



# Iowa Tribe of Oklahoma Vocational Rehabilitation Application

## APPLICATION CHECKLIST:

(ANY WORKER STARTING AN APPLICATION WILL BE RESPONSIBLE FOR COMPLETION OF THAT APPLICATION.)

### Documents Required:

1. **PROOF OF INCOME:** (include income for all family members)
  - a. Social Security Award Letter or VA Award Letter
  - b. Copy of Benefit Check(s)
  - c. Income Verification from the Department of Human Services
  - d. Wages
    - i. Letter from Employer
      1. Must be on letterhead stationary or notarized
      2. Must include dates of employment and total gross wage for the month
    - ii. Copy of Check Stubs
  - e. Notarized Statement
2. **PROOF OF INDIAN DECENT**
  - a. Tribal Membership/Enrollment Card
  - b. Census Card or Letter of Agency
3. **PROOF OF SOCIAL SECURITY NUMBER**
  - a. Social Security Card
  - b. Driver's License
4. **PROOF OF MAILING ADDRESS/RESIDENTIAL VERIFICATION**
  - a. Utility Bill
  - b. Driver's License
  - c. Rent Receipt
  - d. Voter's Registration
5. **PROOF OF DISABILITY**
  - a. Doctor's Statement (dated within 1 year of application date and Disability) and/or School Assessment Records
  - b. Copy of Social Security Disability Check, Aid to Disable Check, VA disability check
  - c. Copy of SSI Check if applicant is less than the age of 65
6. **COPIES OF:** **FAFSA (Pell Grant), TRIBAL HIGHER ED. AWARD LETTER,**  
**PRIVATE SCHOLARSHIPS**

# Iowa Tribe of Oklahoma Rehabilitation Program Initial Application

Applicant Information			
Name:			
Date of birth:	SSN:	Phone:	
Current address:			
City:	State:	ZIP Code:	
Tribal Affiliation:	County of Residence:	Sex:	
Marital Status:	Total Number of Family Members Living in the Home:		
Finding Directions:			
<hr/> <hr/>			
Are you a Veteran?    Yes    No    (Please circle)    Service Connected Disability?			
If yes, please list serial and dates of services:			
Employment Information (Last Three Jobs)			
Current employer:			
Employer address:		Dates Employed To/From:	
Phone:	E-mail:	Fax:	
City:	State:	ZIP Code:	
Reason for Leaving:			
<hr/>			
Previous employer:			
Employer address:		Dates Employed To/From:	
Phone:	Email:	Fax:	
City:	State:	ZIP Code:	
Reason for Leaving:			
<hr/>			
Previous employer:			
Employer address:		Dates Employed To/From:	
Phone:	E-mail:	Fax:	
City:	State:	ZIP Code:	
Reason for Leaving:			
<hr/>			
Medical/Insurance Information			
Do you have Medical/Hospital Insurance including Medicare & Medicaid?    Yes    No    (Please Circle)			
If yes, please fill in the information below:			
Name:		Address:	
City:	State:	ZIP Code:	Policy/group Number:

**Educational History**

**High School:**

City: State: Grade/Hrs. Completed:

Major: Dates To/From:

**College:**

City: State: Grade/Hrs. Completed:

Major: Dates To/From:

**Technical:**

City: State: Grade/Hrs. Completed:

Major: Dates To/From:

**Other:**

City: State: Grade/Hrs. Completed:

Major: Date To/From:

**List Three People Who Will Always Know How to Locate You**

1. Name:

Address: Phone:

Relationship:

2. Name:

Address: Phone:

Relationship:

3. Name:

Address: Phone:

Relationship:

**Are you willing to move if employment is in another city? (Answer required)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What is your disability and dates it occurred? (Answer required)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How does your disability keep you from working? (Answer required)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How can the Iowa Tribe Vocational Rehabilitation Program assist you? (Answer required)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **APPENDIX A. REHABILITATION SERVICES APPLICATION**

My signature to this document constitutes an application for the ITOVR services. In order to affect my rehabilitation, I authorize the release of confidential information from my case file to agencies or others who have adopted regulations for confidentiality. All information, both medical and personal, given or made available to the agency shall be held confidential. Use of such information will be limited to purposes directly connected with the administration of my rehabilitation program. All mandatory information is collected under the authority of the Rehabilitation Act of 1973 as amended by Rehabilitation Amendments of 1992, Title 56.

