**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 __________________________
- 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 __________________________
- Kentucky Unemployment Insurance __________________________
- Federal Employer I.D. Number __________________________

### Type of Ownership
- Individual  □  Partnership  □  Corporation  □  Other (describe)________________________

**□** Hospital Services, Lic. # __________________________
**□** Nursing Facilities Services, Lic. # __________________________
**□** Services of an ICF/MR, Lic. # __________________________
**□** Home Health Care Agency Services, Lic. # __________________________
**□** Supports for Community Living, Lic. # __________________________
**□** Other ____________ Lic. # __________________________

Current or Previous Health Care Provider Tax Account Number: __________________________

**REVERSE SIDE MUST BE COMPLETED**
<table>
<thead>
<tr>
<th>Position</th>
<th>License Number</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
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</thead>
<tbody>
<tr>
<td>President</td>
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<tr>
<td>Vice President</td>
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<td>Secretary</td>
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<tr>
<td>Treasurer</td>
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</tbody>
</table>

Individual

- Home Address: ____________________________
- SSN: __ __ __ – __ __ – __ __ __ __

Partner

- Home Address: ____________________________
- SSN: __ __ __ – __ __ – __ __ __ __

Signature      Title      Date

E-mail        Telephone Number

Other information:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
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