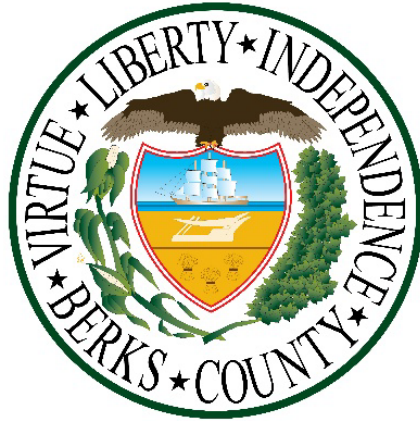


BERKS COUNTY
NONPROFIT DEVELOPMENT CORPORATION



RENTAL ASSISTANCE PROGRAM
APPLICATION PACKET
2026

(Last updated 10/6/26)

Berks County Nonprofit Development Corporation

Rental Assistance Program

Applications available at: 400 E. Wyomissing Avenue

Ground Floor, Suite #2 Mohnton, PA 19540

Hours of Operations: Monday-Friday 9am-4pm

OR

Online at: <https://www.berkspa.gov/departments/berksra>

Return completed application packets and required documentation via email
to: mmartinez@berksredevelop.org



Rental assistance is available.

Documentation needed:

- ☐ Completed client intake application
- ☐ Current PA State ID (All Household Members Age 18 Years+ and Out of Highschool)
- ☐ Social Security Card (All Household Members)
- ☐ Birth certificates (All household children under 18 years)
- ☐ EBT cards (if applicable; all household members)
- ☐ Current Lease Agreement
- ☐ Eviction Notice from District Justice (if applicable)
- ☐ Utility shut off notices (if applicable)
- ☐ Utility bills
- ☐ Proof of Wages/Paystubs or Self-Attestation of Zero Income (Last 30 days /All Household Members Age 18 years+ and Out of Highschool)
- ☐ Landlord Verification Ledger
- ☐ Landlord W-9
- ☐ Benefits Notice
- ☐ HMIS Client Informed Consent & Release of Information Authorization

Proof of Income (Last 30 days)

(ALL Household Members Age 18 years+ and Out of Highschool)

➤ **Wages**

- Weekly (4 paystubs)
- Biweekly (2 paystubs)
- Types:
 - Employment
 - Self-Employment profit
 - Government Employee Pension
 - Periodic receipts from estates & trust
 - Private pensions, regular insurance or annuity payments
 - Railroad retirement
 - Rental income
 - Strike benefits
 - Training stipends

➤ **Benefits**

- Award Letter
 - Types:
 - Food Stamps/SNAP
 - Cash Assistance/TANF
 - Unemployment Compensation
 - Veterans Administration Compensation
 - Workers' Compensation
 - Military Compensation
- Annual Letter
 - Types:
 - Social Security Income (SSI)
 - Social Security Disability Income (SSDI)
- Court Order
 - Types:
 - Child Support
 - Alimony

Client Creation Data

Entry Date _____ Project Name _____

First Name _____ Middle Name _____ Last Name _____

Suffix _____ Name Data Quality: (Full / Partial / Client doesn't know / Client prefers not to answer)

SSN: _____ SSN Data Quality: (Full / Partial / Client doesn't know / Client prefers not to answer)

Date of Birth: _____ DOB Data Quality: (Full / Partial / Client doesn't know / Client prefers not to answer)

Current Address: _____

Phone Number: _____ Email: _____

Household Size: _____

Household Members:

Name	Relationship to Head of Household	Sex	Date of Birth	Social Security Number

Relationship to Head of Household

(select one)

Self (head of household)	Head of household's spouse or partner
Other: (non-relation household member)	Head of household's child
Data not collected	Head of household's other relation

Race and Ethnicity

(select all that apply)

American Indian, Alaska Native, or Indigenous	Native Hawaiian or Pacific Islander
Asian or Asian American	White
Black or African American	Client doesn't know
Hispanic/Latina/o	Client prefers not to answer
Middle Eastern or North African	Data not collected

Berks HUD CoC & ESG Entry All Other Projects (FY 2026)
Fill out separate forms for each household member.

