FFN/RCE Application Instructions

As a new provider, your license beginning date starts when your FBI background checks and required training is completed. Once your application has been approved or denied, a letter will be sent to you with instructions on how to submit your invoices. **If you have questions regarding invoicing, contact the Child Care Resource and Referral facility in your district.**

https://dphhs.mt.gov/ecfsd/childcare/childcareresourceandreferral

TRAINING REQUIREMENTS

MANDATORY TRAINING COURSES

- Health and Safety Overview for Family, Friend, and Neighbor/Relative Care Exempt Providers

  A four hour class that is required for **all** providers. This training must be completed before the initial license (60 days) is approved.

  Please note, this class must be completed every 3 years (FFN & RCE).

- Fundamentals of Family, Friend, and Neighbor/Relative Care Exempt Providers Orientation

  A four hour class that is also required for **all** providers. This class must be completed within 60 days after your initial license has been approved. If this class has not been taken within 60 days, the license will be terminated until the class has been completed.

These classes are available online at https://www.childcaretraining.org/mod/page/view.php?id=25841 and are free of charge. An access code is required to enroll in the classes, which is **HCeibcTm**.

For assistance or problems with childcaretraining.org please call (406) 728-6446.

CPR and FIRST AID (*FFN Providers Only*)

- Required for all FFN Providers (RCE Providers are exempt)
- Please contact your local Child Care Resource & Referral facility for approved classes in your area and to check availability

ANNUAL TRAINING REQUIREMENTS (*FFN Providers Only*)

- After your first license renewal period, a total of 8 hours of yearly training will be required to be completed. Approved training courses can be found and enrolled at:

  https://www.childcaretraining.org/mod/page/view.php?id=28801.

- Training classes may be repeated, and in those years when you are required to retake the Health & Safety Overview class, those hours will count towards the 8 hour requirement for that year.

If you have questions, or need additional help, please visit our website at:

https://www.dphhs.mt.gov/ecfsd/childcare/childcarelicensing/lcpapplication

Family, Friend & Neighbor Child Care (FFN)

Includes Relative Care Exempt (RCE) providers

New Application Checklist

The child care applicant must complete, sign, and submit the following:

1. Completed FFN New Provider Application (15 total pages)
    - Family Association form (p.3)
    - Certification Checklist form (p.4)
    - Health & Safety Checklist form (p.5)
    - Immunization Attestation form (p.6)
    - Medication Administration Attestation form (p.7)
    - Release of Information forms (p.8 & 9)
    - Statement of Health form (p.10)
    - FBI Fingerprint Consent forms (p.11 & 12)
    - W-9 Tax ID Form (p.14)

        To be completed by the Provider if care is in Provider's home

        To be completed by the Parent if care is in the Parent's home
    - EFT Sign Up form (p.15) - required to receive payment via direct deposit

2. Verification of current CPR & First Aid certification (*not required if providing care to related children under the Relative Care Exempt Program*)

** Please note, if the child care is being provided in the Provider's home, the following must also be submitted for **all** household members over the age of 18:

- Release of Information forms (p.8 & 9)
- Statement of Health form (p.10)
- FBI Fingerprint Consent forms (p.11 & 12)
- FBI Background Check (fingerprint card submitted, or scanned at local CCR&R) *

> * A FBI fingerprint background check is required every 5 years for all providers and household member(s) 18years of age or older. Fingerprints and cards can be obtained at local child care resource and referral agencies (CCR&R), sheriff's offices, or police stations. Agencies that provide fingerprinting services may charge over and above the fee to cover their own processing fees.

Visit this link for a list of CCR&R locations : https://dphhs.mt.gov/ecfsd/childcare/childcareresourceandreferral

Email: ffnprogram@mt.gov
PO Box 4210
Phone: (406) 444-2012 Fax: (406) 444-2750
Helena MT 59620

Family, Friend & Neighbor & Relative Care Exempt
New Provider Application

1. I am New applying for FFN/RCE Program child care registration.

I will be providing child care in my home, ☐ or the Parent's home (approval required) ☐

In the past, have you been a Registered or Certified Child Care Provider Yes, ☐ No ☐

If yes, What type: _____ Where: _____ Date: _____

Have you been approved, in any capacity, to provide care in a child care facility? Yes, ☐ No ☐

If yes, Facility Name/Date: _____

2. Provider Information

The Family, Friend & Neighbor Child Care Provider, assumes responsibility for following the program rules and requirements, including penalties and repayment of any overpaid benefits.

