

Network Participation Request Form**Instructions/Checklist****Before you begin...**

- 1) Are you already part of the Optum/OptumHealth Behavioral Solutions of California network?
If you are unsure, check on providerexpress.com > Our Network > [Optum clinician directory](#)
- 2) Are you part of a group practice that is contracted with us?
If so, please consult with your group administrator regarding the process for joining the Optum network prior to submitting any documents.

If you are not currently part of the Optum network and would like to be considered for participation, please fully complete and submit the following documents. Incomplete documents may delay our response to your request.

Network Participation Request Form - Return pages 2, 3, 4, 5 & 8 (Note – if you downloaded this form previously, confirm that you have the current version by comparing the revision date in the lower left corner with the form current available on Provider Express.)

- ☐ Page 2 • Fully complete Sections A and B.
- ☐ Page 3-4 • Check at least one area of expertise/population treated. Do not leave blank.
- ☐ Page 5 • Provide requested supporting documents, if applicable.
 - If no attested specialties are applicable, check the “No Specialties” box.
 - Check Acknowledgment box and sign Attestation page.
- ☐ Page 8 • *Substitute Form W-9* (or *IRS Form W-9*) must be signed and dated by the clinician or the controller of the tax identification number. Each tax identification number requires a separate *Substitute Form W-9* or *IRS Form W-9*.

Individual Contract Documents (not required for clinicians who are part of a contracted group practice)

- ☐
 - Retain a full copy of the Agreement and any Attachments, Amendments, Disclosure Forms and/or state required forms for your records. (Note – The *Network Manual* is, by extension, part of the Agreement. The *Manual* can be review at Provider Express > [Guidelines/Policies](#).)
 - Complete and sign the Agreement signature page.
 - Complete and sign any Attachment/Amendment &/or Disclosure Forms, if signature is required.

How to Submit Your Documents

If you received a direct invitation/application to join the network from our Network team, return completed documents to the fax number or email address shown in the information packet.

If not, fax completed documents to Network Management for your state. To find the fax number, go to providerexpress.com > Contact Us > [Network Management](#) > Network Management Contact Information and select your state.

Optum Network Participation Request Process

Frequently Asked Questions

How do I know whether my license is considered independent and acceptable by Optum?

Check the list of licenses Optum accepts in your state. The list can be found on providerexpress.com > Join Our Network > follow the links to your state.

How long is the credentialing process?

Credentialing is completed in accordance with applicable laws and averages 120 days. If you have not heard back from us after 120 days, you may inquire about the status of your credentialing by contacting Network Management.

What Optum documents should be completed or provided & faxed to Network Management to request network consideration?

- Provider Agreement – contract signature page only (if applicable, this is located on your state's "Join Our Network" page)
- Network Participation Request Form, Clinical Expertise Checklist, Specialty Attestation and Substitute Form W-9 (complete and return pages 2, 3, 4, 5 and 8)
- State-specific Amendments or Attachments (if applicable, these are located on your state's "Join Our Network" page)

May I begin to see Optum members while I am going through the credentialing process? If yes, what is the member's financial responsibility?

You are not considered an "in-network" clinician until your credentialing is complete. In some cases, members may choose to access out- of-network benefits; members will generally incur greater out-of-pocket expenses by making this choice. When you become a network clinician you must log onto Provider Express and request an authorization for each Optum insured member currently in your practice (MDs and RNs do not require authorizations for most routine outpatient services).

Why does Optum use CAQH for credentialing and recredentialing?

The CAQH web-based credentialing tool streamlines the credentialing process by enabling you to complete your credentialing application online and is available to you at no cost 24 hours a day, 365 days a year. You may save your application and return to it at any time.

Do I need to have a CAQH number before I can apply to the Optum network?

No. If you do not already have a CAQH number, Optum will provide you with one once the determination is made to move forward with the recruitment process.

Does CAQH notify Optum when my application is completed or when I make demographic or other updates?

No. It is your responsibility to notify Optum when your application is completed or when you make any updates to demographic or other information included on CAQH.

I have completed my application on CAQH; does that mean I am on the Optum panel?

No. CAQH stores the online application, but Optum must still verify your credentials and evaluate your application through our Credentialing Committee prior to approval of your participation on the panel.