Client Initials _____

Additional Race and Ethnicity Detail:

(Optional)

Sex
(select one)

☐	Female	☐	Client doesn't know
☐	Male	☐	Client prefers not to answer
☐		☐	Data not collected

U.S. Military Veteran?: Yes / No / Client doesn't know / Client prefers not to answer

Housing Move-in Date: ____/____/____

Prior Living Situation

(select one)

☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher	☐ Residential project or halfway house with no homeless criteria
☐ Foster care home or foster care group home	☐ Staying or living in a family member's room, apartment, or house
☐ Hospital or other residential non-psychiatric medical facility	☐ Staying or living in a friend's room, apartment, or house
☐ Hotel or motel paid for without emergency shelter voucher	☐ Substance abuse treatment facility or detox center
☐ Jail, prison, or juvenile detention facility	☐ Transitional housing for homeless persons (including homeless youth)
☐ Long-term care facility or nursing home	☐ Owned by client, no ongoing housing subsidy
☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus, airport or outside)	☐ Owed by client, with ongoing housing subsidy
☐ Psychiatric hospital or other psychiatric facility	☐ Client doesn't know
☐ Rental by client, no ongoing housing subsidy	☐ Client prefers not to answer
☐ Rental by client, with other ongoing housing subsidy	☐ Data not collected

If Rent/Own with housing subsidy: (select one)

☐ GPD TIP housing subsidy	☐ Other
☐ VASH housing subsidy	☐ Housing stability Voucher
☐ RRH or equitant housing subsidy	☐ Family Unification Program Voucher
☐ HCV voucher	☐ Foster Youth to Independence
☐ Public housing unit	☐ Permanent Supportive Housing

Length of stay in Previous Place

(select one)

☐ One night or less	☐ 90 days or more, but less than one year
☐ Two nights to six nights	☐ One year or longer
☐ More than one week, but less than one month	☐ Client doesn't know
☐ One month or more, but less than 90 days	☐ Client prefers not to answer

Housing Assessment

Client Entering from Streets, Emergency Shelter or other place not meant for habitation:

Yes / No / Client doesn't know / Client prefers not to answer /

If Yes: Approximate date this episode of homelessness started: _____

Regardless of where they stayed last night- Number of times the client has been on the street, in shelter, or other place not meant for habitation in the past three years including today:

- | | |
|--|--|
| ☐ One Time | ☐ Client Doesn't Know |
| ☐ Two Times | ☐ Client prefers not to answer |
| ☐ Three Times | ☐ Data Not Collected |
| ☐ Four or More Times | |

Total number of months homeless on the street, in shelter, or other place not meant for habitation in the past three years:

- | | |
|--|--|
| ☐ One Month (this time is the first month) | ☐ 9 |
| ☐ 2 | ☐ 10 |
| ☐ 3 | ☐ 11 |
| ☐ 4 | ☐ 12 |
| ☐ 5 | ☐ More than 12 Months |
| ☐ 6 | ☐ Client Doesn't Know |
| ☐ 7 | ☐ Client prefers not to answer |
| ☐ 8 | ☐ Data Not Collected |

Income and Sources

Data Entry Note: If fields are already filled out and are no longer applicable to the client's current income, place an END DATE on the category that is BEFORE the client entered your project.

DO NOT delete the old record.

Head of Household Name: _____

Income from any source: Yes / No / Client doesn't know / Client prefers not to answer /

Answer YES or NO for each source. IF YES: indicate START DATE and MONTHLY INCOME AMOUNT.

If Earned Income, Name of Employer: _____

If Earned Income, Frequency of Pay: (Circle one) Weekly / Biweekly / Monthly / Other: _____

Type of Income	Yes (If Yes, Start Date)	No	Data Not Collected	Amount
Alimony or other spousal support				
Child support				
Earned income (i.e., employment income)				
General Assistance (GA)				
Other source <i>Specify:</i>				
Pension or retirement income from a former job				
Private disability insurance				
Retirement Income from Social Security				
Social Security Disability Income (SSDI)				
Supplemental Security Income (SSI)				
Temporary Assistance for Needy Families (TANF)				
Unemployment Insurance				
VA Non-Service-Connected Disability Pension				
VA Service-Connected Disability				
Worker's Compensation				
Total monthly income from all sources:				

Income and Sources

Data Entry Note: If fields are already filled out and are no longer applicable to the client's current income, place an END DATE on the category that is BEFORE the client entered your project.

DO NOT delete the old record.

Household Member Name: _____

Income from any source: Yes / No / Client doesn't know / Client prefers not to answer /

Answer YES or NO for each source. IF YES: indicate START DATE and MONTHLY INCOME AMOUNT.

