



Bristol Bay Native Association  
 Child Care Development Funding (CCDF)  
 P.O. Box 310, Dillingham, AK 99576  
 Phone: 907-842-4059 or Fax: 1-833-222-8149  
 Email: CDDAdmin@bbna.com

## CHILD CARE PROVIDER APPLICATION

**Please Note:**

- \*The provider must be 18 or older.
- \*BBNA has 30 days to determine eligibility for your case.
- \*We cannot determine eligibility until we have a completed application with **all** required documents.
- \*Child care is approved from the date we receive all the necessary documents to determine your case; **no child care is approved before that date.**

Camai Provider,

We are pleased that you are interested in applying to be an approved Child Care Provider. In order to establish eligibility, please submit the following:

- Complete Child Care Provider Application
  - BBNA Child Care Health/Safety Checklist
  - Qualifications of Persons Form
  - Notification to Child Care Provider Form
  - 2 – Child Care Provider Reference Forms
  - Authorization for Release of Information and Tribal Background Checks Form
  - Complete W-9 Form
  - Copy of Social Security card and Current ID
  - Copy of Business License
- (Relative are Exempt & get paid hourly only)**

Below is the rate of pay BBNA will remit to the Child Care Provider.

**BBNA will provide notification of the maximum number of approved hours for payment per day, anything over this is the payment responsibility of the parent.**

| Age                | Relative Providers (Only) | Non-Relative Providers (Only) |                 |
|--------------------|---------------------------|-------------------------------|-----------------|
|                    | Hourly Rate               | Half Day                      | Full Day        |
| 0-1 Year           | \$7.00 per hour           | \$35.00 per day               | \$70.00 per day |
| 13-48 Months       | \$6.50 per hour           | \$32.50 per day               | \$65.00 per day |
| 4 Years - 12 Years | \$6.00 per hour           | \$30.00 per day               | \$60.00 per day |

If you have any questions or need additional information, please do not hesitate to contact us.  
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Each person who provides child care for a parent or guardian receiving child care assistance from the Bristol Bay Native Association Child Care Development Department must complete a home visit at least once a year.

**The Bristol Bay Native Association Child Care Development Department reserves the right to deny registration and payment to any person or agency who is determined by the Tribe to be a potential danger to children because of current or past association with or participation in criminal activities, alcohol or other substance abuse, communicable health problems or unsafe child care practices.**

The requirements for child care providers are on page 4.

**\*If the child care provider cares for more than four (4) children, unrelated to him/her, it is necessary that the provider be licensed by the State of Alaska Child Care Program.** In this case, the provider must contact the State of Alaska Child Care Program at 1-888-268-4632 for licensure. You can find information, forms and applications to their website at [Information for Providers \(alaska.gov\)](http://Information for Providers (alaska.gov)). **BBNA requires that caregivers are in compliance with all State and Tribal licensing before authorization of payment.**

### CHILD CARE PROVIDER INFORMATION

|  |          |                                      |                             |
|--|----------|--------------------------------------|-----------------------------|
| <b>NAME:</b> _____   |          |                                      |                             |
| (First)  | (Middle) | (Last)                               | (Also known as/maiden name) |
| <b>SOCIAL SECURITY #</b> ____/____/____                                      |          | <b>DATE OF BIRTH:</b> ____/____/____ |                             |
| <b>GENDER:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female |          |                                      |                             |
| <b>MAILING ADDRESS:</b> _____  |          |                                      |                             |
| (P.O. Box#)  | (City)   | (State)                              | (Zip Code)                  |
| <b>HOME #</b> (____) _____   |          | <b>WORK #</b> (____) _____           |                             |
| <b>CELL#</b> (____) _____  |          |                                      |                             |
| <b>EMAIL ADDRESS:</b> _____  |          |                                      |                             |
| <b>Physical Location where care takes place:</b> _____                       |          |                                      |                             |
| (Street Address)   | (City)   | (State)                              | (Zip Code)                  |

