

**KENTUCKY HEALTH CARE PROVIDER
APPLICATION FOR CERTIFICATE OF REGISTRATION**



Name and Address

FOR OFFICIAL USE ONLY

GENERAL INFORMATION: Kentucky law requires every provider of taxable health care items or services to file an application for a certificate of registration with the Department of Revenue. Partnerships and corporations, including PSCs, must complete a single application; partners, officers or PSC members are to be identified on reverse. A new application is required for each change in ownership. For additional information, contact the Department of Revenue, Frankfort, Kentucky 40620, (502) 564-6823.

INSTRUCTIONS: Complete all sections. Use additional sheets, if necessary, for owners, partners, officers and those with multiple professional licenses or certifications. Owners, partner, member, or executive officer must sign the application. Mail completed application to the Department of Revenue, Station 59, Frankfort, Kentucky 40620.

Name of Applicant	Enter Legal Name	Beginning Date of Operation
Service Location		
	Number and Street	City County State ZIP Code
Mailing Address		
	P.O. Box or Number and Street	City State ZIP Code
Business Information	() _____ Telephone Number	Account Number
	() _____ FAX Number	Kentucky Employer's Withholding _____
	_____	Kentucky Corporation Income and License _____
	_____	Kentucky Sales and Use _____
	_____ - _____ Federal Employer I.D. Number	Kentucky Unemployment Insurance _____
Type of Ownership	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other (describe) _____	

- | | |
|--|--|
| <input type="checkbox"/> Hospital Services, Lic. # _____ | <input type="checkbox"/> Licensed Home Health Care Agency Services, Lic. # _____ |
| <input type="checkbox"/> Nursing Facilities Services, Lic. # _____ | <input type="checkbox"/> HMO Services, Lic. # _____ |
| <input type="checkbox"/> Services of an ICF/MR, Lic. # _____ | <input type="checkbox"/> Outpatient Prescription Drugs, Lic. # _____ |
| <input type="checkbox"/> Physicians' Services, Lic. # _____ | <input type="checkbox"/> Other _____ Lic. # _____ |

Current or Previous Health Care Provider Tax Account Number ►

REVERSE SIDE MUST BE COMPLETED

