WRAP FUND APPLICATION PACKET

Assistance Plus
1604 Benton Ave
Benton, ME 04901

Wrap Fund Application
Cover Page

Wrap Funds help meet the emergency needs of adult individuals with Severe and Persistent Mental Illness (SPMI) that cannot be otherwise met through regular systems of care. **This is a fund of last resort. Applicants must demonstrate they have exhausted all other resources**. There is an application process and criteria for how funds are to be used.

Assistance Plus administers the Wrap Fund for Androscoggin, Franklin, Oxford, Kennebec, and Somerset Counties. If you live in any of these counties, have an emergency need and **meet the eligibility guidelines for Section 17 services**, Please complete the attached application.
We strongly encourage working with your case manager or other provider to complete this application. **Assistance Plus is not responsible for helping you complete the application.**

Completed applications may be returned to:

By Mail: Assistance Plus
ATTN: Wrap Funds
PO Box 358 Fairfield ME 04937

By Fax: (207) 238-6302

Drop Off: 1604 Benton Ave, Benton, ME 04901

For any Wrap related questions please contact:
Hanna Brooks
Assistance Plus 1604 Benton Ave, Benton, ME 04901
(207) 453-4708, EXT. 7 hbrooks@assistanceplus.com

Applications are available on our Website at assistanceplus.com

The WRAP committee meets every Thursday at 8am. Completed applications need to be submitted by 2pm the Wednesday before in order to be reviewed by the committee.

After an application has been reviewed the applicant or requesting case manager will be sent a letter of approval or denial within 5 business days. Any applicant who disagrees with the decision may appeal the denial within ten (10) business days of receipt of the decision in writing to: SAMHS Quality Management Specialist, 41 Anthony Avenue, SHS #11, Augusta, ME 04333-0011.

Wrap Fund Application:

- If applicant **RECIEVES** Section 17 Services, Proof of enrollment and authorized KEPRO by *Atrezzo* must be attached.
- If applicant **DOES NOT RECEIVE** Section 17 services, The section 17 eligibility form must be completed and signed by a licensed professional, **IF** the applicant meets the eligibility criteria on the form.
- Applicants must list other recourses/agencies that have been sought to meet the requested need- at least 3 are recommended.

Each Wrap fund category has specific requirements. Please review them and be sure to provided required information.

Wrap will pay no more then Fair Market Rent Rates as determined by HUD.

2018 Fair Market Rent Rates (HUD)					
County	Efficiency	One Bedroom	Two Bedroom	Three Bedroom	Four Bedroom
Kennebec	$612	$635	$784	$1,026	$1,068
Somerset	$585	$634	$781	$1,037	$1,108
Oxford	$631	$635	$763	$1,110	$1,296
Franklin	$559	$597	$697	$883	$949
Androscoggin	$608	$668	$847	$1,077	$1,328

Requests for assistance will be approved if:

- The request is for an emergency need and that all other resources have been exhausted.
- The Applicant has demonstrated that Wrap funds will create a resolution to this urgent need.
- The Applicant has demonstrated that they have applied for all Federal, State and local subsidies.
- The Applicant's current financial status reflects that they are living within their financial means; and
- The Wrap funds request falls under both the Wrap Fund "Wrap fund Needs" and "Wrap Fund allowable amounts"

For Agency Use Only

Date Received	
Application complete	
Application incomplete	

Adult Mental Health
Wrap-fund Application
For the following counties:
Androscoggin, Franklin, Oxford, Kennebec, and Somerset

All Wrap-fund applications submitted must be legible, in black or blue ink, and completed with all required information. A Wrap-fund application submitted and not completed shall be marked incomplete and returned to the Applicant to resubmit.

Date of Application:________________________

Applicant Name:____ Applicant SSN:______________________

Address:____

City:____Zip Code:________________________________

County:_______________________________Telephone Number:______________________________________

Mailing Address, if different:____

Please complete, if applicable:

Applicant's Provider

Case Manager Name:__________________________________Phone:_________________Fax:_____________

Address: ____

Email: ____

Do you have a Representative Payee? Yes ☐ No ☐ If Yes, please provide:

Name:____

Agency:____

Phone Number:_____________________Email:___________________________________

I certify and attest that the attached information is true and complete to the best of my knowledge and belief.