Legal Name:

Last, First, Middle _____

City

Residential Address: _____

Zip Code

Mailing Address: Same as above ☐ _____

Tribal Affiliation: Yes ☐ No ☐ If yes, which one? _____

Cell Number: _____ Other Ph. No.: _____

Email Address: _____

3. Household Members

A background check is needed for all household members, 18 years of age or older, must complete the following forms:

- **Release of Information:** The Release of Information Criminal/Protective Service Background Check form must be signed by the applicant and any adult in the household 18 years or older. This form is used to obtain information from the Montana Department of Justice, Montana Child Protective Services, Adult Protective Services, and if applicable, the Tribal Law Enforcement and Child Protective Services.
- **Statement of Health:** Applicants must meet certain personal health requirements. As the agency responsible for child care certification, the Department of Public Health and Human Services (DPHHS) must ensure that the health of all providers and family members is adequate to meet the demands of the care being provided. Additional forms are available to download at: https://dphhs.mt.gov/qad/Licensure/LBCCL/Forms- and-Information/FFN application
- FBI - Fingerprint Disclosure Statement: This form is needed regardless of where the individual listed has lived.

Household Member(s) HHM Last, First, Middle Name	Date of birth	Age	Relationship to the Child Care Provider
Provider:			
HHM:			
HHM:			
HHM:			
HHM:			
HHM:			

4. Child Abuse and Neglect

- At any time, have you had a child removed from your home? No ☐ Yes ☐ If yes, where and when date(s)?

_____

- At any time, have you been investigated for possible abuse or neglect by the Department, a child welfare agency or law enforcement in another State? No ☐ Yes ☐ If yes, what are the child's name and your relationship to the child? Where and when did this occur?

_____

_____

TRAINING REQUIREMENTS

MANDATORY TRAINING COURSES

- Health and Safety Overview for Family, Friend, and Neighbor/Relative Care Exempt Providers
  A four hour class that is required for all providers. This training must be completed before the initial license (60 days) is approved. **Please note, this class must be completed every 3 years (FFN & RCE).**

- Fundamentals of Family, Friend, and Neighbor/Relative Care Exempt Providers Orientation
  A four hour class that is also required for all providers. This class must be completed within 60 days after your initial license has been approved. If this class has not been taken within 60 days, the license will be terminated until the class has been completed.

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CPR and FIRST AID (FFN Providers Only)

- Required for all FFN Providers (RCE Providers are exempt)
- Please contact your local Child Care Resource & Referral facility for approved classes in your area and to check availability

ANNUAL TRAINING REQUIREMENTS (FFN Providers Only)

- After your first license renewal period, a total of 8 hours of yearly training will be required to be completed. Approved training courses can be found and enrolled at: https://www.childcaretraining.org/mod/page/view.php?id=28801.
- Training classes may be repeated, and in those years when you are required to retake the Health & Safety Overview class, those hours will count towards the 8 hour requirement for that year.

If you have questions, or need additional help, please visit our website at:

https://www.dphhs.mt.gov/ecfsd/childcare/childcarelicensing/lcpapplication

Family Friends & Neighbor
Child Care Family Association

1. Provider Information

a. Provider Name:
b. TANF: Are you included in the parent's TANF financial grant: YES ☐ NO ☐

2. Family Information

Complete the information below for the family who the FFN child care provider will be providing child care for; and the family that is receiving the Best Beginnings Scholarship

Parent(s) Name:
Parent(s) Address:
Best Beginnings Case worker:
Best Beginnings Case #:
City/County:
Parent(s) Phone #:

Name of Child	Date of Birth:	Age:	Foster Placement?	Relationship to provider:

Are the children listed above a sibling group? Yes ☐ No ☐

Family, Friend & Neighbor

Certification Checklist

Initial each line as applicable for the Child Care Provider or Parent(s) Residence.

_____ I certify that I reside and will be providing care in my home and I agree that I am an independent contractor.

_____ I certify I certify that if I am providing care in the Parent's home, I will only provide care to the children of one family.

I certify that I will be providing care less than 24 hours within the day.

_____ I certify that I will review the health and safety checklist for FFN program providers with the parent.

_____ I certify that I will be the only person transporting children while in my care.

_____ I certify that I will only provide care to the child(ren) of one family or that I will only provide care to no more than two children from separate families.