**Education:** Degree Major: \_\_\_\_\_

|  |  |
|--|--|
| <input type="checkbox"/> Associate of Arts (AA)                              | <input type="checkbox"/> Associates of Applied Science (AAS) |
| <input type="checkbox"/> Bachelor of Arts (BA)                               | <input type="checkbox"/> Bachelor of Science (BS)            |
| <input type="checkbox"/> Masters   |  |
| <input type="checkbox"/> Other: List additional Education or Training: _____ |  |

**HOUSEHOLD MEMBERS:** (Please list ALL household members):

| First, MI and Last Name | Relationship to Applicant | Tribal Enrollment | Date of Birth |
|-------------------------|---------------------------|-------------------|---------------|
|                         |                           |                   |               |
|                         |                           |                   |               |
|                         |                           |                   |               |
|                         |                           |                   |               |
|                         |                           |                   |               |
|                         |                           |                   |               |
|                         |                           |                   |               |
|                         |                           |                   |               |
|                         |                           |                   |               |
|                         |                           |                   |               |

| <b>PROVIDERS ARE REQUIRED TO HAVE THE FOLLOWING:</b>              |                  | HAVE | NEED |
|---|------------------|------|------|
| Business License:   | Expiration Date: |      |      |
| Criminal Background Checks for ALL Household Members 16 and older |                  |      |      |

**What are your hours of care?** (Please check ALL that apply)

- 12:00 a.m.  
  1:00 a.m.  
  2:00 a.m.  
  3:00 a.m.  
  4:00 a.m.  
  5:00 a.m.  
  6:00 a.m.  
  7:00 a.m.  
 8:00 a.m.  
  9:00 a.m.  
  10:00 a.m.  
  11:00 a.m.  
  12:00 a.m.  
  1:00 p.m.  
  2:00 p.m.  
  3:00 p.m.  
 4:00 p.m.  
  5:00 p.m.  
  6:00 p.m.  
  7:00 p.m.  
  8:00 p.m.  
  9:00 p.m.  
  10:00 p.m.  
  11:00 p.m.

**What are your days of care?** (Please check ALL that apply)

- Sunday  
  Monday  
  Tuesday  
  Wednesday  
  Thursday  
  Friday  
  Saturday

Holidays off? (Please list ALL that apply) \_\_\_\_\_

**What age range will you provide care for?** (Please check ALL that apply)

- 0-1 Year  
  13 Months – 48 Months  
  4 Years – 12 Years

**Will you be available for drop-ins?**  Yes  No      **Will you be available for after school care?**  Yes  No

**Does BBNA have permission to give out provider contact information to eligible parents looking for childcare?**  Yes  No

**Where is care provided?**  Home (In Provider Home)     In-Home (In Child’s Home)     In Child’s Home (Relative)  
 (Choose:  Grandparent /  Great-Grandparent /  Aunt /  Uncle /  Sibling (out of home residence))

There may be times when you are ill or need help in an emergency; two back-up providers are recommended. BOTH providers must meet the health and safety requirements listed above. (Criminal Background checks on ALL household members 16 and older).