Name of Applicant/Consumer whom Wrap funds are being applied for:

Name:____

Applicant/Consumer Signature:____

Name of Agency and Representative:

Agency Name:____

Agency representative Name:____

Agency Representative Signature:____

SECTION 1 - ELIGIBILITY

Applicant must meet the Eligibility for Care requirements as stated in 10-144 C.M.R. ch. 101 § 17.02. These requirements must be verified and attested to by a clinician through a signature on the application **OR** authorization by KePro CareConnection®;

Is Applicant currently enrolled in Adult Mental Health Services funded Community Support (Section 17)?
_______Yes_______No. If yes, Applicant's Case Manager should complete the **Verification of Current Section 17 Services** section and attach copy of the authorization by KePro Care Connection to verify enrollment.

- If no, please complete **Section 17 eligibility form** on the next page.

Verification of Current Section 17 Services

1. I hereby affirm the information included below concerning the current situation, current address, and eligibility criteria are true and accurate for this client in the Section 17 eligibility form and application.
2. I verify the Applicant meets the Eligibility for Care for Community Support Services as defined in Section 17 of the MaineCare Benefits Manual.

Case Manager must sign below, and verification of enrollment with KePro CareConnection® attached to application. **Continue to Section 2 – Financial.**

Referring Agency:
Printed Name:
Signature:
Date:

Section 17 Eligibility Form to be completed only for applicants that are not already in Section 17 services.

A Clinician is an individual appropriately licensed or certified in the state or province in which he or she practices, practicing within the scope of that licensure or certification, and qualified to deliver treatment under this Section. A qualified professional with one of the following credentials: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker-conditional (LMSW-conditional clinical); physician, psychiatrist; Psychiatric and Mental Health Nurse Practitioner (PMH-NP); Psychiatric and Mental Health Clinical Nurse Specialists (PMH-CNS); Adult Nurse Practitioner (ANP); Family Nurse Practitioner (FNP); Physician Assistant (PA); or licensed psychologist.

I hereby affirm the below-enclosed information concerning the current situation, current address, and eligibility criteria are true and accurate for this client in the Wrap Section 17 eligibility form and application.

1. I verify the Applicant meets the Eligibility for Care for Community Support Services as defined in Section 17 of the MaineCare Benefits Manual.

Client Information	Diagnosis Information
Name:	Primary Diagnosis:
Date of Birth:	Date Given:
Social Security number:	

Specific Eligibility Requirements.

A member meets the specific eligibility requirements for covered services under this section if:

A. The person is age eighteen (18) or older or is an emancipated minor with:

1. A primary diagnosis of Schizophrenia or Schizoaffective disorder in accordance with the DSM 5 criteria; or
2. Another primary DSM 5 diagnosis or DSM4 equivalent diagnosis with the exception of Neurocognitive Disorders, Neurodevelopmental Disorders, Antisocial Personality Disorder and Substance Use Disorders who:

   a) Has a written opinion from a clinician, based on documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homelessness, criminal justice involvement or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided; based on documented or reported history; for the purposes of this section, reported history shall mean an oral or written history obtained from the member, a provider, or a caregiver; or

   b) Has received treatment in a state psychiatric hospital, within the past 24 months, for a non-excluded DSM 5 diagnosis; or

   c) Has been discharged from a mental health residential facility, within the past 24 months, for a non-excluded DSM 5 diagnosis; or

d) Has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis; or

e)Has been committed by a civil court for psychiatric treatment as an adult; or

f) Until the age of 21, the recipient was eligible as a child with severe emotional disturbance, and the recipient has a written opinion from a clinician, in the last 12 months, stating that the recipient had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided; AND

g)Has significant impairment or limitation in adaptive behavior or functioning directly related to the primary diagnosis and defined by the LOCUS, ANSA, or other acceptable standardized assessment tools approved by the Department. If using the LOCUS, the member must have a LOCUS score, as determined by a LOCUS Certified Assessor, of seventeen (17) (Level III) or greater, except that to be eligible for Community Rehabilitation Services (17.04-2) and ACT (17.04-3), the member must have a LOCUS score of twenty (20) (Level IV) or greater.

