WV DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Provider Tax Identification Reporting Form

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) [_] Individual [_] Sole Proprietorship [_] Partnership
[_] Government/Non Profit [_] Corporation [_] Public Services Corporation [_] Estate Trust

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 Division of Payment & Vendor Maintenance 350 Capitol Street, Room 730 Charleston, WV 25301

W-9