Primary Back-Up Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

Secondary Back-Up Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

**BBNA CHILD CARE HEALTH/SAFETY CHECKLIST:**

| <b>PROVIDER</b>   | <b>YES</b> | <b>NO</b> |
|---|------------|-----------|
| Are you 18 years of age or older?   |            |           |
| Has everyone in home 16 years or older obtained a Criminal Background Check?  |            |           |
| Do you fully understand that you are required by law to report suspected child abuse?   |            |           |
| Do you provide a smoke & alcohol-free environment for the children in your care?<br>This includes the child care site and vehicle used to transport children. |            |           |
| Does each floor of the facility have at least one properly installed and maintained smoke & carbon monoxide detector?   |            |           |
| Are you current on your EC First Aid/CPR Certification? (Submit copy for file)<br>Expiration Date:  |            |           |
| Is there a fire extinguisher, which is readily accessible and maintained in operable condition?   |            |           |
| Is there a First Aid Kit that is in a convenient location and is inaccessible to children?  |            |           |
| Is there a list of emergency contact numbers – including the parent/guardians?  |            |           |
| Is there an emergency/fire plan?  |            |           |
| Are there at least two ways of exiting the child care area?   |            |           |
| Are poisons, toxic materials, cleaning substances, sharp or pointed objects, and guns kept in a safe place or locked up so children cannot get to them?       |            |           |
| Are all outlets covered or non-accessible to children?  |            |           |
| Are all small items checked against choking hazards?  |            |           |
| Is there a safe play area provided, including inside and outside area?  |            |           |
| Are the walls and floors clean and maintained in a condition safe for children?   |            |           |
| Are ventilation, temperature and lighting adequate for children’s safety and comfort?   |            |           |
| Are toys and objects (i.e. highchairs/crib/etc.) safe, durable, easy to clean and non-toxic?  |            |           |
| Do you have homeowner or rental insurance?  |            |           |
| Has your water quality been tested? Last Tested:  |            |           |
| Do you have a woodstove?  |            |           |
| If you answered yes to having a woodstove, do you have a plan to keep children from potential harm?   |            |           |
| <b>CHILD’S HEALTH</b>   | <b>YES</b> | <b>NO</b> |
| Is all medicine prescribed and/or over the counter administered only with written parental instruction?   |            |           |
| Do you use separate towel/washcloth on each child?  |            |           |
| Do you diaper, change and toilet children away from the food preparation area?  |            |           |
| Are parents notified of any accidents or injury to the child?   |            |           |

How do you ensure that allergies to foods / environment are noted and observed? \_\_\_\_\_  
 \_\_\_\_\_

What forms of discipline do you use? \_\_\_\_\_

How do you keep track of mobile children? \_\_\_\_\_

Do you have pets?  No  Yes – Are all pets current on rabies vaccinations?  Yes  No

Have any of these pets harmed anyone either intentionally or by accident?  No  Yes – Explain \_\_\_\_\_  
 \_\_\_\_\_

How do you keep the children / pets safe from harm? \_\_\_\_\_  
 \_\_\_\_\_

List ALL the children you will be providing care for:

| Children's First and Last Name | Date of Birth | Relationship to the Provider |
|--------------------------------|---------------|------------------------------|
|                                |               |                              |
|                                |               |                              |
|                                |               |                              |
|                                |               |                              |
|                                |               |                              |
|                                |               |                              |

Name of Parent #1 (Client) \_\_\_\_\_  
(First) (MI) (Last)

Home Phone: ( ) - Work Phone: ( ) - Cell Phone: ( ) -

Name of Parent #2 (Client) \_\_\_\_\_  
(First) (MI) (Last)

Home Phone: ( ) - Work Phone: ( ) - Cell Phone: ( ) -

*I certify that I will comply with all the requirements set forth by the Bristol Bay Native Association (BBNA) Workforce Development (WFD), Child Development Department (CDD) and the CCDF Program governing the approval of child care providers. My answers to all the questions and statements I have made on the pages of this application are true and correct to the best of my knowledge.*

*As a Child Care Provider, I agree to comply with recommendations made by BBNA. All recommendations will be followed through within 3 weeks from the date of recommendation. I understand that if the recommendations are not completed within 3 weeks that my Child Care Payments will be suspended until I have completed the recommendations.*

*I allow BBNA to provide a copy of Home Visits to clients whom are parents of children I care for.*

*As a provider, I agree to notify BBNA immediately if there is any change in household members, if care is provided in my own home.*

**CHILD CARE PROVIDER:**

PRINT: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PARENT/GUARDIAN OF CHILD/CHILDREN:**

PRINT: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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## QUALIFICATIONS OF PERSONS HAVING REGULAR CONTACT WITH CHILDREN IN A CHILD CARE FACILITY

