

**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, must complete a single application; partners and officers 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 62, Frankfort, Kentucky 40620.

Name of Applicant	Legal Name	Beginning Date of Operation
	DBA	

Service Location				
	Number and Street	City	County	State

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) _____
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<input type="checkbox"/> Hospital Services, Lic. # _____	<input type="checkbox"/> Home Health Care Agency Services, Lic. # _____
<input type="checkbox"/> Nursing Facilities Services, Lic. # _____	<input type="checkbox"/> Supports for Community Living, Lic. # _____
<input type="checkbox"/> Services of an ICF/MR, Lic. # _____	<input type="checkbox"/> Other _____ Lic. # _____

Current or Previous Health Care Provider Tax Account Number: _____

REVERSE SIDE MUST BE COMPLETED

