DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Provider Tax Identification Reporting Form

PLEASE PRINT LEGIBLY – USE BLUE INK ***PROVIDER NUMBER: ________________________**

Organization/Individual Name: ____

***Federal Employer Identification Number** (FEIN) or **Social Security Number**: ______________________*

Business Address: ____

Payment Address: ____

Telephone Number (   ) __________________ ***Contact person:*** ______________________________

[__] ***I wish to withdraw because:***

[_] ***I wish to continue providing services (If you mark this box, you must complete the remainder of the form)***

Pursuant to Internal Revenue Service regulations, Providers must furnish their taxpayer identification number (TIN) to the State. If this number is not provided, you may be subject to a 20% withholding on each payment.

ENTER YOUR NAME AND ADDRESS EXACTLY AS YOU ENTER THEM ON YOUR IRS INCOME TAX FORMS

***1099/Tax Name:** ____

***1099/Tax Address:** ____

***Federal Employer Identification Number (FEIN):** ____________________ **or *Social Security Number:** ________________

List the Type of Service you are Approved/Licensed to provide:

TYPE	COUNTY (IF APPLICABLE)
______________________________	______________________________
______________________________	______________________________

***Type of Business of Provider (Check One)** [_] **Corporation** [_] **Estate Trust** [_] **Individual** [_] **Government/Non Profit**
[_] **Sole Proprietorship** [_] **Partnership** [_] **Public Services Corporation**

Other Tax Account Number(s) (if applicable): **State Sales Tax/Use Tax Number:** ______________________________

State Unemployment Tax Number: _______________ **State Corporation Income Tax Number:** ________________________

State Employers Withholding Tax Number: ____

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

***Name (Print):** ______________________________ *** Signature:** ______________________________

Date: ______________ **Telephone: (   )** ________________ **Title:** ______________________________

Return to: **WVDHHR**
Bureau for Children & Families

***Submitted By:** ______________________________ / ________________
Worker Name (Please Print Legibly) County

***MUST BE COMPLETE FOR PROCESSING**

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