

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (CMS-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the Secretary of appropriate State agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete part II (a) and (b) of this form. Only those title XX providers rendering medical, remedial, or health related home-maker services must complete parts II and III. Title V providers must complete parts II and III.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V – 42CFR 51a.144
Title XVIII – 42CFR 420.200 – 206
Title XIX – 42CFR 455.100 – 106
Title XX – 45CFR 228.72 – 73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

- Item I** (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.
- (b) **For Regional Office Use Only.** If the yes box is checked for item VII, the Regional Office will enter the 5-digit number assigned by CMS to chain organizations.

Item II - Self-explanatory.

Item III - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV – VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII - If yes, list the actual number of beds in the facility now and the previous number.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a) Name of Entity Brevard Alzheimer's Foundation, Inc	D/B/A	Provider No.	Vendor No.	Telephone No.
				321- 253-4430
Street Address 4676 W. Wickham Rd		City, County, State Melbourne Brevard FL		Zip Code 32935

(b) (To be completed by CMS Regional Office) Chain Affiliate No. LB1

II. Answer the following questions by checking "Yes" or "No." If any of the questions are answered "Yes," list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

(a) Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by titles XVIII, XIX, or XX?

Yes No LB2

(b) Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by titles XVIII, XIX, or XX?

Yes No LB3

(c) Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

Yes No LB4

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
	N/A	
		LB5

(b) Type of Entity: Sole Proprietorship Partnership Corporation Unincorporated Associations Other (Specify) LB6

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions:

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

Yes No LB7

Name	Address	Provider Number

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date _____ Yes No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____ Yes No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____ Yes No LB10

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations _____ Yes No LB11

VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
 Yes No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name _____ EIN # _____ Yes No LB13

Address _____

LB14

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If yes, list Name, Address of Corporation, and EIN)
Name _____ EIN # _____ Yes No LB18

Address _____

LB19

VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?
If yes, give year of change _____ Yes No LB15
Current beds N/A LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed) Robert Marchello Title Chief Financial Officer

Signature [Handwritten Signature] Date 10/8/14

Remarks See attached

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0086. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

**BREVARD ALZHEIMER'S FOUNDATION, INC.
2014-2015 BOARD OF DIRECTORS**



BOARD MEMBER	ADDRESS	PHONE
W. Wilson Sims Chair	Work Address: Coastal Directory P.O. Box 33665 Indialantic, FL 32903	321-777-1636 home 321-795-9903 work 321-308-0624 office simseagle@gmail.com
Bryan Hatfield Vice Chair	Work Address: Brighthouse Networks 304 S. Harbor City Blvd, Suite 100 Melbourne, FL 32901	321-757-6391 321-961-4528 cell 321-757-6460 fax Bryan.Hatfield@mybighthouse.com
Priscilla Hament Secretary	Work Address: Harris Corporation Mail Stop 2-11A P.O. Box 37 Melbourne, FL 32902-0037	321-729-7485 (w) 321-693-5522 (c) phament@aol.com
Lee Garner, CPA Treasurer	Work Address: Bullock, Garner, & Leslie, CPA Firm 3962 W. Eau Gallie Blvd., Suite A Melbourne, FL 32934	321-752-5553 work 321-752-5556 fax Lee_Garner@sbullockcpaandco.com
Robert A. Marchello Chief Financial Officer	Work Address: 4676 N. Wickham Road Melbourne, FL 32935	321-253-4430 work 321-253-1993 fax Rmarchello@brevardalz.org
Richard Lewis	Home Address: 124 Lansing Island Drive Indian Harbour Beach, FL 32937	321-622-4217(c) 716-636-7909 (c) Rhinoboy1@verizon.net
Alec Prentice	Work Address: 7630 N. Wickham Road, Ste. 102 Melbourne, FL 32940	321-253-1423 (w) 321-474-0278 (c) alec@prenticelaw.com
David Slonim	Work Address: 2317 N. Wickham Road Melbourne, FL 32935	321-757-5701 (w) 321-960-4715 (c) 866-249-5702 (f) dslonim@slonimlaw.com
Sonny Simerly (Julian C.)	Home Address: 1540 Pioneer Drive Melbourne, FL 32940	321-610-8856 (c) (f) sonnysim@earthlink.net
Rachel Terry	Home Address: 325 Willow St. Titusville, FL 32780	321-269-0573 321-480-2349 cell RachelTerry43@yahoo.com

