

Example

This is an example of the Non-Agency Nurse Application Checklist Provider Enrollment Forms for a Nurse applicant.

You must complete all of the steps listed below and send the required items with your application. Incomplete, incorrect applications or applications missing items will be rejected and returned to you.

- Application (completed, signed & dated)
- Attach the completed and signed Addendum. (Check the appropriate box for residency)
- Attach the completed W-9 form.
- You must submit two forms of identification. *(\*Not included with this example\*)*
  - 1.) A copy of your Social Security Card.
  - 2.) State of Ohio ID, Valid Driver License, other government issue photo ID or Alien Identification Card with an address. If your ID does not list your current address you must submit a current utility bill or pay stub that has your current address on it along with the copy of your ID.
- You must attach a copy of the notice from the NPI Enumerator to verify National Provider Identifier Number. *(\*Not included with this example\*)*
- Attach your completed Declaration of Regarding Material Assistance/Non-assistance to a Terrorist Organization (DMA) form. *(\*Not included with this example\*)*

In order to receive prompt notification of your provider status, please include your email address below and return this page with the rest of your provider packet:

Email: Johnbgoodas@aol.com

**STOP: Double check your work. We want you to get it right the first time. See common errors on the next page.**

If you have any questions please call (614) 466-6742 for assistance.

Please notify me when my provider number is issued, Email address is listed above.

**Ohio Department of Job and Family Services  
Ohio Health Plans Provider Enrollment Application/Time Limited  
Agreement for Individual Practitioners**

*Example  
RN/LPN,*

Submit completed signed application/agreement with required attachments to:  
Bureau of Community Services Policy  
Attention: Application Coordinator  
PO Box 182709, 5<sup>th</sup> Floor  
Columbus, Ohio 43218-2709  
Call the Interactive Voice Response (IVR) System at 1-800-686-1516

(For State Use Only)

Complete all applicable items if you plan to bill Medicaid as an individual physician or non-physician practitioner. All physicians and non-physician practitioners who are members of a group must apply as individuals for Medicaid enrollment.

**Individual Provider Types: - Required** (Mark only ONE box to indicate your Provider Type.)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Chiro/Mechanotherapist (37)        | <input type="checkbox"/> Nurse Anesthetist/Anesthesiologist Assistant (73) | <input type="checkbox"/> Osteopath (22)               |
| <input type="checkbox"/> Chiropractor (27)                  | <input type="checkbox"/> Nurse Midwife (71)                                | <input type="checkbox"/> Physical Therapist (39)      |
| <input type="checkbox"/> Clinical Nurse Specialist (65)     | <input type="checkbox"/> Nurse Practitioner (72)                           | <input type="checkbox"/> Physician (20)               |
| <input type="checkbox"/> Dentist (30)                       | <input type="checkbox"/> Occupational Therapist (41)                       | <input type="checkbox"/> Podiatrist (36)              |
| <input checked="" type="checkbox"/> Nurse, RN, LPN (38)     | <input type="checkbox"/> Optician (75)                                     | <input type="checkbox"/> Psychologist (42)            |
| <input type="checkbox"/> Non-Agency Personal Care Aide (25) | <input type="checkbox"/> Optometrist (35)                                  | <input type="checkbox"/> Waiver Service Provider (45) |

**Provider Identification: - Required** (Print or type entries.)

Name (First) <b>John</b>	(Middle Initial) <b>B.</b>	(Last) <b>Good</b>	Title (M.D., D.O., etc.) <b>RN</b>
Social Security Number (ALL Individual Practitioners) <b>111-11-1111</b>	You must attach a signed W-9 form With individual's name, address, social security number, original signature, and date. Do not use GROUP tax ID number.		Employer Identification Number (Incorporated Individuals, only)
			DEA number

**Address Information: - Required** (Print or type entries.)

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

Building Name / OR / Department / OR / In care of <b>John B. Good, RN</b>			
Practice Address (Number, Street, Avenue, Route, etc.. P.O. and Drop Boxes are not acceptable) <b>25 Cool Lane</b>			Suite Number
City <b>Columbus</b>	County <b>Franklin</b>	State <b>Ohio</b>	Zip Code (Zip +4, if possible) <b>43214-6420</b>
Telephone Number <b>(614) 222-3333</b>			

"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 Practice" 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 Practice" 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)	

(For State Use Only)

Caution

ALL blocks in the licensure section must be completed to avoid return of application/agreement

Licensure Information: (Print or type entries)

License number* <b>RN123456</b>	License Issuance Date (mm/dd/yyyy) <b>05/22/1995</b>	Current License Expiration Date* (mm/dd/yyyy) <b>08/31/2011</b>
------------------------------------	---	--

\*You must attach copy of State Board License

\* You must attach copy of Renewal Card

Medicare Identification Information: Required for Physical/Occupational Therapists and Psychologists

If you are a participating Medicare provider; enter your Medicare information (Print or type entries)

PIN number (s) (Do not use UPIN)	CLIA number*	DMERC number*
----------------------------------	--------------	---------------

\* You must attach copy of the Medicare Certification letter

\* You must attach copy of CLIA Certificate

\* You must attach copy of DMERC Certificate

National Provider Identifier:

If you have received your National Provider Identifier (NPI), and/or if you had a previous NPI, please report it here.