As per 4 AAC 62.210 (b) and (d) as referenced in 4 ACC 65.185 (a) (3): Approved Providers

An individual may not work, volunteer, or reside in a child care facility or in any other part of the premises housing a child care facility, if the individual has the opportunity to access the child care facility and:

- Is the alleged perpetrator of an incident of child abuse or neglect in which the Department of Health and Social Services found the evidence available substantiates the allegation, or the information available the Department demonstrates to the department individual's inability to adequately provide care and supervision to children:
- Has a physical, health, mental health or behavioral problem to an extent that the problem poses a significant risk to the health, safety or well-being of child in care:
- Has a domestic violence or alcohol or other substance abuse problem to an extent that the problem poses a significant risk to the health, safety or well-being of the children in care:
- Was the subject of prior adverse licensing action:
- Subject to the Barrier Crimes requirements as listed by the Barrier Crimes Matrix listed in AAC 10.900(b) with any entity or individual service provider that is subject to the requirements of 7 AAC 10.900 – 7 AAC 10.990 at the website: [BarrierCrimeMatrix.pdf \(alaska.gov\)](#)
- Was, at any time, under indictment, charged by information or complaint, or convicted of any of the following offenses:
  - An offense against the family and vulnerable adults
  - Perjury under AS 11.56.200
  - A serious offense

For a list of Barrier Crime Offenses please request a copy from the Child Care Eligibility Technician.

***I understand that I am a mandatory reporter of any suspected abuse or neglect of the children in my care and that I will notify the appropriate authorities.***

**I have read and understand the above statements.**

**PROVIDER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**



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## **NOTIFICATION TO CHILD CARE PROVIDER**

**The Federal Law Concerning fraud states...** "Whoever in any matter within the jurisdiction of any department or agency of the United States, knowingly and willingly falsifies, conceals or covers up by an trick, scheme or device a material fact, or makes any false fictitious or fraudulent statements or representations or makes or uses any false writing or documents, knowing the same to contain any false, fictitious or fraudulent statement or entry shall be fined not more than \$10,000.00 or imprisoned not more than 5 years or both.

Under the Privacy Act 5.U.S.C. 552 (a) (1) (2), BBNA Child Care Development cannot give out information you give the child care eligibility technician or case worker except CCDF Development can share this information with other Federal, State, Tribal offices and programs who have some responsibility with the BBNA Workforce Development Department for which you are applying. The information can also be given to those agencies when you ask them for a job or for some other benefit and for law enforcement purposes. This can be done without your written consent. For any other person or program wanting information in your case record and you can ask to see it. If you believe some information is inaccurate, ask your case worker about how to change the information in the case record.

This must be read and signed.

**PROVIDER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**



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## CHILD CARE PROVIDER REFERENCE

This is a reference for \_\_\_\_\_ which I have known for \_\_\_\_\_ months/years  
 (Child Care Provider's Name)

In the capacity of \_\_\_\_\_  
 Friend, Co-Worker, Employer, etc. (Not an immediate relative)

I know this person:  Very Well     Casually     Not Well     Enough to give a reference

**Please answer the following questions:**

Does this provider show any serious health, alcohol or drug problems?  No  Yes – Explain: \_\_\_\_\_  
 \_\_\_\_\_

Can you attest to the good character, maturity and sound judgment of this provider?  No  Yes – Explain: \_\_\_\_\_  
 \_\_\_\_\_

How would you assess the provider's ability to provide good care to children?  Excellent  Good  Fair  Poor

List qualities, which you believe will enable the provider to work successfully (or unsuccessfully): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If you needed a Child Care Provider, how would you feel about leaving your children with this provider?