**AMENDMENT NUMBER ONE
ANCILLARY SERVICES PROVIDER AGREEMENT**

This Amendment Number One ("Amendment") is entered into as of _____ by and between Sunshine State Health Plan, Inc. ("Health Plan") and Brevard Alzheimer's Foundation dba Joe's Club ("Provider"), collectively referred to herein as the "Parties".

WHEREAS, Health Plan and Provider have previously entered into a Ancillary Services Provider Agreement (the "Agreement") effective as of January 3, 2014 (defined in the Agreement as the "Effective Date"); and

WHEREAS, the Parties desire to amend the Agreement.

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained, the Parties agree as follows:

1. EXHIBIT 1 TO ATTACHMENT B-2 - LONG TERM CARE PLAN PRODUCT COMPENSATION SCHEDULE will be deleted from the Agreement in its entirety and replaced with the attached EXHIBIT 1 TO ATTACHMENT B-1 – LONG TERM CARE PLAN PRODUCT COMPENSATION SCHEDULE.
2. All other terms and conditions of the Agreement and any amendments thereto, if any, shall remain in full force and effect. If the terms of this Amendment conflict with any of the terms of the Agreement, the terms of this Amendment shall prevail.

[SIGNATURE BLOCK FOLLOWS]

IN WITNESS WHEREOF, the Parties have executed and delivered this Amendment as of the date first set forth above.

Health Plan

Sunshine State Health Plan, Inc.

Authorized Signature

Printed Name: Chris Paterson

Title: President / CEO

Date:

ECM # 130875

Provider

Brevard Alzheimer's Foundation dba
Joe's Club

Authorized Signature



Printed Name:

Robert A. Marchello

Title:

CFO

Date:

7/30/14

Tax ID Number: 59-3369526

State Medicaid Number: 676059700

**EXHIBIT 1
TO ATTACHMENT B-1
LONG TERM CARE PLAN PRODUCT
COMPENSATION SCHEDULE**

The following sets forth the payment rates for Covered Services. The compensation methodology and rates may be amended by Health Plan depending on financial information provided as part of the Long-Term Care Managed Care Program procurement process and/or LTC Contract.

SERVICE DESCRIPTION	HCPC/REV CODE	RATE	UNIT
Personal Care	T1004	N/A	Per 15 Minutes
Adult Companion	S5135	N/A	Per 15 Minutes
Chore	S5120	N/A	Per 15 Minutes
Attendant Care	S5125	N/A	Per 15 Minutes
Homemaker	S5130	N/A	Per 15 Minutes
Respite-In Home	T1005	N/A	Per 15 Minutes
Nurse-LPN	S9124	N/A	Per Hour
Nurse-RN	S9123	N/A	Per Hour
Medication Administration	T1502	N/A	Per Visit
Medication Management	H2010	N/A	Per 15 Minutes
Caregiver Training	S5108	N/A	Per 15 Minutes
Nutritional Risk Reduction	S9470	N/A	Per Visit
Occupational Therapy	S9129	N/A	Per Visit
Physical Therapy	S9131	N/A	Per Visit
Speech Therapy	S9128	N/A	Per Visit
Respiratory Therapy-Eval	S5180	N/A	Per Visit
Respiratory Treatment	S5180 U2	N/A	Per Visit
Emergency Response	S5161	N/A	Per Month
Home Accessibility Adaptation	S5165	N/A	Per Auth
Home Delivered Meals (Hot)	S5170	N/A	Per Meal
Home Delivered Meals (Frozen)	S5170 U2	N/A	Per Meal
Home Delivered Meals (Specialty)	S5170 U3	N/A	Per Meal
Adult Day Care	S5102	\$50.00	Per Day
Transportation (as add on)	T2001	\$10.00	Per Trip
Behavior Management-initial evaluation	H2020	N/A	Per Visit