Current NPI number ** <b>001W00000X</b>
--

Previous NPI number
---------------------

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

Physician/Oral Surgeon Specialty Certification: (Complete only if Board Certified)

<b>PRIMARY</b> Specialty Type	Board Name	Certification Date (mm/dd/yyyy)
<b>SECONDARY</b> Specialty Type	Board Name	Certification Date (mm/dd/yyyy)

Enter any Ohio Medicaid 7-digit Group Provider Numbers you are Affiliated with:

1	2	3	4	5
6	7	8	9	10

Nurse Applicants: - Required (Print or type entries)

Do you have Prescriptive Authority? <input type="checkbox"/> YES <input type="checkbox"/> NO		Are you an APN Pilot Program Participant? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Certification Number*	Certification Date (mm/dd/yyyy)	Current Renewal Date* (mm/dd/yyyy)	
* You must attach copy of Certificate			
Do you have a Certificate of Authority? (NON PILOT PROGRAM PARTICIPANTS) <input type="checkbox"/> YES <input type="checkbox"/> NO			
* You must attach copy of Renewal Card			
Certification Number*	Certification Date (mm/dd/yyyy)	Current Renewal Date* (mm/dd/yyyy)	
* You must attach copy of Certificate			
Specialty Certification Number*	Certification Date (mm/dd/yyyy)	Current Renewal Date* (mm/dd/yyyy)	
* You must attach copy of Certificate			
CRNA Certificate Number*	CRNA Recertification Date (mm/dd/yyyy)	CRNA Recertification Card Expiration Date (mm/dd/yyyy)	
* You must attach copy of Certificate			
* You must attach copy of Recertification Card			
RN /LPN License number*	License Issuance Date (mm/dd/yyyy)	Current License Expiration Date* (mm/dd/yyyy)	
* You must attach copy of License			
* You must attach copy of Renewal Card			
	Master's Degree Certification Date (mm/dd/yyyy)	A Master's Degree in Nursing is an Ohio Medicaid requirement for all advanced practice nurses effective January 1, 2003.	
* You must attach copy of Certificate			

Optional Category of Service: (If you will provide an Optional Category of Service mark your Provider Type, and mark the Categories of Service(s) you intend to provide.)

<input type="checkbox"/> Physician & Osteopath	<input type="checkbox"/> 30-Prescribed Drugs,	<input type="checkbox"/> 32-Supplies and Medical Equipment
<input type="checkbox"/> Nurse Practitioners	<input type="checkbox"/> 30-Prescribed Drugs,	<input type="checkbox"/> 32-Supplies and Medical Equipment
<input type="checkbox"/> Dentist	<input type="checkbox"/> 30-Prescribed Drugs,	<input type="checkbox"/> 43-Physician Services
<input type="checkbox"/> Optometrist	<input type="checkbox"/> 30-Prescribed Drugs,	<input type="checkbox"/> 32-Supplies and Medical Equipment <input type="checkbox"/> 34-Eyeglasses

# Disclosure and Ownership/Control Interest Statement

This information is REQUIRED of all providers.

Answer the following questions by checking "Yes" or "No"; marking the appropriate box; and/or giving the proper dates.

1. A. Have you or any individuals or organizations having a direct or indirect ownership or control interest in the professional association or practice 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	Type of offense and disposition	When? Give date (mm/dd/yyyy)	SSN/EIN
Name	Type of offense and disposition	When? Give date (mm/dd/yyyy)	SSN/EIN

1. B. Have you or any of the employees of your professional association or practice 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	Type of offense and disposition	When? Give date (mm/dd/yyyy)	SSN/EIN
Name	Type of offense and disposition	When? Give date (mm/dd/yyyy)	SSN/EIN

2. Type of Entity or Practice:  Sole Proprietorship  Partnership  Corporation  Unincorporated Associations  
 Professional Corporation/Association  Other (specify) \_\_\_\_\_

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

3. 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 or practice operated by a management company, or leased in whole or part by another organization?  
If yes, give date of change of operations. (mm/dd/yyyy)  
 YES  NO

5. List names, addresses for individuals, and the Employer Identification Number (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	Employer Identification Number
Name	Related	Address	Employer Identification Number
Name	Related	Address	Employer Identification Number
Name	Related	Address	Employer Identification Number

6. Have you or the entity or practice ever been sanctioned by the Medicare Program?  
If "YES", when? (mm/dd/yyyy) How long? (mm/dd/yyyy)  
 YES  NO

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

7. 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
-------------------------	-------------------------	-------------------------	-------------------------

8. Have you or 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 and disposition	When, give date? (mm/dd/yyyy)	SSN/EIN
------	---------------------------------	-------------------------------	---------

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 grant and may result in the loss of other contracts or grants with the State of Ohio.

