TOWN OF NORTHFIELD, NEW HAMPSHIRE
Welfare & General Assistance

21 Summer Street, Northfield, NEW HAMPSHIRE 03276
Telephone: (603) 832-4314 Fax 603-286-3328
welfare@northfieldnh.org

Welfare & General Assistance
Donna J Cilley, Director

WELFARE & GENERAL ASSISTANCE APPLICATION
****PLEASE NOTE****

Before Scheduling a Meeting With The Welfare & General Assistance Director The Following is Required:

A Completed Application with **The Following Are Required**, Unemployment / Work Search Paperwork, Copy of Child Support Check or Paperwork, Medicaid Cards or Paperwork, Food Stamps Determination Letter, Disability Paper work (if you have applied and are pending we need a copy of the pending letter), Employment Pay stub(s), Copy of Driver(s) License.

If You Are Requesting Rental Assistance The Landlord Form Must Be Filled Out And Signed By The Landlord Prior To Meeting With The General Assistance Director. Your Landlord May Drop Off or Fax the Rental Form Back To The Welfare & General Assistance Department at 603-286-3328.

If You Are Requesting Utility Assistance The Welfare & General Assistance Office Must Have Your Disconnection Notice or The Utility Bill Prior To Making A Financial Determination.

If You Are Out of Work Due To A Temporary Medical Problem You Must Provide A Doctor's Statement Stating, For How Long And If You Are Totally Unable To Work.

If You Are Living With Your Parents or At One of Your Parents Residences The Following Documentation Is Required, A Notarized Statement That Your Parents Income Is Not Sufficient To Help You, Along With Your Parents Prior Years Tax Return and Financial Affidavit.

All Food Stamps and TANF Applicants Must Apply For Emergency Funds through the Department Of Health & Human Services Prior To Requesting Town Assistance.

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If you have questions or need help filling out this application out please call 603-832-4314.

If you have an emergency, emergency meaning you are homeless and have no place to sleep this evening or need an emergency prescription that can wait please call 603-832-4314 and identify your emergency.
After business hours or weekend emergency please call 211 for assistance.

REQUIRED CHECK LIST

You must provide the following verification/documentation at your time of scheduled appointment or assistance may be delayed or denied:

_____ Completed Application Form
_____ Rental Verification Form
_____ Last four weeks pay-stubs or other proof of net wages
_____ Last four week's receipts or other proof of bills paid or currently due
_____ Employment verification form filled out from your employer or 4 weekly pay stubs or 2-bi-weekly pay stubs.
_____ Employment termination form from your last employer if less than 30 days
_____ You have applied for/are receiving Social Security benefits (must provide S/S award letter proof)
_____ You have applied at the DHHS District Office for:

- ❑ Emergency Food Stamps
- ❑ Food Stamps
- ❑ TANF
- ❑ Title XX Daycare
- ❑ APTD/MA
- ❑ OAA
- ❑ TANF Emergency Assistance

____ You have applied for/are receiving Electric and Fuel Assistance benefits
____ Verification of injury or illness / out of work (proof necessary)
____ You have applied for/are receiving Unemployment Compensation (proof necessary)
____ If available, picture IL) (Adults)
____ Social Security cards for all household members included in the application.
____ Vehicle registration (all vehicles)
____ Bank Statements/Savings and/or checking account, liquid asset statements, bankbooks
____ Statement child support payments received/Child support court order
____ Statement from roommate(s) if dividing household expenses
Other:_____

I understand that failure to provide the indicated information may result in delay and/or denial of my request for assistance, and I understand that if approved for assistance I may be required to do a job search and participate in workfare.

If you have questions regarding required documents please call the Welfare & General Assistance Director at, 603-832-4314.