SERVICE DESCRIPTION	HCPC/REV CODE	RATE	UNIT
Behavior Management-ongoing treatment	H2019	N/A	Per Unit
Pest Control - Initial Visit	G9004	N/A	1 visit per enrollee
Pest Control - Maintenance	G9005	N/A	Per Visit

The Rates listed above are the maximum rate. The Plan Payment Rate shall not exceed the maximum rate or the billed charges whichever is lesser.



sunshine health

Tango Plan

Tango Provider Application

Please submit the completed and signed application, requested documentation and signed attestation to SSHP. Licenses, insurance and other accrediting documentation must be provided for all locations, as appropriate.

Provider Info:

Legal Name: Brevard Alzheimer's Fdn d.b.a. Joe's Club
 Medicaid Provider ID: 676059700 NPI #: 1174795454
 Contact Info:
 Name: Jarce Miller Email: JMiller@brevardalz.org

Primary Service Location:

Address: 46767 Wickham Rd City: Melbourne Zip: 32935
 Phone: 321-253-4430 Fax: 321-253-1993

Additional Service Locations:

Please use separate sheet for additional service locations, include phone and fax numbers. Indicate all counties served:

- | | | | | |
|---|---------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Alachua | <input type="checkbox"/> Hardee | <input type="checkbox"/> Manatee | <input type="checkbox"/> Orange | <input type="checkbox"/> Santa Rosa |
| <input checked="" type="checkbox"/> Brevard | <input type="checkbox"/> Hernando | <input type="checkbox"/> Marion | <input type="checkbox"/> Osceola | <input type="checkbox"/> Sarasota |
| <input type="checkbox"/> Broward | <input type="checkbox"/> Highlands | <input type="checkbox"/> Martin | <input type="checkbox"/> Palm Beach | <input type="checkbox"/> Seminole |
| <input type="checkbox"/> Citrus | <input type="checkbox"/> Hillsborough | <input type="checkbox"/> Miami-Dade | <input type="checkbox"/> Pasco | <input type="checkbox"/> St. Lucie |
| <input type="checkbox"/> Duval | <input type="checkbox"/> Indian River | <input type="checkbox"/> Monroe | <input type="checkbox"/> Pinellas | <input type="checkbox"/> Volusia |
| <input type="checkbox"/> Escambia | <input type="checkbox"/> Lake | <input type="checkbox"/> Okaloosa | <input type="checkbox"/> Polk | <input type="checkbox"/> Walton |
| <input type="checkbox"/> Other (please list): _____ | | | | |

Services:

- | | | |
|--|--|---|
| <input checked="" type="checkbox"/> Adult Day Care | <input type="checkbox"/> Home Accessibility Adapt | <input type="checkbox"/> Personal Care Services |
| <input type="checkbox"/> Assisted Living Services | <input type="checkbox"/> Home Delivered Meals | <input type="checkbox"/> Personal Emergency Resp. Sys. |
| <input type="checkbox"/> Attendant Care | <input type="checkbox"/> Homemaker | <input type="checkbox"/> Respite Care in ALF |
| <input type="checkbox"/> Caregiver Training | <input type="checkbox"/> Hospice | <input type="checkbox"/> Respite Care in Home |
| <input type="checkbox"/> Chore Services | <input type="checkbox"/> Medication Administration | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Companion | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Consumable Medical Supply | <input type="checkbox"/> Nursing, Intermittent | <input type="checkbox"/> Respiratory Therapy |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Nutritional Risk Assessment | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Escort | <input type="checkbox"/> Nursing, Skilled | <input checked="" type="checkbox"/> Other <u>Transportation</u> |

Billing Info:

Tax ID: 59-3369526 Name as it appears on W9: Brevard Alzheimer's Fdn Inc
 Address: 46767 Wickham Rd City: Melbourne Zip: 32935
 Phone: 321-253-4430 Fax: 321-253-1993

Please provide a copy of the applicable documents:

- ✓ Current Licensing: Medical, Facility or Occupational/Business Tax Receipt, as applicable to provider type.
- ✓ Current General and Professional Liability cover sheet and Workers' Compensation face sheet, or exemption sheet, as applicable, indicating coverage limits and expiration dates.
- ✓ AHCA Level II Background Screening Results (if applicable)
- ✓ DOEA Background Screening Affidavit of Compliance

Indicate the effective date of accreditation or certification, for any of the applicable organizations listed below.