If Earned Income, Name of Employer: _____

If Earned Income, Frequency of Pay: (Circle one) Weekly / Biweekly / Monthly / Other: _____

Type of Income	Yes (If Yes, Start Date)	No	Data Not Collected	Amount
Alimony or other spousal support				
Child support				
Earned income (i.e., employment income)				
General Assistance (GA)				
Other source <i>Specify:</i>				
Pension or retirement income from a former job				
Private disability insurance				
Retirement Income from Social Security				
Social Security Disability Income (SSDI)				
Supplemental Security Income (SSI)				
Temporary Assistance for Needy Families (TANF)				
Unemployment Insurance				
VA Non-Service-Connected Disability Pension				
VA Service-Connected Disability				
Worker's Compensation				
<u>Total monthly income from all sources:</u>				

Income and Sources

Data Entry Note: If fields are already filled out and are no longer applicable to the client's current income, place an END DATE on the category that is BEFORE the client entered your project.

DO NOT delete the old record.

Household Member Name: _____

Income from any source: Yes / No / Client doesn't know / Client prefers not to answer /

Answer YES or NO for each source. IF YES: indicate START DATE and MONTHLY INCOME AMOUNT.

If Earned Income, Name of Employer: _____

If Earned Income, Frequency of Pay: (Circle one) Weekly / Biweekly / Monthly / Other: _____

Type of Income	Yes (If Yes, Start Date)	No	Data Not Collected	Amount
Alimony or other spousal support				
Child support				
Earned income (i.e., employment income)				
General Assistance (GA)				
Other source <i>Specify:</i>				
Pension or retirement income from a former job				
Private disability insurance				
Retirement Income from Social Security				
Social Security Disability Income (SSDI)				
Supplemental Security Income (SSI)				
Temporary Assistance for Needy Families (TANF)				
Unemployment Insurance				
VA Non-Service-Connected Disability Pension				
VA Service-Connected Disability				
Worker's Compensation				
Total monthly income from all sources:				

Non-Cash Benefits

Data Entry Note: If fields are already filled out and are no longer applicable to the client's current non-cash benefit, place an END DATE on the category that is BEFORE the client entered your project. DO NOT delete the old record.

Head of Household Name: _____

Non-cash benefits from any source: Yes / No / Client doesn't know / Client prefers not to answer /

Answer YES or NO for each source. IF YES: indicate START DATE

Type of Non-Cash Benefit	Yes (If Yes, Start Date)	Benefit Amount	No	Data Not Collected
Special Supplemental Nutrition Assistance Program (SNAP/food stamps)				
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)				
TANF Child Care services				
TANF transportation services				
Other TANF-Funded Services				
Other source If yes, specify:				

Non-Cash Benefits

Data Entry Note: If fields are already filled out and are no longer applicable to the client's current non-cash benefit, place an END DATE on the category that is BEFORE the client entered your project. DO NOT delete the old record.

Household Member Name: _____

Non-cash benefits from any source: Yes / No / Client doesn't know / Client prefers not to answer /

Answer YES or NO for each source. IF YES: indicate START DATE

Type of Non-Cash Benefit	Yes (If Yes, Start Date)	Benefit Amount	No	Data Not Collected
Special Supplemental Nutrition Assistance Program (SNAP/food stamps)				
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)				
TANF Child Care services				
TANF transportation services				
Other TANF-Funded Services				
Other source If yes, specify:				

Health Insurance

Data Entry Note: If fields are already filled out and are no longer applicable to the client's current disability information, place an END DATE on the category that is BEFORE the client entered your project. DO NOT delete the old record.

Head of Household Name: _____

Covered by health insurance: Yes / No / Client doesn't know / Client prefers not to answer /

Answer YES or NO for each source. IF YES: indicate START DATE

Type of Health Insurance	Yes (If Yes, Start Date)	No	Data Not Collected
Medicaid			
Medicare			
State Children's Health Insurance Program			
Veteran's Administration (VA) Medical Services			
Employer-Provided Health Insurance			
Health insurance obtained through COBRA			
Private Pay Health Insurance			
State Health Insurance for Adults			
Indian Health Services Program			
Other			

Health Insurance

Household Member Name(s): _____

Covered by health insurance: Yes / No / Client doesn't know / Client prefers not to answer /

Answer YES or NO for each source. IF YES: indicate START DATE

Type of Health Insurance	Yes (If Yes, Start Date)	No	Data Not Collected
Medicaid			
Medicare			
State Children's Health Insurance Program			
Veteran's Administration (VA) Medical Services			
Employer-Provided Health Insurance			
Health insurance obtained through COBRA			
Private Pay Health Insurance			
State Health Insurance for Adults			
Indian Health Services Program			
Other			

Disability Information

Data Entry Note: If fields are already filled out and are no longer applicable to the client's current disability information, place an END DATE on the category that is BEFORE the client entered your project. DO NOT delete the old record.