Application for Welfare & General Assistance
Northfield, New Hampshire

Office Phone #603-832-4314 or Office Fax# 603-286-3328

Date:_____ Phone:_____

Name of **Applicant**:_____

Name of **Other/(Spouse, Friend or Partner)**:_____

Current **Physical Address**:_____ How Long?_____

***Mailing Address if Different (PO Box)*:**_____

Do You **Own**_____ or Do You **Rent**?_____How Long at This Address?_____

Previous Address:_____ How Long?_____

Applicant **Date Of Birth**:_____**Social Security Number of Applicant**:_____

Marital Status (**Please Circle One**) SINGLE MARRIED DIVORCED SEPARATED

For Employment Purposes Only:.Do You Have A High School Diploma or GED?_____

***WHAT IS YOUR REQUEST AT THIS TIME*:**

*Please **attach requested bills** or documentation to this application.*

Request:_____Due Date?_____

Request:_____Due Date?_____

Request:_____Due Date?_____

LIST ALL INDIVIDUALS LIVING IN YOUR HOME:

(Spouse, Boyfriend, Roommate, Parents, Children, Friends & How Long)

_____ How Long?_____
Please print your name Date of Birth

_____ How Long?_____
Please print your name Date of Birth

_____ How Long?_____
Please print your name Date of Birth

_____ How Long?_____
Please print your name Date of Birth

_____ How Long?_____
Please print your name Date of Birth

IFADDITIONAL SPACE IS NEEDED PLEASE USE THE BACK SIDE OF THIS PAPER

HEALTH IINSURANCE INFORMATION:

Do you and your family have health insurance coverage? Yes_____ (or) No_____

Last Two Years Of Work History

(Most Recent Employer First)

APPLICANT:

Employer Name and Address:_____

Type Of Work:_____ Dates of Employment_____ TO_____

Number of Hours Per Week_____ Hourly Wage_____ Take Home Pay_____

Reason For Leaving:_____

Employer Name and Address:_____

Type Of Work:_____ Dates of Employment_____ TO_____

Number of Hours Per Week_____ Hourly Wage_____ Take Home Pay_____

Reason For Leaving:_____

If You Have Additional Employment Please Use The Back Of This Paper

IF YOU ARE UNEMPLOYED, **HOW LONG**?_____

ARE YOU COLLECTING UNEMPLOYMENT?_____ **HAVE YOU APPLIED**?_____

IS THERE ANY *REASON* WHY **YOU ARE NOT WORKING**, PLEASE EXPLAIN:_____

_____ DO YOU HAVE A DOCTORS NOTE

THAT DIRECTS YOU TO BE OUT OF WORK AND FOR **HOW LONG**?_____

OTHER/SPOUSE/ROOMMATE:

Employer Name and Address:_____

Type Of Work:_____ Dates of Employment_____ TO_____

Number of Hours Per Week_____ Hourly Wage_____ Take Home Pay_____

Reason For Leaving:_____

Employer Name and Address:_____

Type Of Work:_____ Dates of Employment_____ TO_____

Number of Hours Per Week_____ Hourly Wage_____ Take Home Pay_____

Reason For Leaving:_____

If You Have Additional Employment Please Use The Back Of This Paper

IF YOU ARE UNEMPLOYED, **HOW LONG**?_____

ARE YOU COLLECTING UNEMPLOYMENT?_____ **HAVE YOU APPLIED**?_____

IS THERE ANY *REASON* WHY **YOU ARE NOT WORKING**, PLEASE EXPLAIN:_____

_____ DO YOU HAVE A DOCTORS NOTE

THAT DIRECTS YOU TO BE OUT OF WORK AND FOR **HOW LONG**?_____

EMPLOYMENT DISCLOSURE STATEMENT

The State of New Hampshire passed a voluntary quit bill under RSA:165 1-d that became law on August 10, 1995. This bill states that any person eligible for public assistance who voluntarily terminated employment within the 60 day period before filing an application for assistance shall be ineligible to receive assistance *for 90 days from the date of employment termination.*

I understand that failure to provide employment information may result in delay and/or denial of my request for assistance. I also understand that if approve for assistance I may be required to participate in a workfare program if the Town of Northfield has one and will be responsible to provide job searches at the time of interview.