Failure to provide this information may prevent the rehabilitation agency from providing services in a timely manner. Information will not be disclosed to any individual agency or organization without my written consent or that of my parent, guardian, or representative as applicable.

### **STUDENT RIGHT AND REMEDIES**

I have been advised of the availability of the Student Assistance Program (CAP) and have received a brochure explaining the purpose of CAP and the procedures for using CAP. I or my representative may call the CAP office for assistance at 1-800-522-8224.

I understand that I may request an informal administrative review or a formal appeal if I do not agree with a decision made by my counselor regarding furnishing or denial of Vocational Rehabilitation Services. A formal appeal may be requested by contacting the Director of the Iowa Tribe of Oklahoma Vocational Rehabilitation Program: Rose Malone, 335588 E. 750 Road, or Box 728, Perkins, OK 74059; or (405) 547-2402 ext. 248.

Student: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/  
Guardian/Rep.: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

# APPENDIX B. AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_, SS # \_\_\_\_\_, DOB \_\_\_\_\_  
(Student's Name) \_\_\_\_\_ Record # \_\_\_\_\_

(doctor, hospital, clinic, or school)  
or its Director, designee or records department, to release information contained in my records to the individual or organization below:

1. Name and title of person's or organization to which disclosure is to be made:

Iowa Tribe of Oklahoma Vocational Rehabilitation Program  
P.O. Box 728  
Perkins, OK 74059

Ph. - 1 (888) 336-4692 or (405) 547-2402  
Fax - (405) 547-1090

2. Specific type of information to be disclosed

Medical     Psychological     Vocational     Other

3. The purpose and need for such disclosure.

Established eligibility for such disclosure  
 Develop a vocation program for Student  
 Determine need for and/or type of treatment  
 Other (specify) \_\_\_\_\_

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION THAT COULD BE CONSIDERED INFORMATION ABOUT COMMUNICABLE OR VERNERAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFIENCY VIRUS, ALSO KNOWN AS AN ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

NOTICE: INFORMATION IN YOUR RECORDS THAT ARE CONFIDENTIAL BY LAW AND CANNOT BE RELEASED WITHOUT YOUR PERMISSION EXCEPT IN LIMITED CIRCUMSTANCES INCLUDING RELEASE TO PERSONS WHO HAVE HARD RISK EXPOSURES. RELEASE FOR STATISTICAL OR EPIDEMOLOGICAL PURPOSES. WHEN SUCH INFORMATION IS RELEASED IT CANNOT CONTAIN INFORMATION FROM WHICH YOU COULD IDENTIFY UNLESS RELEASE OF THAT IDENTIFYING INFORMATION IS AUTHORIZED BY YOU, BY AN ORDER OF THE COURT OR THE DEPARTMENT OF HEALTH BY LAW.

4. This release may be revoked at any time and shall be valid no longer than is reasonably necessary to accomplish the purpose for which is given.  
5. This release expires (12) twelve months following the date signed by me.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

## APPENDIX C. STATEMENT OF INCOME AND LIABILITIES

1. A. Are you or a household member working full-time or part-time and earning money?

[ ] Yes [ ] No      If yes, complete the following information:

Employed Person	Employment	Monthly Take Home Pay

B. Do you have transportation, if necessary for training or employment?

I certify that this information I have given is true, correct, and complete to the best of my knowledge. I agree to notify my Rehabilitation Program Counselor within 20 day if I have changes in my living arrangement, address, income, bank accounts, automobiles, property of any kind, and expenses or needs.