B. Eligible members who are eighteen (18) to twenty-one (21) years of age shall elect to receive services as an adult or as a child. Those members electing services as an adult are eligible for services under this Section. Those electing services as a child may be eligible for services under Chapter II, Section 65, Behavioral Health Services or Section 13 or both.

C. The LOCUS or other approved tools must be administered, at least annually, or more frequently, if DHHS or an Authorized Entity requires it.

Risk Factors: Documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis.

History Of (check all which apply):

- ☐ has received treatment in a state psychiatric hospital, within the past twenty-four (24) months;
- ☐ has been discharged from a mental health residential facility, within the past twenty-four (24) months;
- ☐ has had two (2) or more episodes of inpatient treatment for mental illness, for greater than seventy-two (72) hours per episode, within the past twenty-four (24) months;
- ☐ has been committed by a civil court for psychiatric treatment as an adult;
- ☐ until the age twenty-one (21), the recipient was eligible as a child with severe emotional disturbance.
- ☐ if selecting this qualifier, please indicate a written opinion stating that the recipient, in the last 12 months, had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided.

Based on documented or reported history**, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of (check all which apply):

- ☐ Homelessness
- ☐ Require a mental health inpatient treatment greater than 72 hours
- ☐ Residential treatment unless community support is provided
- ☐ Criminal Justice involvement

**Reported history may include oral or written history from the client, a provider, or a caregiver.

Signatures and Certifications:

I certify and attest that the attached verifications, diagnostic information including LOCUS score and / or ANSA score are in accordance with Specific Requirements section of this form Part A, paragraph 2,sub paragraph a) and is true and complete to the best of my knowledge and belief.

____ ________________

Clinician Signature/Credentials **Date**

(LCPC); (LCPC-conditional); (LCSW); (LMSW-conditional clinical); physician, psychiatrist; Psychiatric and Mental Health Nurse Practitioner (PMH-NP); Psychiatric and Mental Health Clinical Nurse Specialists (PMH-CNS); (ANP); (FNP); (PA); or licensed psychologist.)

____

Printed Name and Credentials

Section 2 - FINANCIAL

Each Wrap -fund application includes all household income, assets and benefit resources.

What is your current household monthly income?

Source	**Applicant**	**Family Member 1**	**Family Member 2**	**Family Member 3**
Social Security Income	$	$	$	$
Public Assistance Payments (TANF, GA, etc.)	$	$	$	$
Employment	$	$	$	$
Rent paid by Housing Subsidy (BRAP, Shelter Plus Care, Section 8, etc.)				
Child Support	$	$	$	$
Alimony Received	$	$	$	$
Worker's Compensation	$	$	$	$
Other Income:	$	$	$	$
TOTAL	$	$	$	$
GRAND TOTAL OF ALL FAMILY MEMBERS INCOME $________________(add total of applicant + family members)				

Do you receive Food Stamps? Yes☐ No ☐ Amount: $____________

Do you receive Section 8 or some other Housing Subsidy? Yes ☐ No ☐ . IF No, are you on a waitlist?

☐Yes (____)

☐ No

What are your current household monthly expenses?

Category	**Household Expenses**	**Category**	**Household Expenses**
Amount of Rent/Mortgage Payment/Lot Rent paid by applicant		Other Necessary Expenses (list):	
Alimony Paid			
Child Support Paid			
*Transportation Expense			
**Heating Expense			
**Electric Expense			
**Water & Sewer			
Telephone/ Cell Phone /Internet/ Cable (circle)			
Total		**Total**	

GRAND TOTAL OF ALL HOUSEHOLD EXPENSES: $______________(add both Household Expense columns)

* **Transportation** expenses include payment, fuel, maintenance, inspections/tags, and insurance.