_____ I certify that I will review and discuss with the parents the immunization record of the children in my care; or, review and discuss the waiver indicating parental choice not to immunize.

_____ I certify that I will examine the home for fire and safety conditions, for the presence of working smoke detector, for placement of a family fire escape plan and discuss the conditions with the parents.

_____ I certify that I will inform parent(s) that the state will NOT make payments until the provider's and parent's applications are approved.

_____ I certify that I am aware it is recommended that the applicant not provide care until a letter of approval is received.

_____ I confirm that neither I, nor anyone present in the home, have been investigated for any alleged harm or physical or sexual abuse to children or adults. If this statement is false, I am providing the information required below about where the investigation occurred:

I attest that the above statements are true and correct to the best of my knowledge.
I understand that if I provide inaccurate information or misrepresent information in writing or verbally on this application, throughout the application process, and while certified, my application may be denied.

_____ _____

Provider Signature Date

Family Friend & Neighbor Care Health and Safety Checklist

*Health and Safety issues should be considered when arranging for child care. Following are topics a parent and child care provider may want to discuss. For more information regarding quality child care, contact your local Child Care Resource and Referral Agency. *No corporal punishment may be inflicted. **

Answer the questions below by selecting YES or NO in the dropdown to the right	YES/NO
Do parents have access to their children at all times?	
Is the provider in good health	
Is the provider trained about basic health and safety issues?	
Is the provider knowledgeable about child development issues?	
Has the provider reviewed applicable FFN Rules and Regulations? ARM37.95.103	
Does the provider wash hands thoroughly, before and after diapering?	
Does the provider wash hands before preparing food?	
Has the provider received guidelines on how to child proof the home?	
Does the provider talk easily with the children and respond to their needs?	
Does the emotional climate foster happiness and trust?	
Does the provider offer learning opportunities to the children?	
Are the children's immunizations current?	
Are emergency telephone numbers and parent telephone numbers posted?	
Is the provider trained in First Aid and CPR?	
Does the provider have an emergency medical authorization signed by the parent?	
Is the first aid kit available in the home?	
Are meals and snacks nutritious?	
Is there a quiet comfortable place for naps?	
Is the play equipment safe?	
Is the home clean?	
Are the children exposed to smoking?	
Are hazards inaccessible to children, both inside and out?	
Are electrical outlets covered?	
Are heaters and wood burning stoves ventilated and screened?	
Are poisonous substances out of reach of children?	
Are smoke detectors in place and operational?	
Is a fire extinguisher readily available?	
Are firearms locked and inaccessible to children?	
Are appropriate automobile restraints and car seats used?	

By signing below, I state that I have read, discussed and understand the above information.

Parent Signature: _____ **Date:**

Provider Signature: _____ **Date:**

Family, Friend & Neighbor
Child Care
Immunization Attestation

I, the Provider, certify that I am in compliance with policy 6-2 that states:

Children in the Family, Friends, and Neighbor Provider [FFN] care is required to have immunizations except:

- *If the child is being cared for by an approved relative (grandparents, great-grandparents, aunt or uncle);*
- *If the child is being cared for in their own home;*
- *If the child has a medical condition that contra-indicates immunization;*
- *If a medical exemption for immunizations is being claimed, a LCP/LCI Immunization Waiver form must be completed.*

☐ **One or more of the above criteria, required for the exception to have immunizations, has been met.**

I certify that (child's name) _____, has all the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

I certify that (child's name) _____, has all the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

I certify that (child's name) _____, has all the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

I certify that (child's name) _____, has all the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

I certify that (child's name) _____, has all the legally required immunizations, and that I keep a copy of that record at my home where the child care is provided and updated as needed.

_____

Provider Signature/Date

Family, Friend & Neighbor
Child Care
Medication Administration Attestation

The authority for the Medication Administration Attestation is MCA 52-2-736

I, _____, the Provider, acknowledge that I have discussed with the parent about administering medication while their child or children are in my care. I will log the medication on a Medication Administration Log as given to the child or children while in my care.

I, _____, the Parent, will sign a Medication Authorization form for each prescription and non-prescription medication to be given to my child or children while in the care of the provider.

By signing below, I state that I have read, discussed and understand the above information.