If I am added to the panel, how will Optum notify me of my contract start date?

Once approved, you will receive an acceptance letter stating your effective date with Optum.

Does my credentialing/re-credentialing correspondence address have to be the same as my practice location?

No. The credentialing/re-credentialing correspondence address does not have to be the same as your practice location. It cannot, however, be a P.O. Box; it must be a physical address. There is one re-credentialing address per clinician, not per location.

Am I required to have a secure fax number or secure email?

While it is recommended that you have both a secure fax number and a secure email, you are required to have only one of these forms of secure electronic communication for transmittal of confidential information. The definition of a secure fax is having a business dedicated fax number in a secure location (not accessible or visible to your clients, visitors or family while you are in session or away from the office). The definition of secure email is that the email account be a business dedicated, password protected account accessible only to you and appropriate office staff.

Am I required to have online capabilities?

Yes. Optum requires all claims be submitted electronically either through our Provider Express portal (available at no cost to you) or through an Electronic Data Interchange (EDI) vendor. Additionally, other critical information regarding your contract will be posted on line.

Are there other requirements?

In applying to the Optum panel you are agreeing to participate in all Care Management and Quality Improvement Programs sponsored by Optum including, but not limited to the submission of patient Wellness Assessment forms as part of our outcomes evaluation program, ALERT®.

Network Participation Request Form

Behavioral Solutions of California

IMPORTANT NOTE: Please complete fully. Incomplete forms will delay the response to this inquiry. For clinicians in "any willing provider" states, please note that network inclusion is based solely on meeting our minimum credentialing standards as outlined in the Credentialing Plan. Information submitted on this form must match your CAQH application.

SECTION A - CLINICIAN INFORMATION:

Clinician's Name _____ Gender ☐ Female ☐ Male

Credentialing/Re-credentialing contact information

(Disclaimer: we can only hold 1 credentialing contact name/address per clinician & a correspondence address cannot be a P.O. Box)

Credentialing Contact Name Teresa Lloyd Phone 502-905-9494
 Address 4010 Dupont Circle Suite 582 City Louisville State KY Zip 40207
 Fax # 502-899-5411 Email tlloyd@transformationsllc.net

Council for Affordable Quality Healthcare (CAQH) Participant? ☒ Yes ☐ No If yes, list CAQH # * _____

If you do not have a CAQH number, Optum will provide the number, once the determination is made to recruit.

* Optum accepts credentialing application submission through CAQH or by other state approved applications, as applicable. For more information regarding CAQH you may visit their website at www.CAQH.org.

(1) Professional License Type _____ & License # _____ Original Independent License Issue Date _____

(2) Professional License Type _____ & License # _____ Original Independent License Issue Date _____

IMPORTANT NOTE: Please list any independent license previously held in another state (if applicable).

SS# _____ DOB _____ Clinician's e-mail _____@transformationsllc.net

Individual NPI (Type I) _____ Individual Taxonomy Code _____

Group NPI (Type II) 1427229483 Group Taxonomy Code 251S00000X

Individual Medicaid # _____ Individual Medicare # _____

Board Certified Physician ☐ Yes If yes, list board/cert date _____
☒ No If no, psychiatric fellowship/residency training completion date _____

Hospital Affiliation(s) _____ Attending ☐ Yes ☒ No

SECTION B - PRACTICE INFORMATION: - addresses & TIN(s) below must match CAQH application

Primary Practice

Practice Name Transformations hope for today's families LLC TIN # 61-1351752

Website www.transformationsllc.net

Physical Practice Address 4010 Dupont Circle Suite 582

City Louisville State KY Zip 40207 County Jefferson

Phone # 502-899-5411 Secure fax# 502-899-5411

Additional Practice

Practice Name _____ TIN # ** _____

Physical Practice Address _____

City _____ State _____ Zip _____ County _____

Phone # _____ Secure fax# _____

****If you have more than one additional TIN/group affiliation, please complete information contained in Section B on an additional piece of paper & include corresponding Substitute Form W-9 or IRS W-9 for the additional TIN(s).**

Mailing Address 4010 Dupont Circle Suite 582

City Louisville State KY Zip 40207 County Jefferson

LIST ALL LANGUAGES (including sign language) in which you are able to conduct treatment:

English

Optional—Clinician's own Ethnicity (data utilized to meet member referral requests):

☐ African American ☐ Alaska Native ☐ Native-American Indian ☐ Asian
☐ Caucasian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ Other

Optum

Clinical Expertise Checklist

Clinician Name: _____

CAQH # _____

Clinicians in the credentialing or recredentialing process have the following rights:

- to review information submitted to support his/her (re)credentialing application
- to correct erroneous information obtained by Optum to evaluate his/her (re)credentialing application (not including references, recommendations and other peer-review protected information)
- to submit any corrections, in writing, within ten (10) days
- to obtain, upon request, information regarding the status of their application

Areas of Clinical Expertise

Please check all areas you have clinical training and experience **AND** are currently willing to treat in your practice.

- | | |
|--|---|
| <input type="checkbox"/> Abuse (Physical, Sexual, etc.) | <input type="checkbox"/> Evaluation and Assessment – Mental Health |
| <input type="checkbox"/> Adoption Issues | <input type="checkbox"/> Eye Movement Desensitization & Reprocessing (EMDR) |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Feeding and Eating Disorders |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Forensic |
| <input type="checkbox"/> Assertive Community Treatment (ACT) | <input type="checkbox"/> Gay/Lesbian Identified Clinician |
| <input type="checkbox"/> Assessment and Referral – Substance Abuse | <input type="checkbox"/> Gay/Lesbian Issues |
| <input type="checkbox"/> Attention Deficit Disorders (ADHD) | <input type="checkbox"/> Grief/Bereavement |
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Health and Behavior Assessment and Intervention Services |
| <input type="checkbox"/> Bariatric/Gastric Bypass Evaluation | <input type="checkbox"/> Hearing Impaired Populations |
| <input type="checkbox"/> Behavior Modification | <input type="checkbox"/> HIV/AIDS/ARC |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Home Care/Home Visits |
| <input type="checkbox"/> Bisexual Issues | <input type="checkbox"/> Hypnosis |
| <input type="checkbox"/> Blindness or Visual Impairment | <input type="checkbox"/> Independent/Qualified Medical Examiner |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Certified Pastoral Counselor | <input type="checkbox"/> Intellectual and Developmental Disability |
| <input type="checkbox"/> Child Welfare | <input type="checkbox"/> Intensive Individual Support |
| <input type="checkbox"/> Christian Counseling | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Co-Occurring Disorders Treatment (Dual Diagnosis) | <input type="checkbox"/> Long Term Care |
| <input type="checkbox"/> Cognitive Behavioral Therapy | <input type="checkbox"/> Long-Acting Injectable (LAI) Administrator |
| <input type="checkbox"/> Community Integration Counseling | <input type="checkbox"/> Medical Illness/Disease Management |
| <input type="checkbox"/> Community Psych Support and Treatment | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Compulsive Gambling | <input type="checkbox"/> Military/Veterans Treatment |
| <input type="checkbox"/> Crisis Diversionary Services | <input type="checkbox"/> Mobile Mental Health Treatment |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Multi-Systemic Therapy (MST) |
| <input type="checkbox"/> Dialectical Behavioral Therapy | <input type="checkbox"/> Naltrexone Injectable MAT |
| <input type="checkbox"/> Disability Evaluation/Management (submit "Memorandum of Understanding", located on providerexpress.com) | <input type="checkbox"/> Nursing Home Visits |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> Obsessive Compulsive Disorder |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Opioid Treatment Service (OTS) |
| <input type="checkbox"/> Electroconvulsive Therapy (ECT) | <input type="checkbox"/> Organic Disorders |

Areas of Clinical Expertise (cont)