* **Public** *transportation can be listed under other necessary expenses.*

** If heating, electric, water and sewer is included in rent, write **INCLUDED**.

If no monthly income is reported, please explain this circumstance:

Are you behind in any of your bills? Yes ☐ No ☐. If yes, please explain:

VETERANS BENEFITS (Does not impact eligibility for Wrap funds- *this section is meant to inform applicant of other potential sources of assistance if applicant or other household member has served in the Military*)

Did you or anyone in your household serve in the US Military? Yes ☐ No ☐

If yes, please answer the following questions for each individual:

Question 1	Name of Individual in household who served in the military	Branch of the military served	Dates of Service (Start Date – End Date)

Question 2	Have you or anyone in your household ever applied for VA benefits? Yes ☐ No ☐
2a	If no, would you like help from the Maine Veterans' Service to apply for VA benefits? Yes ☐ No ☐
2b	If yes, please complete a Authorization to Release Information form from your Case Management Agency to authorize______________________Assistance Plus to release information to "Maine Veterans' Service".

Verification of other resources (i.e. General Assistance, Section 8 housing, LHEAP, Salvation Army, etc.).
Must list other resources you have tried. List name of organizations/agencies/resources, name of person you spoke with, phone number, date of interaction, and outcome (approval or denial to receive resource).

Organization/Contact	Phone Number	Outcome

Section 3 – Request for Assistance

Is this an emergency need? Yes ☐ No ☐

If **NO**, you are not eligible for Wrap funds

If **YES**,

1) Please provide as much detail as possible as to why you are requesting WRAP Funding, and
2) Explain how this will resolve the emergency need.

Use an additional sheet and attach to application if needed. The requests are reviewed by Wrap fund committees that do not know you and your circumstances behind the need. The most current and concise information you can provide will be helpful.

Section 3-Request for Assistance continued

Applicant to complete Wrap fund Category. Please select category, and include amount of request and any other required documents.
*If the Security Deposit, Rent Assist or Temporary Housing in a Motel exceeds over $500, any amount over will make up the total allowance for the applicant for state fiscal year of July 1, 2017–June 30, 2018. Applicant cannot apply for Wrap -funds until the start of the next state fiscal year, July 1, 2019.
** Funds may be used for more than one (1) need below, but cannot exceed $500.00 per State fiscal year per Applicant for non-Housing Assistance.

_______***Security Deposit** (*must provide Security Deposit Agreement Form)* ; not to exceed one month's Fair Market Rent as published by the U. S. Department of Housing and Urban Development).

- Applicant must demonstrate they have, or are in the process of applying for State, Federal, local housing subsidies and/or General Assistance and/or BRAP/Shelter Plus Care to show efforts are being made to obtain permanent and stable housing.

Please provide amount of rent paid by applicant $________and amount of rent paid by subsidy program$___________

If none, what are the sources of income to pay rent: ____

___________# of bedrooms ____________________City/town of housing

_______***Rent Assistance** (*must provide eviction notice or documentation of what is currently owed*; not to exceed one month's Fair Market Rent as published by the U. S. Department of Housing and Urban Development).

- Applicant must demonstrate they have, or are in the process of applying for State, Federal , local housing subsidies and/or General Assistance to show efforts are being made to obtain permanent and stable housing.

a. Wrap can fund applicant/ tenant portion of their rent equal to or less than one month's FMR value.

b. These funds can pay for applicant/tenant portion of back rent owed equal to or less than one month's total rent FMR value. This will allow for applicants back rent to be funded by Wrap equal to or less than FMR but would not be restricted to one month's rent.

c. The Wrap applicant is required to provide documentation on the Wrap application that their tenant portion is equal to or less than one-month FMR, if they receive a housing subsidy and can demonstrate /document that this will be a permanent resolution.

Please provide amount of rent paid by applicant $________and amount of rent paid by subsidy program$___________

If none, what are the sources of income to pay rent: ____

___________# of bedrooms ____________________City/town of housing

________**Temporary Housing in a motel**

Criteria 1-5 must be verified by consumer and/or 3rd party.

1) Applicant is homeless, and/or Applicant has been denied access to homeless shelter.
2) Applicant has behavioral and/or physical health issues which prohibits staying at a homeless shelter.
3) Applicant must provide two (2) hotel rates from area motels
4) Temporary housing may not exceed two (2) weeks unless approved by the Department.
5) Applicant must demonstrate they have, or are in the process of applying for State, Federal, local housing subsidies and/or General Assistance to show efforts are being made to obtain permanent and stable housing.

