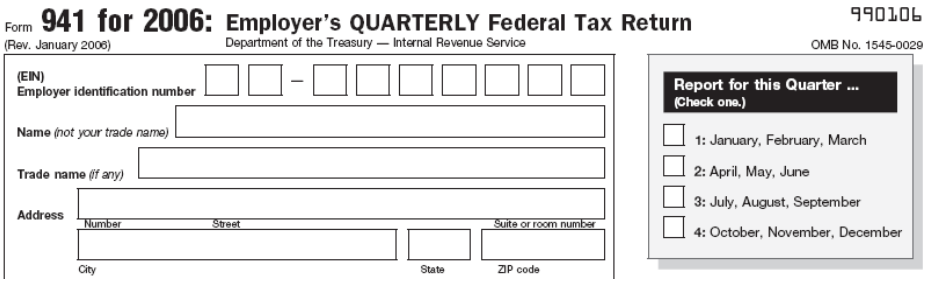
OMB No. 1545-0028

2005

You must complete this section.	Name (as distinguished from trade name)	Calendar year
	Trade name, if any	Employer identification number (EIN)
	Address (number and street)	City, state, and ZIP code

T	
FF	
FD	
FP	
I	
T	

- **941 Federal Unemployment Tax Form**



Form **941 for 2006:** Employer's QUARTERLY Federal Tax Return

(Rev. January 2006) — Department of the Treasury — Internal Revenue Service

990106

OMB No. 1545-0029

(EIN) Employer identification number

Name *(not your trade name)*

Trade name *(if any)*

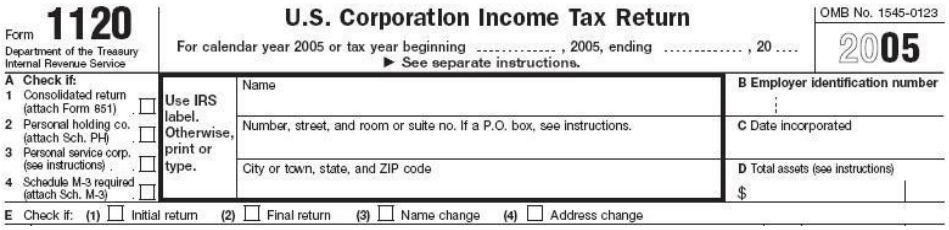
Address — Number, Street, Suite or room number

City, State, ZIP code

Report for this Quarter ... (Check one.)

- ☐ 1: January, February, March
- ☐ 2: April, May, June
- ☐ 3: July, August, September
- ☐ 4: October, November, December

- **1120 Federal Income Tax Form**



Form **1120** — Department of the Treasury, Internal Revenue Service

U.S. Corporation Income Tax Return

For calendar year 2005 or tax year beginning ....., 2005, ending ....., 20....

▶ See separate instructions.

OMB No. 1545-0123

2005

A Check if:
1 Consolidated return (attach Form 851)
2 Personal holding co. (attach Sch. PH)
3 Personal service corp. (see instructions)
4 Schedule M-3 required (attach Sch. M-3)

Use IRS label. Otherwise, print or type.

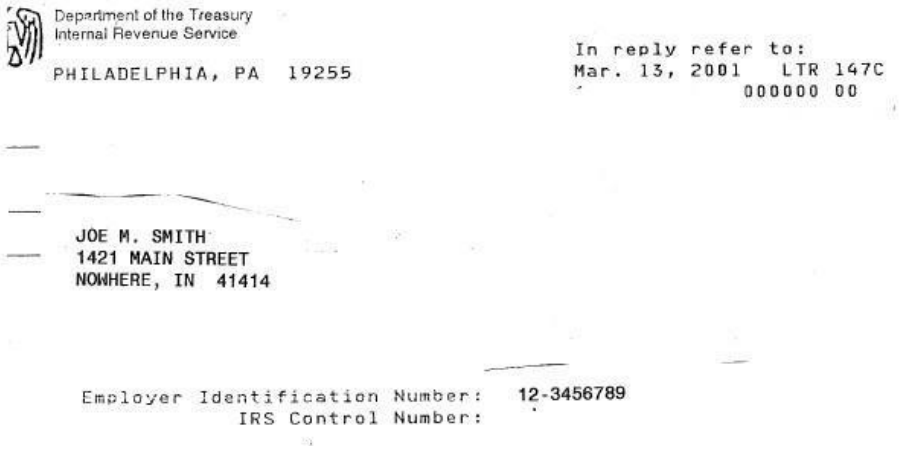
Name | B Employer identification number

Number, street, and room or suite no. If a P.O. box, see instructions. | C Date incorporated