Provider Signature	Date	Parent Signature	Date

STATE OF MONTANA

Department of Public Health and Human Services

Family, Friend & Neighbor Child Care

Release of Information

Criminal, CPS, and Motor Vehicle Background Checks

1. Personal Information

I am the applicant ☐ **I am a member of the household** ☐ **Female** ☐ **Male** ☐

Legal Name:
Last, First, Middle _____

Maiden Name _____ Alias(s) _____

Date of Birth: _____ Marital Status _____ Race _____

SSN _____ DL# _____

Residential Address: _____

City: _____ County: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Tribal Affiliation: **Yes** ☐ No ☐ If yes, which one? _____

2. Past Residences

Out of state or tribal background checks, may be required. There may be an associated cost for those background checks. Please indicate if the residence is on an Indian Reservation.

Have you lived in another state in the past five years? Yes ☐ No ☐

Date: _____ City: _____ State: _____ Reservation: _____

Date: _____ City: _____ State: _____ Reservation: _____

Date: _____ City: _____ State: _____ Reservation: _____

Have you been convicted of, plead guilty to, or currently charged with a crime classified as an offense against any person or family? Yes ☐ No ☐ If "Yes," give details, including name of person, date, place and nature of the conviction and disposition:

Have you ever been named as a perpetrator in a Substantiated report of child or adult abuse or neglect (or exploitation of an adult)? Yes ☐ No ☐ If "Yes," Please explain:

Have you or any person living in the home been convicted of a crime involving, child or Elder abuse or neglect, including sexual abuse, physical assault, or other act of violence? Yes ☐ No ☐ If yes, please explain.

3. Authorization Statement and Signature

As part of the initial and subsequent annual application process, I do hereby authorize any law enforcement and/or protective services agency to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services.

I am aware that The State of Montana, Department of Public Health and Human Services, has requested confidential information, in accordance with 41-3- 205(3)(o), MCA as part of a review of my personal background in connection with said entity.

I am aware that Child and Family Services Division and, Department of Justice records may contain information that could adversely affect my Legally Certified Provider approval. These records will relate to criminal history records, as well as any report(s) of child abuse or neglect in Montana that indicates a risk to children. Records that indicate a risk to children are those that show a substantiation of child abuse/neglect on the person; and/or a history that shows that a child in the care of the person was adjudicated by a court as a youth in need of care, and/or a history that shows that the person has had their caregiver rights to a child terminated. As a household member, I understand that I am also subject to the above requirements.

I am also aware that although the entities or individuals requesting and receiving confidential CFSD information are bound by law or agreement with DPHHS to protect or preserve its confidential nature, DPHHS has no ability or authority to ensure that confidentiality is maintained after this information is released by DPHHS.

In full acknowledgement of the above information and notice, I authorize CFSD to provide the requested confidential information to the provider or its authorized representative identified above, and I hereby also release CFSD from any claims or causes of action which may subsequently arise from release of this confidential information.

_____

Signature/Date

Name: _____

Please check one of the boxes below:

- ☐ I am applying to be the child care provider.
- ☐ I am the spouse of the applicant.
- ☐ I am a member of the applicant's household.

Applicants and household members must meet certain health requirements. As the agency responsible for approving payment numbers, the Department of Public Health and Human Services (DPHHS) must ensure that the health of each provider is adequate to meet the demands of the care being provided.

I attest that I have no disabling chronic conditions; physical, mental, or emotional illness that would prohibit me from providing care to children.

COMMENTS:

_____

Signature/Date

Applicant Rights and Consent to Fingerprint

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification[1] by _DPHHS/QAD/FFN_ that your fingerprints will be used to check the criminal history records of the FBI.
- You must be provided, and acknowledge receipt of, an adequate Privacy Act Statement when you submit your fingerprints and associated personal information. This Privacy Act Statement should explain the authority for collecting your information and how your information will be used, retained, and shared.
- If you have a criminal history record, the officials deciding of your suitability for employment, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the criminal history record.[2]

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.[3]

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at http://www.fbi.gov/about-us/cjis/background-checks.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI at the same address as provided above. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency.

If a change, correction, or update needs to be made to a Montana criminal history record, or if you need additional information or assistance, please contact Montana Criminal Records and Identification Services at DOJCRISS@mt.gov or 406-444-3625.

Your signature below acknowledges this agency has informed you of your privacy rights for fingerprint-based background check requests used by the agency.