EMPLOYMENT VERIFICATION FORM

Northfield Welfare & General Assistance Department
Town of Northfield, New Hampshire
21 Summer Street, Northfield, NH 03276
Office 603-832-4314
Fax 603-286-3328

THIS FORM MUST BE FILLED OUT BY YOUR CURRENT EMPLOYER OR PRIOR EMPLOYER *UNLESS*,

YOU CAN PROVIDE 4 WEEKS CURRENT PAY STUBS OR 2 BI-WEEKLY STUBS

To Employer_____Date_____

Address _____

Phone _____

For the purpose of administration of municipal general assistance, the following information is required for:

_____
Name of Employee, Please Print

Date of Hire _____ ____ Date starting / started work _____ Hourly Pay Rate _____

Full/part time _____ Hours per week _____ Paid ❑ weekly ❑ biweekly ❑ other _____

Date of first/most recent paycheck _____ Net amount _____

==========

If _____ is no longer employed by your company:

Date of termination/separation _____ Date/net amount of last paycheck _____

Reason for termination/separation_____

_____ _____
Signature and Title of immediate supervisor or person completing form Date

Company Phone Number:_____

MEDICAL RELEASE AND REPORT

TO BE FILLED OUT BY YOUR PHYSICAN
ONLY IF YOU ARE CURRENTLY NOT ON DISABILITY AND ARE CLAIMING YOU ARE DISABLED OR UNABLE TO WORK

APPLICANT NAME/SS#:_____ **DOB:**_____

I hereby request the release by a doctor, hospital or clinic to the Municipal Welfare Department, or its authorized representative, any information regarding my medical diagnosis, medical history, treatment plan or hospitalization. A photocopy of this signed release may be used in place of an original, in effect for six months from date of my signature below:

_____ _____
APPLICANT SIGNATURE **DATE**

TO THE PHYSICIAN OR CLINIC:

The person named above has indicated that he/she is currently unable to work and is in treatment with you. New Hampshire General Assistance laws require able-bodied welfare applicants to seek and retain work as a condition of continued assistance, with the goal of minimizing the period of assistance necessary. The Municipality also may require welfare recipients to work in any capacity that the recipient is able in exchange for assistance. For these reasons, please briefly respond to the following questions:

What is the condition(s) for which you are treating this person?_____

What is the nature and extent of this individual's limitations?_____

Is this person disabled? No ❑ Yes ❑ (If yes, please clarify below)
❑ Temporarily ❑ Permanently ❑ Partially ❑ Totally

Date incapacity began: _____Expected to end: _____

When will this individual be capable of returning to work? What type of work would be suitable for this individual? Please describe any limitations:_____
_____
_____

Medications Prescribed:_____

_____ _____
Physician Name / Signature **Date**

Thank you for taking the time to complete this form.
Please contact the Welfare & General Assistance Director if you have any questions, 603-832-4314.

Work Program

When you receive General Assistance, you will potentially be required to participate in the Work Program through the Welfare & General Assistance Department. If you have a medical problem that limits the type of duties you can perform, you will be required to provide a medical statement outlining your medical limitations. If you are physically or mentally unable to participate in the Work program you will also be required to provide a medical form completed by your physician affirming your disability. The exception to your physician's requirement is if you have already been deemed disabled and you're currently collecting disability.

While you are on the Work Program, you will be expected to perform your duties in a courteous and respectful manner. That is, you are to show respect to the supervisor, coworkers and citizens, and you are expected to perform your duties as instructed. If you are dismissed from the Work Program for any reason, (see examples below), you will be suspended from receiving benefits for 7 days and before you can reapply for further benefits you will need to complete the required time of workfare that you missed.

Examples: *Reasons for dismissal may be, but are not limited to: use of foul language, showing disrespect to the supervisor, refusal to perform the job as instructed, not reporting to workfare on time, actions causing a disruption of the work flow and any and all other rules applied to Full or Part Time wage earning Town Employees.*

The Work Program as stated above has been discussed with me and I agree to participate on the program if requested. I am aware that willful noncompliance of the Work Program will result in disqualification for General Assistance.