- | | |
|---|--|
| <input type="checkbox"/> Outpatient Medically Supervised Withdrawal | <input type="checkbox"/> School Based Services |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> Serious Mental Illness |
| <input type="checkbox"/> Parent Support and Training | <input type="checkbox"/> Sex Offender Treatment |
| <input type="checkbox"/> Personality Disorders | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Personalized Recovery Oriented Services | <input type="checkbox"/> Sleep-Wake Disorders |
| <input type="checkbox"/> Phobia | <input type="checkbox"/> Somatoform Disorders |
| <input type="checkbox"/> Physical Disabilities | <input type="checkbox"/> Targeted Case Management |
| <input type="checkbox"/> Police/Fire Fighters | <input type="checkbox"/> TBI Waiver – Case Management |
| <input type="checkbox"/> Positive Behavioral Interventions & Supports | <input type="checkbox"/> TBI Waiver – Community Integration Counseling |
| <input type="checkbox"/> Post-Partum Depression | <input type="checkbox"/> TBI Waiver – Positive Behavior |
| <input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD) | <input type="checkbox"/> Transgender |
| <input type="checkbox"/> Psych Testing | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Psychosocial Rehabilitation (PSR) | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Psychotic/Schizophrenic Disorders | <input type="checkbox"/> Weapons Clearance |
| <input type="checkbox"/> Rape Issues | <input type="checkbox"/> Workers' Compensation |
| <input type="checkbox"/> Regional Behavioral Health Authority (RHBA) | |
| <input type="checkbox"/> Respite Care | |

Population(s) Treated (check all that apply):

- ☐ Adult
- ☐ Child/Adolescent
- ☐ Geriatric
- ☐ Couples/Marriage Therapy
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ Inpatient

Optum Specialty Attestation

You must sign this document even if you are not requesting any of these specialty designations in your provider record. Additional training, experience, requirements, and/or outside agency approval is required for the following populations, professional certifications, and specialties. **Please review Specialty Requirements on pages 6-7.**

If you are not requesting a specialty designation, please check the "No Specialties" box at the bottom of the list to indicate you have read this form and acknowledge that you have not requested these specialties.

I have reviewed the Optum Specialty Requirements criteria that a Clinician must meet to be considered a specialist in the following treatment areas. After reviewing the criteria, I hereby attest that by placing a check next to a specialty or specialties, I meet Optum requirements for that treatment area.

Physician Specialties	Non-Physician Specialties
<input type="checkbox"/> Child/Adolescent (please specify all ages that you treat) <div style="margin-left: 20px;"> <input type="checkbox"/> Infant Mental Health (0-3 years) <input type="checkbox"/> Preschool (0-5 years) <input type="checkbox"/> Children (6-12 years) <input type="checkbox"/> Adolescents (13-18 years) </div> <input type="checkbox"/> Geriatrics <input type="checkbox"/> Buprenorphine – Medication Assisted Treatment (MAT) (submit DEA registration with the DATA 2000 prescribing identification number) <input type="checkbox"/> Chemical Dependency / Substance Abuse / Substance Use Disorder (SUD) <input type="checkbox"/> Neuropsychological Testing <input type="checkbox"/> Substance Abuse Expert (submit Nuclear Regulatory Commission qualification training certificate) <input type="checkbox"/> Transcranial Magnetic Stimulation (TMS)	<input type="checkbox"/> Child/Adolescent (please specify all ages that you treat) – Psychologists only <div style="margin-left: 20px;"> <input type="checkbox"/> Infant Mental Health (0-3 years) <input type="checkbox"/> Preschool (0-5 years) <input type="checkbox"/> Children (6-12 years) <input type="checkbox"/> Adolescents (13-18 years) </div> <input type="checkbox"/> Certified Employee Assistance Professional (submit CEAP certificate) <input type="checkbox"/> Chemical Dependency / Substance Abuse / Substance Use Disorder (SUD) <input type="checkbox"/> Critical Incident Stress Debriefing (submit CISM certificate) <input type="checkbox"/> Employee Assistance Professional <input type="checkbox"/> Neuropsychological Testing – Psychologists only <input type="checkbox"/> Nurses–Prescriptive Privileges (submit ANCC certificate, Prescriptive Authority, DEA certificate and/or State Controlled Substance certificate, based upon state requirement) <input type="checkbox"/> Substance Abuse Expert (submit Nuclear Regulatory Commission qualification training certificate) <input type="checkbox"/> Substance Abuse Professional (submit Department of Transportation certificate) <input type="checkbox"/> Veterans Administration Mental Health Disability Examination – Psychologists only

☐

No Specialties (must be checked if no other specialties are being designated)

I understand that Optum may require documentation to verify that I meet the criteria outlined under Specialty Requirements pertaining to the specialty or specialties I have designated above. I will cooperate with an Optum documentation audit, if requested, to verify that I meet the required criteria.