Agency Name	Acronym	Effective Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers	AAHC		
American Board for Certification in Orthotics & Prosthetics, Inc	ABCOP		
American College of Radiology	ACR		
American Osteopathic Hospital Association	AOHA		
Board of Orthotist/Prosthetist Certification	BOCUSA		
Commission on Accreditation for Rehab Facilities	CARF		
Clinical Laboratory Improvement Act	CLIA		
Community Health Accreditation Program	CHAP		
Healthcare Quality Association on Accreditation	HQAA		
Joint Commission on Accreditation of Healthcare Organizations	JCAHO		
National Association of Boards of Pharmacy	NABP		
National Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc	URAC		
The National Board of Accreditation for Orthotic Suppliers	NBAOS		
Other: _____			

Credentiaing Attestation:

Circle One:

Have you been involved in any professional liability claims within the last 5 years?	Yes	<u>No</u>
Have you, the corporation, any officer or board member ever been convicted of or plead <i>nolo contendere</i> to any felony?	Yes	<u>No</u>
Have any sanctions been imposed on you by Medicare or Medicaid, in any state?	Yes	<u>No</u>
Have you had any disciplinary action imposed or loss or limitation of privileges, in this or any state?	Yes	<u>No</u>
Has your license ever been restricted, suspended or revoked, in this or any state?	Yes	<u>No</u>
Have you ever been subjected to sanctions by a Professional Review Organization, a Third Party Payor, or a Regulatory Agency?	Yes	<u>No</u>
Do you have any ownership or management participation in this facility/organization?	<u>Yes</u>	No
I attest that staff has received appropriate training in reporting abuse, neglect and exploitation and will report knowledge or reasonable suspicion of these activities via the Florida abuse statewide toll free hotline (1-800-96-Abuse).	<u>Yes</u>	No
I agree to immediately notify Sunshine State Health Plan of any changes to the above.	<u>Yes</u>	No

I certify that I have answered the questions and application truthfully, correctly and completely.

Provider Signature:

Robert Amosullo

Date:

7/30/14

Submitted by:

Janice E Miller

Signature

Print Name

Relationship to Provider:

Chief Operating Officer

CERTIFICATE #: 2262

LICENSE #: 8856

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

Adult Day Care Center

Standard

This is to confirm that BREVARD ALZHEIMERS FOUNDATION INC has complied with Chapter 429, Part III, laws of the State of Florida and with 58A-6, rules of the State of Florida and is authorized to operate the following:

JOE'S CLUB
4676 North Wickham Road
Melbourne, FL 32935

TOTAL CAPACITY: 76

EFFECTIVE DATE: 04/07/2014

EXPIRATION DATE: 04/06/2016


Deputy Secretary, Division of Health Quality Assurance



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
5/29/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Lassiter-Ware Insurance of Leesburg 1317 Citizens Blvd. Leesburg FL 34748		CONTACT NAME: Debra Linkous PHONE (A/C, No, Ext): (800) 845-8437 FAX (A/C, No): (888) 883-8680 E-MAIL ADDRESS: DebraL@lassiter-ware.com															
INSURED Brevard Alzheimer's Foundation, Inc. 4676 North Wickham Road Melbourne FL 32935		<table border="1"> <tr> <th>INSURER(S) AFFORDING COVERAGE</th> <th>NAIC #</th> </tr> <tr> <td>INSURER A: Great American E&S Ins Co</td> <td>37532</td> </tr> <tr> <td>INSURER B: Great American Alliance Ins Co</td> <td>26832</td> </tr> <tr> <td>INSURER C: Wesco Insurance Company</td> <td>25011</td> </tr> <tr> <td>INSURER D:</td> <td></td> </tr> <tr> <td>INSURER E:</td> <td></td> </tr> <tr> <td>INSURER F:</td> <td></td> </tr> </table>		INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A: Great American E&S Ins Co	37532	INSURER B: Great American Alliance Ins Co	26832	INSURER C: Wesco Insurance Company	25011	INSURER D:		INSURER E:		INSURER F:	
INSURER(S) AFFORDING COVERAGE	NAIC #																
INSURER A: Great American E&S Ins Co	37532																
INSURER B: Great American Alliance Ins Co	26832																
INSURER C: Wesco Insurance Company	25011																
INSURER D:																	
INSURER E:																	
INSURER F:																	