_________***Prescribed Medications** (up to a two (2) week supply)

1) Applicant must attach copy of the prescription signed by the prescriber to Wrap-fund application
2) Applicant must attach a pharmacy bill to the Wrap -fund application.

_________ ***Electric bill to maintain power in Applicant's residence**.

1) The Applicant must provide a copy of the disconnect notice and attach it to the Wrap -fund application with the amount of payment required to prevent disconnection of power;
2) The Applicant must provide a copy of an approved payment plan from power vendor for remaining amount and attach to the Wrap -fund application.

_________***Emergency fuel** (one hundred (100) gallons, or one hundred (100) pounds lbs. of propane, or one (1) cord of wood)

1) Applicant must verify they have an appointment for fuel assistance and/or or must be actively applying for State, Federal and town heating assistance programs.
2) Applicant to verify that it is the Applicant's obligation to pay for fuel under a lease/occupancy Agreement under the Applicant's name.

________***Vision /Eye Care**-not to exceed $250.00 (Please attach estimate of vision/eye care cost).

________***Oral/Dental Care**-not to exceed $250.00 (Please attach estimate of dental care cost).

________***Transportation to include car repairs and transportation to access mainstream services**-not to exceed $250.00 (Please attach estimate of repair cost).

_______ ***Other Emergency Need** -not to exceed $250.00 (Please attach estimate)

Please describe "Other Emergency Need":

____

____

________***Emergency Need as referred by the Department**

Wrap -fund amount requested by Applicant $_______________

Section 4- Applicant and Committee Checklist

For each application, the **Wrap -funds Applicant and Committee** must answer "YES" to the following five (5) criteria for Wrap -funds to be approved:

Criteria	Answer
Does the applicant verify that the need for Wrap -funds is an emergency (an urgent need requiring financial aid)?	Yes or No
Do Wrap -funds create a resolution to this emergency need?	Yes or No
Has the applicant verified that they have applied for all federal, state and community subsidies?	Yes or No
Does the applicant's current household budget and income plan reflect that they are living with in their financial means?	Yes or No
Does the Wrap -funds request fall under the Wrap -fund emergency need and allowable amount?	Yes or No

Note: All approved applications requests for Wrap -funds must fall under the following Wrap -fund needs and Wrap -fund Allowable Amounts as described in Table A. Wrap -funds can be used for housing or emergency needs, within the State fiscal year of July 1, 2017 –June 30, 2018.

Wrap Funding will not pay for: *telephone or cell phone payments, vehicle payments, vehicle insurance, vehicle registration, cable bills; mental health services, any legal services/representation, additional funding stream for contracting agencies, Court ordered DEEP or offender treatment; purchasing computers; car repairs which exceed sixty percent (60%) of the vehicle's Kelley Blue Book value, or when other transportation resources are available; debt consolidation or credit counseling services; and internet services.*

Assistance Plus SECURITY DEPOSIT AGREEMENT

For Security Deposits only: Must be signed by new Landlord.

Landlord	Tenant
Business Name:	Name:
Business Address and phone number:	Address of Leased Premises:
Tax ID or SSN- Required:	Number of Bedrooms at rented location

MONTHLY RENT:	$
TOTAL SECURITY DEPOSIT:	$
Assistance Plus PORTION OF SECURITY DEPOSIT:	$

- **Please note: Assistance Plus portion of the Security Deposit is dependent upon the applicant's Wrap application being approved.**
- **In consideration of the Landlord's leasing residential premises to Tenant as above indicated and the landlord's following agreements concerning the security deposit, Assistance Plus is willing to pay the indicated Assistance Plus portion of the security deposit. Landlord therefore agrees as follows:**

The Assistance Plus portion of the security deposit shall in all respects be subject to the provisions of Maine law governing residential security deposits, 14 MRSA §§ 6031-6039. Without limiting the foregoing, Landlord shall treat the Assistance Plus portion of the security deposit as provided in 14 MRSA §§ 6035 and 6038 during the tenancy and upon any termination of Landlord's interest in the leased premises. Landlord shall promptly notify Assistance Plus in writing of any termination of the lease or of Tenant's habitation of the leased premises and shall return the Assistance Plus portion of the security deposit to Assistance Plus within thirty (30) days after the date Tenant vacates the leased premises, subject only to amounts Landlord may lawfully retain due to nonpayment of rent or physical damage to the leased premises beyond normal wear and tear. In the event any amounts are so retained, Landlord shall within that thirty (30) day period provide Assistance Plus a written itemization of all amounts charged against the security deposit together with payment of any remaining balance of the Assistance Plus portion of the security deposit after application of the itemized retentions. In no event shall Assistance Plus be liable for any damages, costs or claims of any kind under the lease either in excess of the Assistance Plus portion of the security deposit or arising from reasons other than those which may lawfully be applied to retention of a security deposit for residential premises.