_____ _____

Applicant Signature Date

_____ _____

Co-Applicant Signature Date

Applicant Income Verification Check List

APPLICANT *(Check One or Both)*	**Yes**	**No**
Savings or Checking Account	____	____

Savings Account# & Amount_____

Checking Account# & Amount_____

INCOME	**Yes**	**No**	**Amount Receiving**
Weekly Take Home Pay	____	____	_____
Unemployment	____	____	_____
Sub-Contracted Monies	____	____	_____
Workmen's Comp	____	____	_____
Military or Pension Monies	____	____	_____
Severance Pay or Settlement Money	____	____	_____
Rental Property Income	____	____	_____
Child Support Received	____	____	_____
Money from Relatives or Boarders	____	____	_____
Disability Money, SSI, APT or Other	____	____	_____
Social Security Money	____	____	_____
TANF	____	____	_____
Fuel Assistance I CAP	____	____	_____
Medicaid	____	____	_____
Food Stamps	____	____	_____
NH Housing or Housing Assistance	____	____	_____
Other:	____	____	_____

_____

_____

I hereby affirm that all the information stated in this Income Verification Check List is *true.*

I hereby affirm that the income listed above represents all income I receive.

I also understand that False Representation will terminate any and all assistance and possibly result in court action.

Applicant's Signature_____ **Date**_____

Co-Applicant Income Verification Check List

CO-APPLICANT (Spouse/Friend) *(Check One or Both)*	**Yes**	**No**
Savings or Checking Account	____	____

Savings Account# & Amount_____

Checking Account# & Amount_____

INCOME	**Yes**	**No**	**Amount Receiving**
Weekly Take Home Pay	____	____	_____
Unemployment	____	____	_____
Sub-Contracted Monies	____	____	_____
Workmen's Comp	____	____	_____
Military or Pension Monies	____	____	_____
Severance Pay or Settlement Money	____	____	_____
Rental Property Income	____	____	_____
Child Support Received	____	____	_____
Money From Relatives or Boarders	____	____	_____
Disability Money, SSI, APT or Other	____	____	_____
Social Security Money	____	____	_____
TANF	____	____	_____
Fuel Assistance I CAP	____	____	_____
Medicaid	____	____	_____
Food Stamps	____	____	_____
NH Housing or Housing Assistance	____	____	_____
Other:	____	____	_____

_____

_____

I hereby affirm that all the information stated in this Income Verification Check List is *true.*

I hereby affirm that the income listed above represents all income I receive.

I also understand that False Representation will terminate any and all assistance and possibly result in court action.

Co-Applicant's Signature_____ **Date**_____

AUTHORIZATION FOR THE RELEASE OF INFORMATION — DHHS

I, _____, the undersigned, understand that from time to time,
Print Your Name
the local welfare administrator for _____ may require certain information about
Town/City
Assis tance I am applying for or receiving from the New Hampshire Department of Health and Human Services, Division of Family Assistance (DFA). When information cannot be provided by me personally, I hereby authorize DFA to release the following information to the local welfare administrator for the specific purposes outlined below:

Type of Information	**Purpose for Requesting this Information**
Date of DFA application(s), type(s) of assistance applied for, date of eligibility determination, expected date of benefit issuance, amount of cash grant (if applicable) and/or the reason my case closed or my application was denied	Basic administration of my local welfare assistance case including verification of information provided by me for determining eligibility for local welfare assistance
Date my Medicaid case opened and my Medicaid Identification Number(s)	Processing of Medicaid reimbursements if/when, during the time my Medicaid application was pending, the local welfare administrator makes an expenditure on my behalf for an item covered by Medicaid
Date of any sanction of my cash assistance grant	Determining countable household income also called "deeming"
Reason for any sanction of my cash assistance grant	Helping me to remove the sanction

I understand that I have the option to provide any or all of the requested information myself.

I understand that any use of the above information inconsistent with these purposes is forbidden.

I understand that the local welfare administrator may not release information provided under this authorization to any other person without my written permission.

This authorization shall expire 180 days from the date it is signed.

_____ _____
Signature Date

If the signature above is not that of the person to whom the requested information pertains, the relationship of the signer to that person must be indicated, the signature must be witnessed, and verification that the signer has the authority to represent the person in these matters with DFA must be provided upon DFA request.