COVERAGES **CERTIFICATE NUMBER: 14-15 Master** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY			MAC062865214001	6/1/2014	6/1/2015	EACH OCCURRENCE \$ 1,000,000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						MED EXP (Any one person) \$ 10,000
							PERSONAL & ADV INJURY \$ 1,000,000
							GENERAL AGGREGATE \$ 3,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG \$ 3,000,000
	<input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC						\$
B	AUTOMOBILE LIABILITY			CAP062865714018	6/1/2014	6/1/2015	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
	<input checked="" type="checkbox"/> ANY AUTO						BODILY INJURY (Per person) \$
	<input type="checkbox"/> ALL OWNED AUTOS		<input type="checkbox"/> SCHEDULED AUTOS				BODILY INJURY (Per accident) \$
	<input checked="" type="checkbox"/> HIRED AUTOS		<input checked="" type="checkbox"/> NON-OWNED AUTOS				PROPERTY DAMAGE (Per accident) \$
							\$
A	UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR			EXC062865314001	6/1/2014	6/1/2015	EACH OCCURRENCE \$ 1,000,000
	<input checked="" type="checkbox"/> EXCESS LIAB		<input type="checkbox"/> CLAIMS-MADE				AGGREGATE \$ 1,000,000
							\$
	DED		RETENTIONS				
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			WPP11007920014054	6/1/2014	6/1/2015	WC STATUTORY LIMITS
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input type="checkbox"/> Y/N	N/A				E.L. EACH ACCIDENT \$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE \$ 1,000,000
							E.L. DISEASE - POLICY LIMIT \$ 1,000,000
A	Professional Liability Abuse & Molestation			MAC062865214001	6/1/2014	6/1/2015	\$1,000,000/\$3,000,000 \$1,000,000/\$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER		CANCELLATION	
(866) 699-2898 Sunshine State Health Plan Jacqui Braun - contract Negotiator 3505 E Frontage Road Suite 300 Tampa, FL 33607		SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE Doug Childers/DEBRAL	



Background Screening Result

Provider Name: BREVARD
 ALZHEIMER'S FOUNDATION
 INC
 Printed by: JANICE MILLER
 Provider File #: 30580
 Medicare #: N/A
 Medicaid #: N/A

This individual's eligibility status as of 1/23/2014 for Employment, Provider Licensure and Medicaid Provider Enrollment is provided below. The employer must retain a hard copy of this result in the individual's employee file. If AHCA becomes aware of a change to the individual's background screening eligibility status, the most recent employer on record in the Background Screening System will be notified by email. If you become aware of an event that may change the employee's eligibility please contact the AHCA Background Screening Unit at (850) 412-4503. The employer must take the appropriate action when a change in status occurs in accordance with Section 435.06, Florida Statutes.

Applicant Name:	SSN:	Date of Birth:	Race:	Sex:
ROBERT A. MARCHELLO	XXX-XX-1180	1/17/1976	WHITE	MALE

Agency for Healthcare Administration (AHCA) Eligibility Status

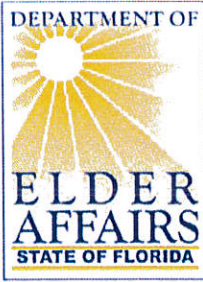
Retained Prints Expiration Date: 12/18/2018
 Clearinghouse Screening Available?: Yes

Eligibility

Type	Item	Status	Screening Completion Date
Employment	Medicaid / Medicare Participating Provider	Eligible	1/21/2014
Employment	Non-Medicaid / Medicare Participating Provider	Eligible	1/21/2014
Position	Medicaid Provider Enrollment	Eligible	1/21/2014
Position	AHCA Provider/Facility Licensure	Eligible	1/21/2014

Employment History (as reported to AHCA by health care provider employer)

Provider	Position	Hire Date	End Date
No records to display.			