I understand that the information I have given will be carefully studied and that I might be asked to provide proof of the answers given. I further understand that any false statement make me subject to prosecution for fraud. I hereby authorize the Iowa Tribe of Oklahoma Vocational Rehabilitation Program (ITOVR) to make any necessary investigation to verify the information I have given.

When this form is returned, the ITOVR will review the information and discuss the services that can be provided and determine the amount of financial participation.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# IOWA TRIBE VOCATIONAL REHABILITATION PROGRAM GENERAL HEALTH CHECKLIST

Full Name \_\_\_\_\_ Case # \_\_\_\_\_

Counselor \_\_\_\_\_ DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Please circle YES or NO if you have any of the following symptoms or conditions:	Has it kept you from working? (Please check the box accordingly) Yes                  No	
1. A disorder of eyes, ears, nose, or throat? YES or NO		
2. Frequent dizziness, fainting, headaches, seizures, convulsions, paralysis, or stroke? YES or NO		
3. A mental or nervous disorder? YES or NO		
4. Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of the lungs? YES or NO		
5. Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, or other disorders of the heart or blood vessels? YES or NO		
6. Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver, or gall bladder? YES or NO		
7. Disorder of kidneys, bladder, prostate, or reproductive system? YES or NO		
8. Diabetes, thyroid, or other endocrine disorders? YES or NO		
9. Arthritis, or other disorder of the muscles or bones, including spine, back or joints? YES or NO		
10. Absence of amputation of any body part? YES or NO		
11. Loss of use of arms or legs, or other body parts? YES or NO		
12. A tumor, cancer, or disorder of the lymph glands? YES or NO		
13. Allergies? YES or NO		
14. Anemia or other disorder of the blood? YES or NO		
15. Excessive use of alcohol or any habit forming drugs? YES or NO		
16. Any other physical or mental condition? YES or NO		

If you answered YES to Question 16, please specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# IOWA TRIBE VOCATIONAL REHABILITATION PROGRAM

## GENERAL HEALTH CHECKLIST (cont.)

Name and address of your personal physician/clinic: (If none, please state so):

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PLEASE ANSWER THESE QUESTIONS FOR ANY CONDITIONS MARKED "YES" ON THE PREVIOUS PAGE.

Have you been or are being treated for any of these conditions? [ ] Yes [ ] No

If yes, which conditions? \_\_\_\_\_

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Have you been hospitalized for any of these conditions? [ ] Yes [ ] No

If yes, under what conditions? \_\_\_\_\_

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Are you taking any medications? [ ] Yes [ ] No

If yes, list medications: \_\_\_\_\_

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Do you have any restrictions from these conditions? [ ] Yes [ ] No

If yes, what restrictions: \_\_\_\_\_

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**To the best of my knowledge, what I have said is true and I have not withheld any information.**

\_\_\_\_\_  
(Date) (Signature of Student)

Person who provided information, if not applicant: \_\_\_\_\_

Signature of Person Providing Information: \_\_\_\_\_

## Certification of Eligibility for Federal Assistance in Certain Programs

I understand that 34 CFR 75.60, 75.61, and 75.62 require that I make specific certification of eligibility to the U.S. Department of Education as a condition of applying for Federal funds in certain programs and that these requirements are in addition to any other eligibility requirements that the U.S. Department of Education imposes under program regulations.

Under 34 CFR 75.60-75.62:

I certify that:

A. I do not owe a debt, or I am current in repaying a debt, or I am not in default (as that item used at 34 CFR Part 668) on a debt.