City or town, state, and ZIP code | D Total assets (see instructions) $

E Check if: (1) ☐ Initial return (2) ☐ Final return (3) ☐ Name change (4) ☐ Address change

- **IRS Letter 147C**



Department of the Treasury
Internal Revenue Service

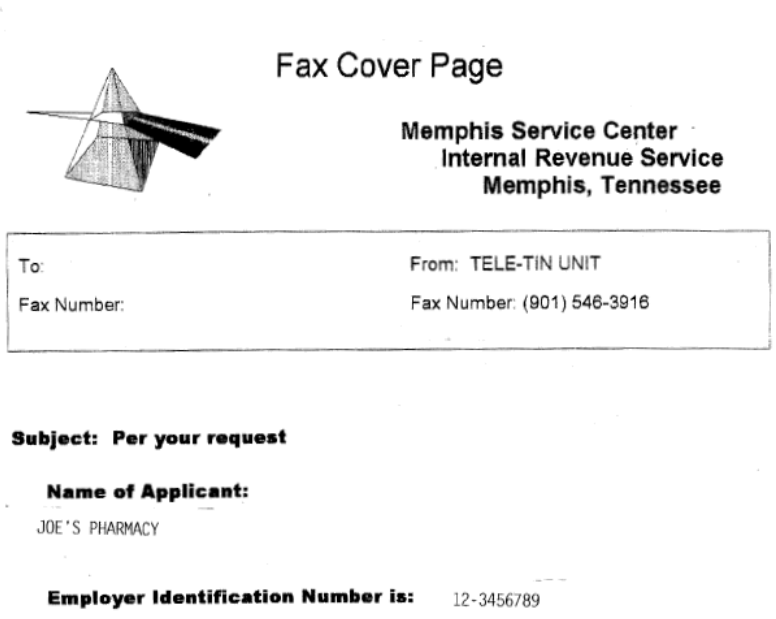
PHILADELPHIA, PA 19255

In reply refer to:
Mar. 13, 2001 LTR 147C
000000 00

JOE M. SMITH
1421 MAIN STREET
NOWHERE, IN 41414

Employer Identification Number: 12-3456789
IRS Control Number:

- **IRS Fax Cover Page**



Fax Cover Page

Memphis Service Center
Internal Revenue Service
Memphis, Tennessee

To:	From: TELE-TIN UNIT
Fax Number:	Fax Number: (901) 546-3916

Subject: Per your request

Name of Applicant:

JOE'S PHARMACY

Employer Identification Number is: 12-3456789

- **IRS Form 1040 (1040 A & 1040 EZ are also acceptable)**

Form **1040** Department of the Treasury—Internal Revenue Service **U.S. Individual Income Tax Return** **2005** (99) IRS Use Only—Do not write or staple in this space.

Label (See instructions on page 16.) **Use the IRS label.** Otherwise, please print or type. LABEL HERE

For the year Jan. 1–Dec. 31, 2005, or other tax year beginning , 2005, ending , 20 — OMB No. 1545-0074

Your first name and initial	Last name	Your social security number
If a joint return, spouse's first name and initial	Last name	Spouse's social security number
Home address (number and street). If you have a P.O. box, see page 16.	Apt. no.	▲ You must enter your SSN(s) above. ▲
City, town or post office, state, and ZIP code. If you have a foreign address, see page 16.		Checking a box below will not change your tax or refund.

Presidential Election Campaign ▶ Check here if you, or your spouse if filing jointly, want $3 to go to this fund (see page 16) ▶ ☐ You ☐ Spouse

- **Social Security Card**

- **Form W-2**

a Control number	22222	OMB No. 1545-0008	
b Employer identification number (EIN)		1 Wages, tips, other compensation	2 Federal income tax withheld
c Employer's name, address, and ZIP code		3 Social security wages	4 Social security tax withheld
		5 Medicare wages and tips	6 Medicare tax withheld
		7 Social security tips	8 Allocated tips
d Employee's social security number		9 Advance EIC payment	10 Dependent care benefits
e Employee's first name and initial Last name Suff.		11 Nonqualified plans	12a
		13 Statutory employee ☐ Retirement plan ☐ Third-party sick pay ☐	12b
		14 Other	12c
			12d
f Employee's address and ZIP code			

15 State Employer's state ID number	16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax	20 Locality name

Form **W-2** Wage and Tax Statement **2006** Department of the Treasury—Internal Revenue Service

Copy 1—For State, City, or Local Tax Department

- **Social Security Statement (MUST include BOTH pages 1 & 2)**

Page 1:

Prevent identity theft—protect your Social Security number

Your Social Security Statement

Prepared especially for Wanda Worker

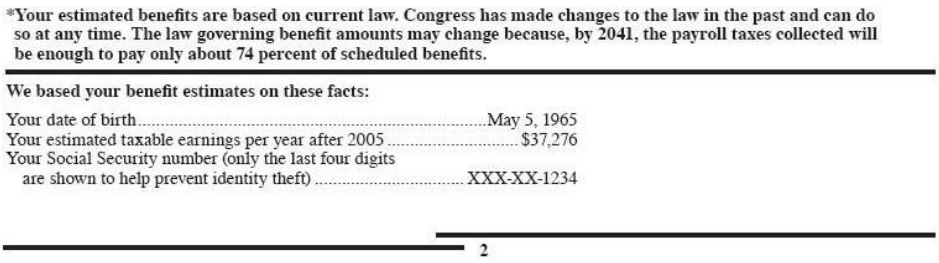
January 6, 2006

See inside for your personal information →

WANDA WORKER
456 ANYWHERE AVENUE
MAINTOWN, USA 11111-1111

What's inside…

Page 2:



***Your estimated benefits are based on current law. Congress has made changes to the law in the past and can do so at any time. The law governing benefit amounts may change because, by 2041, the payroll taxes collected will be enough to pay only about 74 percent of scheduled benefits.**

We based your benefit estimates on these facts:

Your date of birth	May 5, 1965
Your estimated taxable earnings per year after 2005	$37,276
Your Social Security number (only the last four digits are shown to help prevent identity theft)	XXX-XX-1234

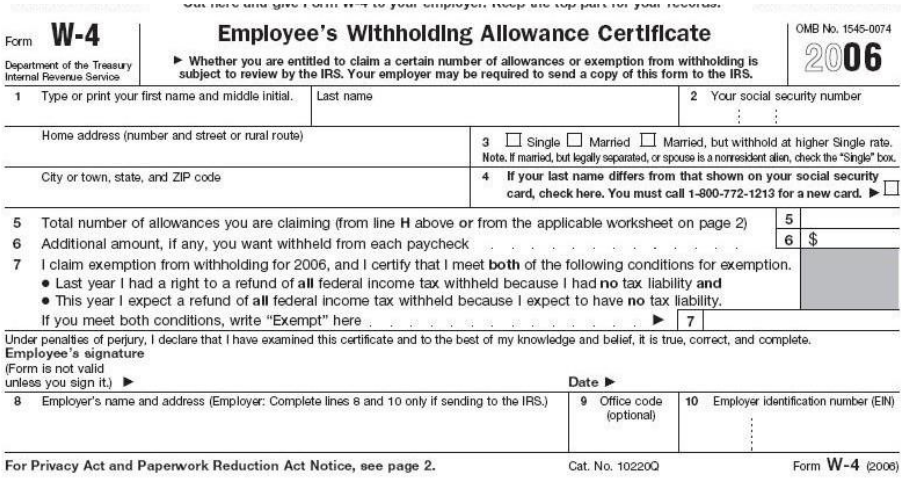
2

Examples of Unacceptable Documentation to Verify IRS Numbers

The following documents are **NOT** acceptable as verification of the IRS/SSN number:

NOTE: Only the applicable portions of the documents have been included.

- **Form W-4**



Form **W-4** (2006)

Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074

2006

1 Type or print your first name and middle initial. | Last name | 2 Your social security number

Home address (number and street or rural route) | 3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. ► ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | 5

6 Additional amount, if any, you want withheld from each paycheck | 6 $

7 I claim exemption from withholding for 2006, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here ► | 7

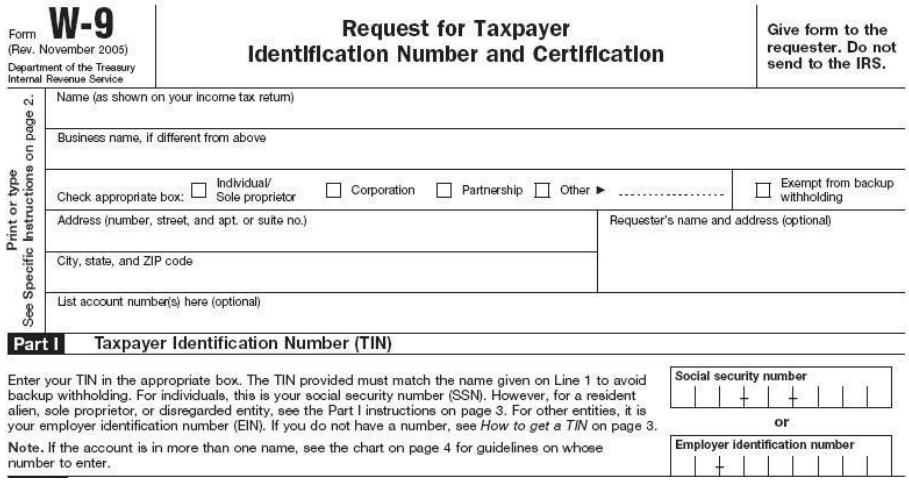
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (Form is not valid unless you sign it.) ► Date ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) | 10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2006)