Very Enthusiastic     Somewhat Enthusiastic     Worried     Would NOT

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PRINT: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
 (P.O. Box #)                      (City)                      (State)                      (Zip Code)

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_







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**AUTHORIZATION FOR RELEASE OF INFORMATION**  
**A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL**

*I authorize and release any and all information needed by Bristol Bay Native Association (BBNA) Child Care Development Center (CCD) or its agents within the Department of Law. I understand the requested information will only be used in the administration of BBNA and BBNA Child Care Development services, and will not be released to any other person or agency outside BBNA or its agents within the Department of Law.*

*Persons or organizations that may be contacted include, but are not limited to: Department of Law; Department of Public Safety; Department of Fish and Game; Department of Labor; Department of Military and Veterans Affairs; Department of Revenue; Bureau of Citizenship and Immigration Services; Alaska Housing Finance Corporation; Social Security Administration; Tribal Children's Service Worker (CTSW); Office of Child Services (OCS); Commercial Fishing Companies; Funeral Homes; Local Governments; City Councils; Village Councils; State, Federal, and Private Educational agencies; Public Assistance program contractors and grantees; tax assessors; financial institutions; Native Corporations; stock brokerage firms; landlords; employers; school authorities; and private individuals.*

Information requested can be sent to: **Bristol Bay Native Association**  
**Child Care Development**  
**P.O. Box 310**  
**Dillingham, AK 99576**  
**Fax: 1-833-222-8149 or 1-800-285-2262**

*This release will remain in effect while I am an applicant or recipient of BBNA CCD program services, and for any later investigations of my eligibility and receipt of benefits.*

**PRINT:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



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### **Authorization for Release of Information to conduct Tribal Background Checks**

Providers and all other household members, 16 years and older, living in the residence where care is provided must complete this authorization for the release of information every 12 months.

I hereby authorize BBNA to conduct a Tribal Approved Background Check initially and annually thereafter to obtain information that is required to approve my provider application and renewals.

I understand this exchange of information will be made solely to benefit the provision of services I am requesting, and all information will be kept confidential. Copies of this release will be considered valid as the original.

| Full Printed Name<br>First, Middle, Last | Date of Birth | Relationship to Child | Signature | Date |
|--|---------------|-----------------------|-----------|------|
|  |               |                       |           |      |
|  |               |                       |           |      |
|  |               |                       |           |      |
|  |               |                       |           |      |
|  |               |                       |           |      |
|  |               |                       |           |      |

# Request for Taxpayer Identification Number and Certification

Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

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

**Before you begin.** For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

|  |           |   |   |
|--|-----------|---|---|
| <b>Print or type.<br/>See Specific Instructions on page 3.</b> | <b>1</b>  | Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)   |   |
|  | <b>2</b>  | Business name/disregarded entity name, if different from above.   |   |
|  | <b>3a</b> | Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only <b>one</b> of the following seven boxes.<br><br><input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate<br><br><input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____<br><b>Note:</b> Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.<br><br><input type="checkbox"/> Other (see instructions) _____ | <b>4</b> Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):<br><br>Exempt payee code (if any) _____<br><br>Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____<br><br><i>(Applies to accounts maintained outside the United States.)</i> |
|  | <b>3b</b> | If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions _____ <input type="checkbox"/>   |   |
|  | <b>5</b>  | Address (number, street, and apt. or suite no.). See instructions.  | Requester's name and address (optional)   |
|  | <b>6</b>  | City, state, and ZIP code   |   |
|  | <b>7</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 generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

|                                       |  |  |  |  |  |  |  |  |  |
|---------------------------------------|--|--|--|--|--|--|--|--|--|
| <b>Social security number</b>         |  |  |  |  |  |  |  |  |  |
|                                       |  |  |  |  |  |  |  |  |  |
| <b>or</b>                             |  |  |  |  |  |  |  |  |  |
| <b>Employer identification number</b> |  |  |  |  |  |  |  |  |  |
|                                       |  |  |  |  |  |  |  |  |  |

**Note:** If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

## 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 for Part II, later.

|                  |                          |      |
|------------------|--------------------------|------|
| <b>Sign Here</b> | Signature of U.S. person | Date |
|------------------|--------------------------|------|

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

## What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they