Head of Household Name: _____

Disabling Condition (all clients): Yes / No / Client doesn't know / Client prefers not to answer /

Answer YES or NO for each Disability Type. If Yes, is the disability expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

Disability Type	Yes (Start Date)	Long Duration?	No	Client doesn't know	Client prefers not to answer
Alcohol Use Disorder		YES / NO			
Both Alcohol & Drug Use Disorder		YES / NO			
Chronic Health Condition		YES / NO			
Developmental		YES / NO			
Drug Use Disorder		YES / NO			
HIV/Aids		YES / NO			
Mental Health Disorder		YES / NO			
Physical		YES / NO			

Notes on Disability:

(optional, as needed)

Disability Information

Data Entry Note: If fields are already filled out and are no longer applicable to the client's current disability information, place an END DATE on the category that is BEFORE the client entered your project. DO NOT delete the old record

Household Member Name: _____

Disabling Condition (all clients): Yes / No / Client doesn't know / Client prefers not to answer /

Answer YES or NO for each Disability Type. If Yes, is the disability expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

Disability Type	Yes (Start Date)	Long Duration?	No	Client doesn't know	Client prefers not to answer
Alcohol Use Disorder		YES / NO			
Both Alcohol & Drug Use Disorder		YES / NO			
Chronic Health Condition		YES / NO			
Developmental		YES / NO			
Drug Use Disorder		YES / NO			
HIV/Aids		YES / NO			
Mental Health Disorder		YES / NO			
Physical		YES / NO			

Notes on Disability:

(optional, as need

Domestic Violence

Is client a domestic violence victim/survivor?

Yes / No / Client doesn't know / Client prefers not to answer /

IF YES when did the experience occur?

- | | |
|--|--|
| ☐ Within the past three months | ☐ One year ago or more |
| ☐ Three to six months ago | ☐ Client doesn't know |
| ☐ Six months to one year ago | ☐ Client prefers not to answer |

IF YES for Domestic Violence Victim/Survivor, are you currently fleeing?

- | | |
|---|--|
| ☐ Yes | ☐ Client prefers not to answer |
| ☐ No | ☐ Data not collected |
| ☐ Client doesn't know | |

COCA-Funded Programs Only

Was a level of care assessment completed? Yes / No

Substance Abuse Information

Type of addiction: _____

Start Date: _____

End Date: _____

Method: _____

How much do you use?: _____

Frequency of use: Daily / Periodic / Several times per week / Weekends only /

Additional substance abuse information (optional):



BERKS COUNTY NONPROFIT DEVELOPMENT CORPORATION

400 E. Wyomissing Avenue
Ground Floor, Suite #2
Mohnton, PA 19540

Phone (610) 478-6325
www.co.berks.pa.us

Self-Attestation of Zero Income

This form is to confirm that _____ **(Your name)**

Has no current income and that the income over the past two months was \$ _____

*Documentation of lost income is required (E.G., a termination letter from the prior employer)

I hereby certify that I do not individually receive income from any of the following sources:

1. Wages from employment (including commissions, tips, bonuses, fees, etc.).
2. Income from operation of a business.
3. Rental income from real or personal property.
4. Interest or dividends from assets.
5. Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits.
6. Unemployment or disability payments.
7. Public assistance payments.
8. Periodic allowances such as alimony, child support, or gifts received from persons not living in my household.
9. Sales of personal goods or services.
10. Any other source not named above.

If further documentation or information is needed, please fill out the information below.

Email address: _____ **Phone:** _____

I (we) certify that the above information is true and correct to the best of my (our) knowledge and belief. I (we) hereby authorize the Redevelopment Authority to obtain verification of any and all information contained on this form.

WARNING: PENALTY FOR FALSE OR FRAUDULENT STATEMENTS

Any false, fictitious, or fraudulent statements or representations made knowingly or willfully may subject the signer to penalties under Section of 1001 of Title 18 of the United States Code.

Signature: _____ **Date:** _____

Print Name: _____



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Homeless Management Information System (HMIS) Client Informed Consent & Release of Information Authorization

I, (print consumer's name) _____, understand that (Service Provider) _____ collected information about me and/or dependents listed below to enter it into a database system called Homeless Management Information System (HMIS). This database helps us to better understand homelessness, to improve service delivery to the homeless, and to evaluate the effectiveness of services provided to the homeless. Participation in data collection and release, although optional, is a critical component of our community's ability to provide the most effective services and housing possible. The information that is collected in the HMIS database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with the standards set forth by federal, state, and local regulations governing confidentiality of client records. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

The information gathered and prepared by this agency will be included in a HMIS database of participating agencies (list available), and only to participating agencies, who have entered into an Inter-Agency HMIS Data Sharing Agreement and shall be used to:

- Produce a client profile at intake that will be shared by collaborating agencies
- Produce anonymous, aggregate-level reports regarding use of services
- Track individual program-level outcomes
- Identify unfilled service needs and plan for the provision of new services
- Allocate resources among agencies engaged in the provision of new services
- Disclose if required by court order or as required by law

I permit this agency of Reading and Berks County to allow the following agencies access to my demographic information for intake assessment and/or provision of services:

Initial below next to each specific agency listed for permission

- _____ Berks Coalition to End Homelessness
- _____ Berks Counseling Center
- _____ Berks County VA
- _____ BCAP
- _____ Council on Chemical Abuse
- _____ Family Promise
- _____ Hope Rescue Mission
- _____ Mid-Penn Legal Services
- _____ Opportunity House
- _____ Service Access & Management
- _____ Salvation Army of Reading
- _____ YMCA of Reading and Berks County
- _____ Berks County Assistance Office
- _____ Safe Berks

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

I authorize the participating agencies and their representatives to share basic information regarding my family members listed below and/or me. I understand that this information is for the purpose of assessing my/our needs for housing, utility assistance, food, counseling and/or other services.

The information may consist of the following Protected Identifying Information (PII):

- Name
- Date of Birth
- Social Security Number
- Gender
- Ethnicity & Race
- Program entry date
- Program exit date
- Income and non-cash benefits information
- Housing information
- VI-SPDAT
- Residence prior to project entry
- Homeless history
- Zip Codes of last permanent address
- Family composition
- Employment status
- Veteran Status
- HIV/AIDS
- Domestic Violence
- Mental Health
- Disabling condition
- Alcohol & drug
- Legal history
- Photo (if applicable)

I UNDERSTAND THAT:

- Use of my likeness in a photograph will be viewable by other participating agencies and may be cropped or edited, as needed. I waive the right to approve or inspect the finished photograph.
- The participating agencies have signed agreements to maintain confidentiality regarding my information.
- The release of my information does not guarantee that I will receive assistance, and my refusal to authorize the use of my information does not disqualify me from receiving assistance.
- My records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise provided for in the regulations, law, or court order.
- Auditors or funders who have legal rights to review the work of this agency, including the U.S. Department of Housing & Urban Development and the State of California may see my information.
- People using HMIS information to write reports may see my information. Researchers must sign an agreement to protect my privacy before seeing HMIS data. My private information will never appear in research reports.
- This authorization will remain in effect until I revoke it in writing, and I may revoke authorization by signing a "Revocation of Consent to Release Information form", but that cancellation will not be retroactive.
- Additionally, I understand that participation in data collection is optional, and I may choose not to participate.
- This release is valid for three (3) years from the date of my signature below.
- I also understand that I may withdraw my consent at any time.
- I understand that my personal information will not be made public and will only be used with strict confidentiality.

IMPORTANT: To ensure the absolute safety of our clients, we do not enter any personally identifying information into HMIS for clients who are: 1) in a domestic violence agency; 2) currently fleeing or in danger from a domestic violence situation, including dating violence, sexual assault, stalking, or other qualifying situation. **If any of the above situations apply to you – DO NOT SIGN THIS FORM.**

Client Print Name

Client Signature

Date

Case Manager Print Name

Case Manager Signature

Date

******TO BE COMPLETED BY LANDLORD ONLY!**

BCNDC Landlord Verification Ledger

Rental Assistance Program

Tenant Applicant Name: _____

Rental Property Address: _____

City _____ **State:** PA **Zip Code:** _____

How long has tenant lived at residence (Month/Year) _____ **Monthly Rent \$** _____

Are utilities included? _____ **If yes, what?** _____

Was an eviction notice given? _____ **If yes, when?** _____

Month	Rent Past Due	Late Fees	Court Costs	Utilities Owed
January ____ (YR)				
February ____ (YR)				
March ____ (YR)				
April ____ (YR)				
May ____ (YR)				
June ____ (YR)				
July ____ (YR)				
August ____ (YR)				
September ____ (YR)				
October ____ (YR)				
November ____ (YR)				
December ____ (YR)				

Total Amount Due: _____

*This document should ONLY be filled out by the landlord/property manager.

I CERTIFY THAT THE FACTS SET FORTH IN THIS REPORT ARE TRUE AND CORRECT.

******TO BE COMPLETED BY LANDLORD ONLY!**

Landlord/Property Manager Printed Name: _____

Landlord/Property Manager Phone Number: _____

Total Amount Due: _____ Landlord Signature: _____

******TO BE COMPLETED BY LANDLORD ONLY!**

**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)	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.)	
	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 ☐		
	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:

- 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 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