- **Form W-9**



Form **W-9** (Rev. November 2005)

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 ☐ Other ► ☐ Exempt from backup withholding

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.

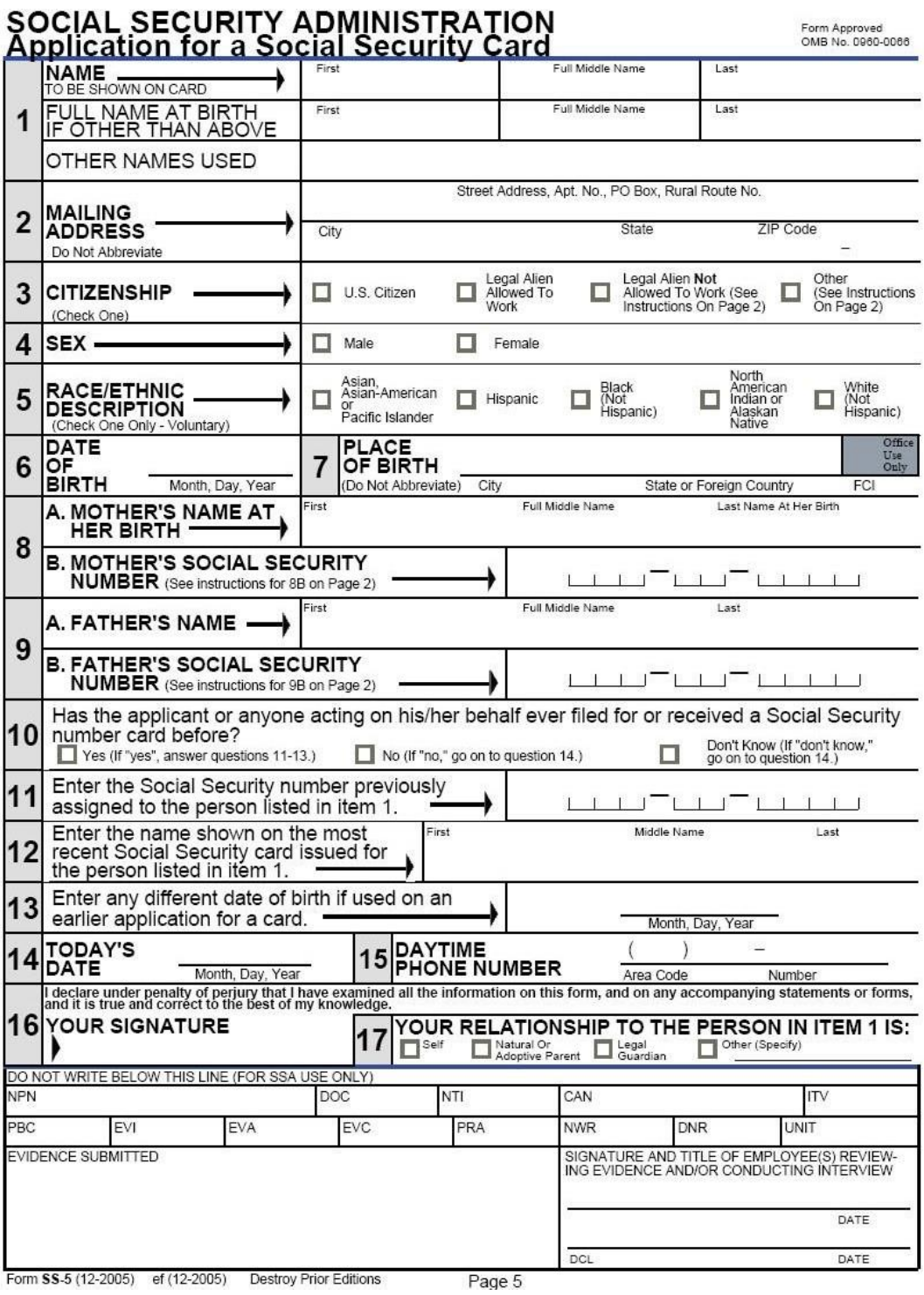
Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

