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**SS-4 Application for Employer Identification Number** OMB No. 1545-0045

Form SS-4 (Rev. January 2019) (For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

Department of the Treasury Internal Revenue Service

1 Legal name of entity (or individual) for whom the EIN is being requested

2 Trade name of business (if different from name on line 1) 3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box) 4b Street address (if different) (Do not enter a P.O. box.)

4c City, state, and ZIP code (if foreign, see instructions) 4d City, state, and ZIP code (if foreign, see instructions)

5 County and state where principal business is located

6a Name of responsible party 6b SSN, TIN, or EIN

7a Is this application for a limited liability company (LLC) or a foreign equivalent?  Yes  No 7b If "Yes," enter the number of LLC members

8a If "Yes," was the LLC organized in the United States?  Yes  No

8b Type of entity (check only one box). Caution: If "Yes," see the instructions for the correct box to check.

9a If a corporation, name the state or foreign country (if applicable) where incorporated. State Foreign country

10 Reason for applying (check only one box)

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year

13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.

14 If you expect your employment tax liability to be \$1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be \$1,000 or less if you expect to pay \$4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter.

15 First date wages or annuities were paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year).

16 Check one box that best describes the principal activity of your business.

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.

18 Has the applicant entity shown on line 1 ever applied for and received an EIN?  Yes  No

Third Party Designee: Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name: ( ) Designee's telephone number (include area code): ( )

Address and ZIP code: ( ) Designee's tax number (include area code): ( )

Signature: ( ) Date: ( )

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cut No. 160509 Form SS-4 (Rev. 1-2019)

DATE OF SERVICE \_\_\_\_\_ RU# \_\_\_\_\_

STAFF # \_\_\_\_\_ HOURS \_\_\_\_\_ MINUTES \_\_\_\_\_

Code Activity:  361 EVAL/RX Location:  1 Office  2 Field  4 Home  5 School Satellite  18 Other

**Service Strategies:** (Please check up to three, if applicable)

50 Peer/Fam Deliv Svcs  53 Supportive Education  56 Ptnrshp/Soc Svcs  59 Integrated Svcs:MH-D/v/p Disabled

51 Psych Education  54 Ptnrshp/Law/Entom  57 Ptnrshp:Subs Abuse  60 Ethnic-Specific Service Strategy

52 Family Support  55 Ptnrshp:Health Care  58 IntSvcs:MH/Aging  61 Age-Spec Svc Strategy  99 Unknown

Assessment in language other than English:  Spanish  Other \_\_\_\_\_

Interpreter Name of Interpreter: \_\_\_\_\_

**Identifying Information:**

Legal Name: \_\_\_\_\_ DOB/Age: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Gender:  Male  Female  Transgender F-M  Transgender M-F  Intersex  Other \_\_\_\_\_

Marital Status:  Single  Married  Significant Other  Separated  Divorced

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact / Significant Other: \_\_\_\_\_

Name Phone

Primary concerns per consumer: \_\_\_\_\_

Presenting Problem/ Recent Course of Illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Consumer and Family Strengths (Positive factors to facilitate treatment e.g. faith, resilience, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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