Signed:

_____ _____ _____

Name Date

[1] Written notification includes electronic notification, but excludes oral notification.
[2] See 28 CFR 50.12(b).
[3] See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).

NCPA/VCA Applicants

Your Name _____:

You have applied for employment with, will be working in a volunteer position with, will be residing in a child care setting or will be providing vendor or contractor services to (write in Agency or Entity name)_DPHHS/QAD/FFN for the position of (please be specific) CHILD CARE PROVIDER/ FFN PROGRAM.

The National Child Protection Act of 1993 (NCPA), Public Law (Pub. L.) 103-209, as amended by the Volunteers for Children Act(VCA), Pub. L. 105-251 (Sections 221 and 222 of Crime Identification Technology Act of 1998), codified at 42 United States Code (U.S.C.) Sections 5119a and 5119c, authorizes a state and national criminal history background check to determine the fitness of an employee, or volunteer, or a person with unsupervised access to children, the elderly, or individuals with disabilities.

1. Provide your name, address, and date of birth, as appears on a document made or issued by or under the authority of the United States Government, a State, political subdivision of a State, a foreign government, a political subdivision of a foreign government, an international governmental or an international quasi-governmental organization which, when completed with information concerning a particular individual, is of a type intended or commonly accepted for the purpose of identification of individuals. 18 U.S.C. §1028(D)(2).
2. Provide a certification that you (a) have not been convicted of a crime, (b) are not under indictment for a crime, or (c) have been convicted of a crime. If you are under indictment or have been convicted of a crime, you must describe the crime and the particulars of the conviction, if any.
3. Prior to the completion of the background check, the entity may choose to deny you unsupervised access to a person to whom the entity provides care.

The entity shall access and review State and Federal criminal history records and shall make reasonable efforts to make a determination whether you have been convicted of, or are under pending indictment for, a crime that bears upon your fitness and shall convey that determination to the qualified entity. The entity shall make reasonable efforts to respond to the inquiry within 15 business days.

Your Name: _____

First Middle Maiden Last

Date of Birth: _____

Address: _____

_____

City State Zip

☐ I have been convicted of, or am under pending indictment for, the following crimes [include the dates, location/jurisdiction, circumstances and outcome];

☐ I have not been convicted of, nor am I under pending indictment for, any crimes;

☐ I authorize Montana Department of Justice, Criminal Records and Identification Services Section to disseminate criminal history record information to _DPHHS/QAD/FFN_.

_____

Signature of Applicant Date

PRIVACY ACT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Additional Information: The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any systems(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

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

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

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

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

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

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

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

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

General Instructions

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

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

What's New

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

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

Purpose of Form

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

DEPARTMENT OF ADMINISTRATION
STATE ACCOUNTING BUREAU
PO BOX 200102
HELENA, MT 59620-0102

204 - ELECTRONIC FUNDS TRANSFER SIGN UP

Questions please contact Warrant Writer. E-Mail: warrantwriter@mt.gov, Phone: 444-3092, Fax: 444-2812

Note: All incomplete/altered forms will not be processed.

1) Request Type: ☐ Initial Request (1-7,10) ☐ Change/Add Account (1-10) ☐ Remove Account (5-10)

2) I, , hereby certify that the account indicated on this form is under my direct control and access; therefore, I authorize the State Treasurer as fiscal agent for the State of Montana to initiate, change or cancel credit entries to that account as indicated on this form.

This authority is to remain in full force and effect until the State of Montana has received written notification from either me or an authorized officer of the organization of the account's termination in such time and in such a manner as to afford the State of Montana a reasonable opportunity to act upon it.

3) New Bank Information:

Bank Name:	
Routing Number:	**Account Number:**
Account Type: ☐ Checking ☐ Savings	

5) Supplier Name:

6) Tax ID Number: *(must be 9 digits)*										**Type:** ☐ SSN ☐ FEIN

7) Address: *(limited to 45 characters per line)*

Line 1		
Line 2		
Line 3		
City	State/Province	Postal Code
Country	Phone Number	
E-mail		

8) Confirmation of existing bank account information:

Bank Name:	
Routing Number:	**Account Number:**
Account Type: ☐ Checking ☐ Savings	

9) This authorization will remain in effect until either cancelled in writing or an updated form is submitted to the Agency you currently do business with.

10) Authorized Signature	Title (If Applicable)	Date

REVISED 8/2019