_____ _____ _____
Relationship to You Witness Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION — DHHS

I, _____, the undersigned, understand that from time to time,
Print Your Name
the local welfare administrator for _____ may require certain information about
Town/City
assistance I am applying for or receiving from the New Hampshire Department of Health and Human Services, Division of Family Assistance (DFA). When information cannot be provided by me personally, I hereby authorize DFA to release the following information to the local welfare administrator for the specific purposes outlined below:

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Date my Medicaid case opened and my Medicaid Identification Number(s)	Processing of Medicaid reimbursements if/when, during the time my Medicaid application was pending, the local welfare administrator makes an expenditure on my behalf for an item covered by Medicaid
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I understand that I have the option to provide any or all of the requested information myself.

I understand that any use of the above information inconsistent with these purposes is forbidden.

I understand that the local welfare administrator may not release information provided under this authorization to any other person without my written permission.

This authorization shall expire 180 days from the date it is signed.

_____ _____
Signature Date

If the signature above is not that of the person to whom the requested information pertains, the relationship of the signer to that person must be indicated, the signature must be witnessed, and verification that the signer has the authority to represent the person in these matters with DFA must be provided upon DFA request.

_____ _____ _____
Relationship to You Witness Date

Town of Northfield Welfare & General Assistance
Budget Worksheet

Applicant:_____Date:_____

PLEASE LIST ALL <u>MONTHLY</u> OR <u>WEEKLY</u> EXPENSES

Please Circle One: Mortgage / Rent / Board $_____ Monthly or Week $_____

Electricity $_____ EAP % reduction per mo._____%
Food $_____ **(The amount spent <u>after</u> Food Stamps)**
Personal's $_____ **(Items <u>not covered</u> by Food Stamps)**
Prescriptions $_____
Phone $_____
Propane $_____
Heat / Oil $_____ (The amount *spent after* CAP/Fuel Assistance)
Day Care $_____ (The amount *after state reimbursement*)
Health Ins $_____
Life Ins $_____
Child Support $_____ Month / Week **(paid out)**$_____
Total Expenses$_____

Non-Essential Expenses:

Cable TV $_____
Car Payment $_____
Car Payment $_____
Gasoline $_____
Rent to Own Furniture $_____
Master Card $_____
VISA Card $_____
Other Charge Cards $_____
Other $_____
$_____

Total Expenses $_____

****

All Expenses Paid Out $_____

All Income Received $_____ **(Include All**: Work or Unemployment, Disability Income, TANF, Child Support)

Paid Expenses *minus* **All Income** =$_____ **Monthly** Please circle one (negative) or (positive income)

I hereby affirm that the expenses listed above represents all my monthly expenses.

I hereby affirm that all the information stated in this Budget Work Sheet is *true*. I also understand that *False Representation* will terminate any and all assistance and possibly result in court action.

Applicant's Signature_____ Date_____
Co-Applicant Signature_____ Date_____

Assets Verification

Applicant:

Location of Property owned by the Applicant:_____

_____

Cash On Hand At This Time:_____

List All:

Cars_____ _____ Amount Owed:_____

Trucks_____ _____ Amount Owed:_____

Boats, Snowmobiles, Campers, Etc._____

_____

I hereby affirm that the assets listed above are a complete listing of my assets.

I hereby affirm that all the information stated in this Assets Verification Sheet is *true*. I also understand that *False Representation* will terminate any and all assistance and possibly result in court action.

Applicant's Signature_____ Date_____

Co-Applicant:

Location of Property owned by the Applicant:_____

_____

Cash On Hand At This Time:_____

List All:

Cars_____ _____ Amount Owed:_____

Trucks_____ _____ Amount Owed:_____

Boats, Snowmobiles, Campers, Etc._____

_____

I hereby affirm that the assets listed above are a complete listing of my assets.

I hereby affirm that all the information stated in this Assets Verification Sheet is *true*. I also understand that *False Representation* will terminate any and all assistance and possibly result in court action.

Co-Applicant's Signature_____ Date_____

Permission to Release Information to
The Town of Northfield

I hereby give permission for the release of information to The Town of Northfield Welfare & General Assistance Department, 21 Summer Street, Northfield, NH 03276 and to assist with rendering a financial decision based on my request for Welfare & General Assistance. I grant permission to releasing any information necessary to determine my eligibility for Welfare & General Assistance including wages, income, assets, debts, vehicle registrations verification through the town clerk tax collector's office, financial obligations, benefit amounts, settlements, past / present employment, and housing information. This information may be released in writing, over the telephone, or in person to the Welfare & General Assistance Department. This permission statement is valid for a maximum *of ninety days* from the signing of this form.