I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the Optum network.

Please note that standard credentialing criteria must be met before specialty designation can be considered. All clinicians must sign this form whether specialties are applicable or not. Failure to sign this form may cause a delay in the processing of your initial credentialing file.

☒ I acknowledge that I have read the Agreement, *Network Manual*, and, if applicable for my state, the State Regulatory Attachment, Medicare Regulatory Attachment and/or Medicaid Regulatory Attachment.

Printed Name of Applicant: _____

Signature of Applicant _____

Signature stamps are not accepted.

Important Note: Signature on the Optum Specialty Attestation page is required of all applicants

PHYSICIAN SPECIALTY REQUIREMENTS	
CHILD/ADOLESCENT:	<ul style="list-style-type: none"> Completion of an ACGME approved Child and Adolescent Fellowship OR recognized certification in Adolescent Psychiatry (This specialty includes Infants, Preschool, Children and Adolescents)
GERIATRICS:	<ul style="list-style-type: none"> Completion of an ACGME approved Geriatric Fellowship OR recognized certification in Geriatric Psychiatry
BUPRENORPHINE – MEDICATION ASSISTED TREATMENT:	<ul style="list-style-type: none"> DEA registration certificate with the DATA 2000 prescribing identification number
CHEMICAL DEPENDENCY / SUBSTANCE ABUSE / SUBSTANCE USE DISORDER:	<ul style="list-style-type: none"> Completion of an ACGME Board certification in addiction psychiatry OR certification in addiction medicine OR certified by the American Society of Addiction Medicine (ASAM)/renamed American Board of Addiction Medicine (ABAM)
NEUROPSYCHOLOGICAL TESTING:	<ul style="list-style-type: none"> Recognized certification in Neurology through the American Board of Psychiatry and Neurology OR Accreditation in Behavioral Neurology and Neuropsychiatry through the American Neuropsychiatric Association <p>AND all of the following criteria:</p> <ul style="list-style-type: none"> State medical licensure does not include provisions that prohibit neuropsychological testing service; Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested; Physician and supervised psychometrician adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation.
SUBSTANCE ABUSE EXPERT (SAE) – Nuclear Regulatory Commission (NRC):	<ul style="list-style-type: none"> Certificate of NRC SAE qualification training (agencies providing such certification include, but are not limited to, ASAP, Inc, Program Services, and SAPAA)
TRANSCRANIAL MAGNETIC STIMULATION (TMS)	<ul style="list-style-type: none"> Completed all training related to use of devices utilized in the Neurostar TMS Therapy System or Brainsway Deep TMS system

PSYCHOLOGISTS, NURSES & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS	
CHILD/ADOLESCENT – Psychologists Only:	<ul style="list-style-type: none"> Completion of an APA approved or other accepted training/certification program in Clinical Child Psychology (This specialty includes Infants, Preschool, Children and Adolescents)
CERTIFIED EMPLOYEE ASSISTANCE PROFESSIONAL (CEAP):	<ul style="list-style-type: none"> Certificate from the Employee Assistance Certification Commission
CHEMICAL DEPENDENCY / SUBSTANCE ABUSE / SUBSTANCE USE DISORDER:	<ul style="list-style-type: none"> Completion an APA or other accepted training in Addictionology <p>OR</p> <ul style="list-style-type: none"> Certification in Addiction Counseling <p>AND one (1) or more of the following:</p> <ul style="list-style-type: none"> Ten (10) hours of CEU in Substance Abuse in the last twenty-four (24) month period Evidence of twenty-five percent (25%) practice experience in substance abuse
CRITICAL INCIDENT STRESS DEBRIEFING:	<ul style="list-style-type: none"> Certificate of CISD training from American Red Cross or Mitchell model Documentation of training and CEU units in the provision of CISD services
EMPLOYEE ASSISTANCE PROFESSIONAL (EAP):	<ul style="list-style-type: none"> Minimum of two (2) years' experience in the delivery of EAP core technology as defined by EAPA, and Minimum of one (1) annual training (CEU credits or professional development hours) in any of the eight (8) EAP content areas
NEUROPSYCHOLOGICAL TESTING – Psychologists Only:	<ul style="list-style-type: none"> Member of the American Board of Clinical Neuropsychology OR the American Board of Professional Neuropsychology <p>OR</p> <ul style="list-style-type: none"> Completion of courses in Neuropsychology including: Neuroanatomy, Neuropsychological testing, Neuropathology, or Neuropharmacology Completion of an internship, fellowship, or practicum in Neuropsychological Assessment at an accredited institution <p>AND</p> <ul style="list-style-type: none"> Two (2) years of supervised professional experience in Neuropsychological Assessment
NURSES REQUESTING PRESCRIPTIVE AUTHORITY MUST:	<ul style="list-style-type: none"> Possess a currently valid license as a Registered Nurse in the state(s) in which you practice Be authorized for prescriptive authority in the state in which you practice Meet state specific mandates for the state in which you practice regarding DEA license and physician supervision Attest that you meet your state's collaborative or supervisory agreement requirements Specifically request prescriptive privileges on the Optum application above