AGREED BY LANDLORD:

Signature:	
Date:	
Printed Name:	
Title:	

******Please complete this form as well as a W-9.*** (This form will be sent with the application when security deposits and rent assistance are being requested).

VENDOR INFORMATION FOR ALL REQUESTS THAT ARE NOT SECURITY DEPOSITS:

Check Payable To:
Mailing Address:
Phone Number:
Federal Tax ID # or Social Security Number:

Please return completed application and all documents requested by any one of the following choices to

WRAP Fund Program:

By fax at: 207-238-6302 "Attention WRAP"

By email at: info@assistanceplus.com Subject Line "WRAP"

By mail: at PO Box 358 Fairfield Maine 04937

For Questions please call 1-800-781-0070 Option #7 or 207-453-4708 Option #7

Dear Vendor,

Thank you for doing business with the agency. In order to keep our records up to date please complete a W-9 Form.

When completing the W-9, Please use your name as it appears on your Federal income tax return. If you conduct a business under a different name or company name, please enter that on line 2.

Select the correct classification for you business. If you are an individual or self employed business, you would choose “Individual/Sole Proprietor” While other types of business should choose which type of business they are operating under -- “C Corporation”, “S Corporation”, “Partnership” or “Trust/ Estate”. (Typically this would follow what type of federal income tax return you file.)

Complete the address section by listing your full mailing address along with your city, state, and zip code.

Fill in the appropriate identification number as it appears on your federal income tax return. For individual/self employed business, this would be your social security number. For other types of business, this would be your employer indemnification number (EIN) that you have received from the internal Revenue services. (Again this number can be found on your federal income tax return)

Sign and date the form. You should keep a copy for your files and fax it to 238-6302.

If you have any questions/concerns, please feel free to contact me at (207) 453-4708 Ext. 7 or hbrooks@assistanceplus.com.

Sincerely,

Wrap

Admin

Substitute Form
(Rev. February 2005)

Article II. Request for Taxpayer
Article III. Identification Number and Certification

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

Please 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 ______
☐ LLC filing as Sole Proprietor ☐ LLC filing as Corporation ☐ LLC filing as Partnership

☐ 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)

Section 3. 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 3 for guidelines on whose number to enter.*

(i) Social security

or

1) Employer

Section 3. 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. person (including a U.S. resident alien).

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 3.)

Section 3.0 Sign Here | **Signature of U.S. person ►** | **Date ►**

i) 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.

U.S. person. 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 the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

b) **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.*

c) For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

d) Foreign person. If you are a foreign person, do not use For 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 recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on a 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 (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, non-employee 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, or
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
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.

i) 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.

ii) Specific Instructions

(b) Name

If you are an individual, you must generally enter the name shown on your social security card. 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 enter in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

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.).

i. Exempt from backup withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" 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.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

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 recipients listed above, 1 through 15.

2) If the payment is for…	THEN the payment is exempt for…
Interest and dividend payments	All exempt recipients except for **9**
Broker transactions	Exempt recipients **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 recipients **1** through **5**
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients **1** through **7** [2]

[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-owner LLC that is disregarded as an entity separate from its owner (see Limited liability company (LLC) on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: See the chart on this page 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/online/ss5.pdf.* 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 ID Numbers under Related Topics. 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: Writing "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.*

a) 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 recipients, see Exempt from backup withholding 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 non-employee 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.

(c) 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 single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole Proprietorship or single-owner LLC	The owner [3]
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,** but you may also enter your business or "DBA" name. You may use either your SSN or your EIN (if you have one).
[4] List first and circle the name of the legal 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.)

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.