Individual Practitioner Name and Title (please print) :

John B. Good, RN.

Individual Practitioner Initial: JBG Date: 07/10/2009

A copy of Executive Order 2007-01S can be found on our website at:  
<http://jfs.ohio.gov/ohp/>

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.

Individual Practitioner Name and Title (please print) :

John B. Good, RN

Individual Practitioner Initial: JBG Date: 07/10/2009

Occupational Therapy Practitioners only:

I attest that I am an independent Occupational Therapist and I am not associated with an institutional facility or a school system.

Individual Practitioner Name and Title (please print) :

\_\_\_\_\_

Individual Practitioner Initial: \_\_\_\_\_ Date: \_\_\_\_\_

(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. This agreement is limited to 3 years from the effective date.

Individual Practitioner Name and Title (please print): John B. Good, RN

Individual Practitioner Signature: John B. Good, RN Date: 7/10/2009 (mm/dd/yyyy)

For State Use Only

Signature of Authorized Agent: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)

(For State Use Only)

For help completing the application, please call the Provider Enrollment Customer Service Line. You can reach the Provider enrollment Unit through the Interactive Voice Response Unit.

The telephone number is:

800-686-1516

Our business hours are 8:00 am to 4:30 pm Monday through Friday.

**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		Ticket Number	

Ohio Department of Job and Family Services  
**PROVIDER ENROLLMENT APPLICATION**  
**ADDENDUM E**  
**NON-AGENCY WAIVER SERVICE PROVIDER**  
*Non-Agency RN / Non-Agency LPN*

Provider Type 38, 71, 72

Name <u>John B. Good</u>	Medicaid Number
--------------------------	-----------------

*Failure to read and sign this addendum shall result in the applicant being denied for enrollment as a Medicaid Provider.*

- My signature below serves as verification that I comply with the requirements for enrollment as a ODJFS Non-agency Waiver Service Provider – Non-agency RN/Non-agency LPN as a provider of home and community-based nursing as set forth in Ohio Administrative Code (OAC) 5101:3;
  - I agree to comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04. I understand that in order to submit a claim for reimbursement, I must be identified as the provider on the consumer's All Services Plan and bill accordingly;
  - I agree to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;
  - I agree to attend all required ODJFS/CMA training sessions;
  - I agree to be part of the interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's all service's plan;
  - I am an Ohio Licensed Registered Nurse (RN) OR an Ohio Licensed Practical Nurse (LPN) under the direction of an RN practicing within the scope of my nursing license pursuant to Chapter 4723 of the Revised Code
- If LPN, give RN Supervisor Name: \_\_\_\_\_ License # RN. \_\_\_\_\_

- I will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).

**Relationship to consumer**

- My signature below serves as verification that I meet eligibility requirements for a provider serving a consumer as specified in OAC 5101:3-45-04, 5101:3-47-04 and 5101:3-50-04;

**Ohio residency - check as appropriate**

- I HAVE been a resident of Ohio for at least the past five (5) years and I have successfully completed a criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-45-08; **(The results of your background check must be mailed from BCI to ODJFS - Bureau of Community Services Policy - ATTN: BCI Coordinator - P.O. Box 182709 5<sup>th</sup> floor - Columbus Ohio 43218-2709)**
- I HAVE NOT been a resident of Ohio for at least the past five (5) years and I have successfully completed a criminal records check conducted by the Bureau of Criminal Identification and Investigation (BCI&I) and an additional FBI criminal check **(The results of your background check must be mailed from BCI&I to ODJFS - Bureau of Community Services Policy - ATTN: BCI Coordinator - P.O. Box 182709 5<sup>th</sup> floor - Columbus Ohio 43218-2709)**

*I certify that I am the individual practitioner who 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.*

Name and Title (Please Print) <u>John B. Good</u>	
Signature <u>John B. Good, RN</u>	Date <u>07/10/2009</u>

**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) <b>John B. Good</b>	
Business name, if different from above	
Check appropriate box: <input checked="" 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.) <b>25 Cool Lane</b>	Requester's name and address (optional)
City, state, and ZIP code <b>Columbus, Ohio 43214-6420</b>	
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.

Social security number 
or
Employer identification number 

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

**Part II Certification**

Under penalties of perjury, I certify that:

- 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
- 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
- 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.

<b>Sign Here</b>	Signature of U.S. person	Date <b>07/10/2009</b>
------------------	--------------------------	------------------------

**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:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- 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,