PSYCHOLOGISTS, NURSES & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS (cont.)

SUBSTANCE ABUSE EXPERT (SAE) - Nuclear Regulatory Commission (NRC):

To qualify as an SAE for the NRC, you must possess one of the following credentials:

- Licensed or certified social worker
- Licensed or certified psychologist
- Licensed or certified employee assistance professional
- Certified alcohol and drug abuse counselor - The NRC recognizes alcohol and drug abuse certification by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission (NAADAC) or by the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC/AODA).

AND

- Certificate of NRC SAE qualification training (agencies providing such certification include, but are not limited to, ASAP, Inc., Program Services, and SAPAA)

SUBSTANCE ABUSE PROFESSIONAL (SAP):

- Certificate of training in federal Department of Transportation SAP functions and regulatory requirements (agencies providing such certification include, but not limited to, Blair and Burke, EAPA and NMDAC)

VETERANS ADMINISTRATION MENTAL HEALTH DISABILITY EXAMINATION – Psychologists Only:


- Graduate of an American Psychological Association accredited university (qualification counts even if accreditation occurred after date of graduation)
- Wheelchair accessible office
- PC user (Macintosh/Mac computers do not interface with the testing software used in the Disability Examination)
- Agree to participate in initial and annual training programs as required by LHI
- Agree to offer appointments within 10 to 14 days of the request for services
- Agree that beneficiary will not wait longer than 20 minutes in the office before being tested

**IMPORTANT TAX DOCUMENT
SUBSTITUTE FORM W-9**

Request for Taxpayer Identification Number

As part of the contracting process, we are requesting that you complete this Substitute Form W-9. We are required by law to obtain this information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a penalty imposed by the Internal Revenue Service under Section 6723 of the Internal Revenue Code.

This information must be consistent with the data provided on Page 2 of the application (clinic information).

- | | |
|--|---|
| 1. Taxpayer Name
(To whom the check is payable) | Transformations hope for today's families LLC |
| | (A legal entity name if a corporation or partnership) |
| Doing Business as:
(A division name if a corporation or the name
of the business if a sole proprietor) | DBA Transformations |
| 2. Taxpayer Address | 4010 Dupont Circle |
| | Suite 582 |
| | Louisville KY 40207 |
| 3. Taxpayer Identification Number | |
| a. Corporation | |
| | (List employer identification number) |
| b. Partnership | |
| | (List employer identification number) |
| c. Sole Proprietorship | |
| | (List social security number or employer identification number) |
| d. Tax Exempt Entity | |
| | (List employer identification number) |
| e. Other – Please Explain | 61-1351752 Limited Liability Company |
| 4. Effective Date of Taxpayer Name and TIN | 7/1/1998 |
| 5. Form Completed By | Teresa Lloyd |
| | (Print name) |
| 6. Signature |  |
| | (Signature) |
| 7. Today's Date | 08/20/2015 |
| 8. Daytime Phone Number | (502) 905-9494 |

PLEASE NOTE: INFORMATION REPORTED ON LINES 1-3 MUST BE CONSISTENT WITH DATA ON FILE WITH THE IRS AND SOCIAL SECURITY ADMINISTRATION.