1. To the Federal Government under a nonprocurement transaction (e.g., a previous loan, scholarship, grant, or cooperative agreement):
2. For a fellowship scholarship, stipend, discretionary grant, or loan in any program of the U.S. Department of Education that is subject to 34 CFR 57.50, 75.61, and 75.62, including:
  - Federal Pell Grant Program (20 U.S. 107a, et seq)
  - Federal Supplemental Educational Opportunity Grant (SEOG) Program (20 U.S. 1070 (b), et seq)
  - State Stafford incentive Grant Program (SSIG) 20 U.S. 1070c, et seq
  - Federal Perkins Loan Program (20 U.S.C. 1087aa, et seq)
  - Income Contingent Direct Loan Demonstration Project (20 U.S.C. 1087a, note):
    - Federal Stafford Loan Program, Federal Supplemental Loans for students [SLS], Federal PLUS, or Federal Consolidation Loan Program (20 U.S. 2601, et seq)
  - Cuban Student Loan Program (20 U.S.C. 2601, et seq)
  - Robert C. Byrd Honors Scholarship Programs (20 U.S.C. 1070d-31, et seq)

- Jacob K. Javits Fellowship Program (20 U.S.C. 1134h-1134)
- Patricia Roberts Harris Fellowship Program (20 U.S.C. 1134h-1134)
- Christa McAuliffe Fellowships Program (20 U.S.C. 1105-1105j)
- Bilingual Education Fellowship Program (20 U.S.C. 3321-3262)
- Rehabilitation Long Term Training Program (29 U.S.C. 774(b))
- Paul Douglas Teacher Scholarship Program (20 U.S.C. 1104, et seq)
- Law Enforcement Education Program (42 U.S.C. 3775)
- Indian Fellowship Program (29 U.S.C. 774 (b))

B. I have made arrangements satisfactory to the U.S. Department of Education to repay a debt as describes in A.1 or A.2 (above) on which I had not been current in repaying or know which I was in default (as that term is used in 34 CFR Part 668).

C. I certify also that I have not been declared by a judge, as a condition of sentencing under section 5301 of the Anti-Drug Abuse Act of 1988 (21 U.S.C. 862), ineligible to receive Federal assistance for the period of this requested funding.

I understand that providing a false certification to any of the statements above makes me liable for repayment to the U.S. Department of Education for fund received on the basis of this certification, for civil penalties, and for criminal prosecution under 18 U.S.C. 1001.

\_\_\_\_\_  
(Student Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Typed or Printed Name)

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

## Contacts

### Main Office

Physical Address: 335588 E. 750<sup>th</sup> Road

P.O. Box 728

Perkins, OK 74059

Phone: 405-547-2402

Toll Free: 1-888-336-IOWA (4692)

Fax: 405-547-1090

<b>ITOVR</b> Rose Malone, Director  Ext. 248	<b>ITOVR</b> Ron Baker, Counselor  Ext. 245	<b>ITOVR</b> Christa Tsotaddle, Transitional Counselor  Ext. 168
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### Satellite Office

CPN Employment & Training

Rowana Condry, Counselor

300 East Walnut

Tecumseh, OK 74873

Ph.: 405-598-0797

Toll Free: 1-800-880-9880

Fax: 405-598-6273



**Iowa Tribe of Oklahoma**  
**Vocational Rehabilitation Program**

335588 E. 750<sup>th</sup> Road

Perkins, OK 74059

405-547-2402

**CERTIFICATION OF INTENT TO PURSUE EMPLOYMENT**

I am applying for services with the Iowa Tribe Vocational Rehabilitation Program. I understand I must have a documented physical or mental disability that causes an impediment to attaining and/or maintaining gainful employment.

I understand that in order to be eligible for this program and receive services, I must intend to work progressively toward attaining/maintaining suitable employment. I understand that all services provided by this program are for the sole purpose of retaining/obtaining EMPLOYMENT.

I certify that it is my full intent to work with my Rehabilitation Counselor to establish an Individualized Plan of Employment that will outline the goals and objective I need to meet in order to retain/obtain suitable EMPLOYMENT.