Applicant's Name ***(please print)*** **Applicant's Signature** **Date**

Co-Applicant's Name ***(please print)*** **Co-Applicant's Signature** **Date**

I authorize and request any relative, physician, lawyer, banker, employer, insurance company, fraternal order, or any other person or organization having information concerning my eligibility for Welfare & General Assistance to furnish such information to the Welfare & General Assistance Director.

Applicant's Signature **Date** **Co-Applicant's Signature** **Date**

I also understand I will repay the Town of Northfield for any assistance I am given, and understand by signing this document the Town will place a lien on all real estate owned by me pursuant to R5A165:28-a..

Applicant's Signature **Date** **Co-Applicant's Signature** **Date**

I hereby certify that I have been given; read and fully understand all my responsibilities to each of the above mentioned signed obligations or authorizations within this application. I understand that any falsification within this application or verbal information may result in denial of further assistance from the Town of Northfield. I may also be subject to penalties for material misrepresentation, and falsification of an unsworn document, which may result in court action.

Applicant's Signature **Date** **Co-Applicant's Signature** **Date**

Income Tax Refund

Please be advised that if you are requesting assistance from the Welfare & General Assistance Office all income tax refunds will be considered income and must be used for allowable basic needs such as rent (including rental arrearages), utilities, medications, medical bills, and child care.

You are required to provide The Welfare & General Assistance Office with **a copy of your current (this year's) Income Tax Return** filed with all supporting tax return paperwork. This **rule applies between January 1st and April 30th of the filing year.**

If your refund was not received during your application period, the Town of Northfield will calculate all income tax monies received 45-days prior to your request for assistance in your basic needs computation. If your income tax has been approved and you are awaiting receipt of said funds the Welfare & General Assistance department will be more than happy to assist you on making contact with outstanding vendors until such funds arrive.

I have read and understand all of the annual income tax return requirements. I will also keep all receipts of what refund monies have been spent on and will be prepared to provide them to the Welfare & General Assistance Department at the time of my Welfare & General Assistance scheduled interview.

Name **Date**

Name **Date**

LANDLORD RENTAL VERIFICATION FORM

Northfield Welfare & General Assistance Department
21 Summer Street, Northfield, NH 03276 603-832-4314

THIS FORM MUST BE COMPLETED BY THE LANDLORD
(You may fax this form back to 603-286-3328)

Tenant's Name: _____ Date: _____

Address: _____

Number of Authorized Adult Household Members: _____ Number of Authorized Children_____

List All Household Members: _____

_____

_____

Type of dwelling: Duplex___, Multi___, Room___, Mobile Home___, Single Residential Home____

Age of Rental Unit:____ Number of Bedrooms:___ Occupancy date: ____ Does tenant have a lease Yes __or No___

Is Security Deposit Paid in Full: Yes ___or No___ Amount Paid: $ _____ Date Paid: $_____

Rent amount: $_____ ❑ mo. ❑wk ❑other _____ If rent is subsidized please list your tenant's portion: $_____

What type of Heat (please check one): ❑ Electric ❑ Oil ❑ Gas ❑ Other_____

Rent Includes: ❑ All utilities ❑ No Utilities ❑ Hot Water ❑ Heat ❑ Electric

Is The Tenant current with his or her rent, Yes ___ or No___ Amount Last Paid: $_____

Is tenant under eviction, Yes____ or No____ Date rent was last paid: _____How Much was paid $_____

Back rent owed **TODAY**: $_____ Are you (the landlord) going to follow through with the eviction if the tenant's rent is paid in full? (Please **circle** one and **initial**) YES _____ or NO _____

List any comments or explanations in the space below if necessary:

Form **W-9**
(Rev. December 2014)
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.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ►
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally 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 instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
___ - ___ - ____

or

Employer identification number
__ - _____

Part II 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. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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.

Sign Here Signature of U.S. person ► Date ►