BACKGROUND SCREENING Affidavit of Compliance - Employer

AUTHORITY: This form is required annually of all employers to comply with the attestation requirements set forth in section 435.05(3), Florida Statutes.

- The term "employer" means any person or entity required by law to conduct background screening, including but not limited to, Area Agencies on Aging, Aging Resource Centers, Aging and Disability Resource Centers, Lead Agencies, Long-Term Care Ombudsman Program, Serving Health Insurance Needs of Elders Program, Service Providers, Diversion Providers, and any other person or entity which hires employees or has volunteers in service who meet the definition of a direct service provider. See §§ 435.02, 430.0402, Fla. Stat.
- A direct service provider is "a person 18 years of age or older who, pursuant to a program to provide services to the elderly, has direct, face-to-face contact with a client while providing services to the client and has access to the client's living area, funds, personal property, or personal identification information as defined in s. 817.568. The term includes coordinators, managers, and supervisors of residential facilities; and volunteers." § 430.0402(1)(b), Fla. Stat.

ATTESTATION:

As the duly authorized representative of Brevard Alzheimer's Fellowship Joe's Club
Employer Name
 located at 4676 N. Wickham Rd, Melbourne FL 32935
Street Address City State ZIP code


I, Robert A. Marchello do hereby affirm under penalty of perjury
Name of Representative

that the above named employer is in compliance with the provisions of Chapter 435 and section 430.0402, Florida Statutes, regarding level 2 background screening.

Robert A. Marchello 8/4/14
Signature of Representative Date

STATE OF FLORIDA, COUNTY OF Brevard

Sworn to (or affirmed) and subscribed before me this 4th day of August, 2014, by Robert A. Marchello (Name of Representative) who is personally known to me or produced none as proof of identification.

 JANICE ELAINE MILLER
 MY COMMISSION # EE001917
 EXPIRES October 04, 2014
Print Name, Type, or Stamp Commissioned Name of Notary Public FloridaNotaryService.com

Janice Elaine Miller
Notary Public

**Request for Taxpayer
 Identification Number and Certification**

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

Name (as shown on your income tax return)
Brevard Alzheimer's Foundation, Inc.

Business name/disregarded entity name, if different from above
Joe's Club

Check appropriate box for federal tax classification:
 Individual/sole proprietor C Corporation S Corporation Partnership Trust/estate
 Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____
 Other (see instructions) ▶ _____

Exemptions (see instructions):
 Exempt payee code (if any) _____
 Exemption from FATCA reporting code (if any) _____

Address (number, street, and apt. or suite no.)
4627 N. Wickham Rd

City, state, and ZIP code
Melbourne FL 32935

Requester's name and address (optional)

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.

Social security number
 [] [] [] - [] [] - [] [] []

Employer identification number
59-3369526

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. citizen or other U.S. person (defined below), and
- 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 ▶ Robert D. Nachels Date ▶ 7/30/14

General Instructions

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

Future developments. The IRS has created a page on www.irs.gov/w9 for information about Form W-9, at www.irs.gov/w9. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

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, payments made to you in settlement of payment card and third party network transactions, 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:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- 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, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and 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 under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 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 section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity,
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust, and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (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 payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an 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, give the requester the appropriate completed Form W-8 or Form 8233.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, 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,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
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 *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* on page 1.

What is FATCA reporting? The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

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.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. 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 entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulation section 301.7701-2(c)(2)(iii). Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Note. Check the appropriate box for the U.S. federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the U.S. federal tax classification in the space provided. If you are an LLC that is treated as a partnership for U.S. federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation, as appropriate. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for U.S. federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required U.S. 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/disregarded entity name" line.

Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the Exemptions box, any code(s) that may apply to you. See *Exempt payee code and Exemption from FATCA reporting code* on page 3.

Exempt payee code. 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. Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following codes identify payees that are exempt from backup withholding:

- 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
- 5—A corporation
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission
- 8—A real estate investment trust
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10—A common trust fund operated by a bank under section 584(a)
- 11—A financial institution
- 12—A middleman known in the investment community as a nominee or custodian
- 13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 5 ²
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

¹ See Form 1099-MISC, Miscellaneous Income, and its Instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements.

- A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)
- B—The United States or any of its agencies or instrumentalities
- C—A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities
- D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Reg. section 1.1472-1(c)(1)(i)
- E—A corporation that is a member of the same expanded affiliated group as a corporation described in Reg. section 1.1472-1(c)(1)(i)
- F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

- G—A real estate investment trust
- H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940
- I—A common trust fund as defined in section 584(a)
- J—A bank as defined in section 581
- K—A broker
- L—A trust exempt from tax under section 664 or described in section 4947(a)(1)
- M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

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-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 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. 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 Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting 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, apply for a TIN and 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. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

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, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 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 nonemployee for services, payments made in settlement of payment card and third party network transactions, 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.

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) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee ¹
5. Sole proprietorship or disregarded entity owned by an individual	The actual owner ¹
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The owner ³
	The grantor ⁴
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity ⁴
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. 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
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

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 and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the 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.) Also see *Special rules for partnerships* on page 1.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

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.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN.
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.ftc.gov/idtheft or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

**EXHIBIT 1
TO ATTACHMENT B-1
LONG TERM CARE PLAN PRODUCT
COMPENSATION SCHEDULE**

The following sets forth the payment rates for Covered Services. The compensation methodology and rates may be amended by Health Plan depending on financial information provided as part of the Long-Term Care Managed Care Program procurement process and/or LTC Contract.

SERVICE DESCRIPTION	HCPC/REV CODE	RATE	UNIT
Personal Care	T1004	N/A	Per 15 Minutes
Adult Companion	S5135	N/A	Per 15 Minutes
Chore	S5120	N/A	Per 15 Minutes
Attendant Care	S5125	N/A	Per 15 Minutes
Homemaker	S5130	N/A	Per 15 Minutes
Respite-In Home	T1005	N/A	Per 15 Minutes
Nurse-LPN	S9124	N/A	Per Hour
Nurse-RN	S9123	N/A	Per Hour
Medication Administration	T1502	N/A	Per Visit
Medication Management	H2010	N/A	Per 15 Minutes
Caregiver Training	S5108	N/A	Per 15 Minutes
Nutritional Risk Reduction	S9470	N/A	Per Visit
Occupational Therapy	S9129	N/A	Per Visit
Physical Therapy	S9131	N/A	Per Visit
Speech Therapy	S9128	N/A	Per Visit
Respiratory Therapy-Eval	S5180	N/A	Per Visit
Respiratory Treatment	S5180 U2	N/A	Per Visit
Emergency Response	S5161	N/A	Per Month
Home Accessibility Adaptation	S5165	N/A	Per Auth
Home Delivered Meals (Hot)	S5170	N/A	Per Meal
Home Delivered Meals (Frozen)	S5170 U2	N/A	Per Meal
Home Delivered Meals (Specialty)	S5170 U3	N/A	Per Meal
Adult Day Care	S5102	\$50.00	Per Day
Transportation (as add on)	T2001	\$10.00	Per Trip
Behavior Management-initial evaluation	H2020	N/A	Per Visit

SERVICE DESCRIPTION	HCPC/REV CODE	RATE	UNIT
Behavior Management-ongoing treatment	H2019	N/A	Per Unit
Pest Control - Initial Visit	G9004	N/A	1 visit per enrollee
Pest Control - Maintenance	G9005	N/A	Per Visit

The Rates listed above are the maximum rate. The Plan Payment Rate shall not exceed the maximum rate or the billed charges whichever is lesser.