I understand that AFTER I retain/obtain employment, I will be expected to provide my Rehabilitation Counselor with information regarding the wages I am earning, name, and address of employer, and the date of employment. I understand that this information will be used to for statistical/reporting purposes only. I understand that my personal information will NOT be revealed without my written permission.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Rehabilitation Counselor

\_\_\_\_\_  
Date

**(Student Copy)**



**Iowa Tribe of Oklahoma**  
**Vocational Rehabilitation Program**

335588 E. 750<sup>th</sup> Road

Perkins, OK 74059

405-547-2402

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\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Rehabilitation Counselor

\_\_\_\_\_  
Date

**(Counselor Copy)**



# **Iowa Tribe of Oklahoma Vocational Rehabilitation Transitional Services**

## **Student Responsibilities**

To make the rehabilitation effort a success, the student and the ITOVR staff must work together to reach chosen goals. This shared responsibility requires that the consumer or applicant for services accept the basic responsibilities listed below. It is the counselor's responsibility to fully and appropriately inform the student of student responsibilities.

1. Keep appointments for medical examinations and evaluations.
2. Follow the advice of doctors and other licensed treatment professionals.
3. Take an active part in developing the Individualized Plan for Employment (IPE).
4. Provide enrollment documents upon high school graduation and enrollment of post-secondary education: FAFSA submission confirmation letter, Tribal award letter and letters of all scholarships received.
5. Attend school classes on a regular basis, unless it is an excused absence (doctor's note, etc.).
6. Take part in regular reviews (at least once a year, unless otherwise specified) of the Individualized Plan of Employment (IPE; including all amendments to the program).
7. Maintain satisfactory progress toward completing the IPE.
8. Must abstain from any use of alcohol and/or drugs. Individuals who abuse drugs and/or alcohol while receiving services will be referred to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and/or appropriate agencies for purposes of seeking treatment. All case services will be suspended. If the consumer refuses or fails to cooperate with seeking treatment, or is not available to pursue a DRS program, this will be considered as reasonable cause for case closure.
9. Inform ITOVR staff of any changes in address, financial status and any other programs related changes.
10. Apply for and make appropriate use of any comparable benefits and services for which the consumer is eligible to defray in whole or in part the cost of services in the student's IPE and provide verification of financial aid award status to counselor.
11. Working with the counselor to obtain suitable gainful employment/education or appropriate independent living outcomes as services are being completed.
12. Student must submit resume and high school diploma upon request by VR counselor.

I, the Student, agree to practice the above responsibilities for acceptance of receiving services from the Iowa Tribe of Oklahoma Vocational Rehabilitation Transitional Services.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Student Copy)**



# Iowa Tribe of Oklahoma Vocational Rehabilitation Transitional Services

## Student Responsibilities

To make the rehabilitation effort a success, the student and the ITOVR staff must work together to reach chosen goals. This shared responsibility requires that the consumer or applicant for services accept the basic responsibilities listed below. It is the counselor's responsibility to fully and appropriately inform the student of student responsibilities.

1. Keep appointments for medical examinations and evaluations.
2. Follow the advice of doctors and other licensed treatment professionals.
3. Take an active part in developing the Individualized Plan for Employment (IPE).
4. Provide enrollment documents upon high school graduation and enrollment of post-secondary education: FAFSA submission confirmation letter, Tribal award letter and letters of all scholarships received.
5. Attend school classes on a regular basis, unless it is an excused absence (doctor's note, etc.).
6. Take part in regular reviews (at least once a year, unless otherwise specified) of the Individualized Plan of Employment (IPE; including all amendments to the program).
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Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Counselor Copy)**

## 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.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification (required): <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	
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶	
	<input type="checkbox"/> Other (see instructions) ▶	
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)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line 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 4 for guidelines on whose number to enter.

<b>Social security number</b>									
				-			-		

<b>Employer identification number</b>									
				-					

### 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).

**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 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### General Instructions

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

#### 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.

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 that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**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.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.