- **Form SS-5 (Application for a Social Security Card)**



SOCIAL SECURITY ADMINISTRATION
Application for a Social Security Card

Form Approved
OMB No. 0960-0066

1	NAME TO BE SHOWN ON CARD	First	Full Middle Name	Last
	FULL NAME AT BIRTH IF OTHER THAN ABOVE	First	Full Middle Name	Last
	OTHER NAMES USED			
2	MAILING ADDRESS Do Not Abbreviate	Street Address, Apt. No., PO Box, Rural Route No.		
		City	State	ZIP Code
3	CITIZENSHIP (Check One)	☐ U.S. Citizen ☐ Legal Alien Allowed To Work ☐ Legal Alien **Not** Allowed To Work (See Instructions On Page 2) ☐ Other (See Instructions On Page 2)		
4	SEX	☐ Male ☐ Female		
5	RACE/ETHNIC DESCRIPTION (Check One Only - Voluntary)	☐ Asian, Asian-American or Pacific Islander ☐ Hispanic ☐ Black (Not Hispanic) ☐ North American Indian or Alaskan Native ☐ White (Not Hispanic)		
6	DATE OF BIRTH Month, Day, Year	7 PLACE OF BIRTH (Do Not Abbreviate) City	State or Foreign Country	Office Use Only FCI
8	A. MOTHER'S NAME AT HER BIRTH	First	Full Middle Name	Last Name At Her Birth
	B. MOTHER'S SOCIAL SECURITY NUMBER (See instructions for 8B on Page 2)	___ - ___ - ____		
9	A. FATHER'S NAME	First	Full Middle Name	Last
	B. FATHER'S SOCIAL SECURITY NUMBER (See instructions for 9B on Page 2)	___ - ___ - ____		
10	Has the applicant or anyone acting on his/her behalf ever filed for or received a Social Security number card before? ☐ Yes (If "yes", answer questions 11-13.) ☐ No (If "no," go on to question 14.) ☐ Don't Know (If "don't know," go on to question 14.)			
11	Enter the Social Security number previously assigned to the person listed in item 1.	___ - ___ - ____		
12	Enter the name shown on the most recent Social Security card issued for the person listed in item 1.	First	Middle Name	Last
13	Enter any different date of birth if used on an earlier application for a card.	Month, Day, Year		
14	TODAY'S DATE Month, Day, Year	15 DAYTIME PHONE NUMBER ( ) – Area Code Number		
16	I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. YOUR SIGNATURE	17 YOUR RELATIONSHIP TO THE PERSON IN ITEM 1 IS: ☐ Self ☐ Natural Or Adoptive Parent ☐ Legal Guardian ☐ Other (Specify)		

DO NOT WRITE BELOW THIS LINE (FOR SSA USE ONLY)

NPN		DOC	NTI		CAN		ITV
PBC	EVI	EVA	EVC	PRA	NWR	DNR	UNIT
EVIDENCE SUBMITTED					SIGNATURE AND TITLE OF EMPLOYEE(S) REVIEWING EVIDENCE AND/OR CONDUCTING INTERVIEW DATE DCL DATE		

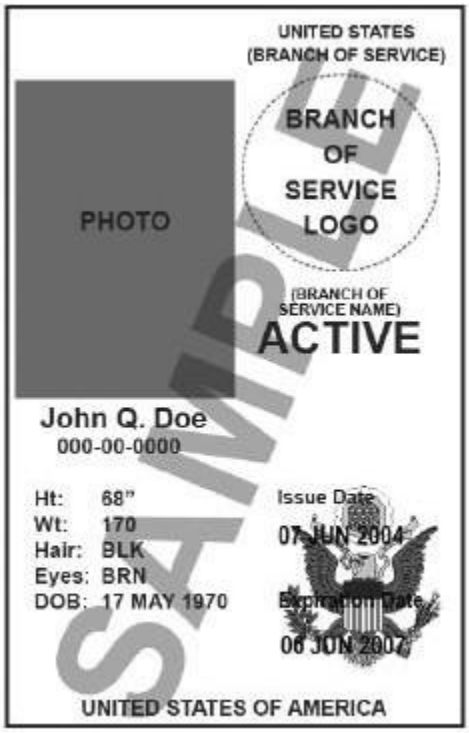
Form SS-5 (12-2005) ef (12-2005) Destroy Prior Editions Page 5

- **State Driver's License**

- **Military ID**

Uniformed Services Identification Card - Active Duty

Uniformed Services Identification Card - Active Duty Family Member



Common Access Card

- **Health Insurance Card**

- **State Corporation Papers**
- **State Tax Papers**