Cheyenne Regional Medical Center

Cheyenne Regional Medical Group

Charity Care Application

Cheyenne Regional Medical Center provides patient care regardless of ability to pay or insurance coverage status. You may be eligible to receive care that is free or at a reduced cost through our Charity Care program, which is designed to help individuals who cannot afford the healthcare they need and who are not eligible for public programs.

Cheyenne Regional Medical Center and Cheyenne Regional Medical Group are pleased to support the GoalConnect initiative. It is a tool that allows various agencies to determine if you and your family qualify for their services from the information you provide in your Charity Care application.

To complete an application:

1. Make copies of the required documents. They are listed on Page 2.

2. Complete the Application
   - Page 4 – **SIGNATURE needed on this page**
   - Page 7 – **SIGNATURE needed on this page**
   - Page 9 – **SIGNATURE needed on this page** GoalConnect consent
   - Page 10 – If you do not file a tax return, IRS form 4506-T is provided so that you can provide the income verification required on page 2. If you have a tax return, you do *NOT* need to complete this page.

3. Mail or scan and email the required documents and application to:

Cheyenne Regional Medical Center
Charity Care Program
PO Box 1649
Cheyenne, WY 82003
OR
Charity.Care@crmcwy.org

Have questions while completing the application? Call 633-3000.

Cheyenne Regional Intake Form for the Sliding Fee Scale

What you need to provide to apply:

- **Photo Identification**
  - **Examples are Driver's license, passport, student ID**
- **Proof of Residency**
  - **Examples – Utility bill with name and address, rent receipt with name and address, proof of staying in a group home, shelter or residential treatment facility**
- **Income Verification**
  - In order to determine where you fall on the sliding fee scale, we must first determine family/household income. We make this determination based on the individuals listed on your tax return or a return where you are listed as a spouse or dependent. In order to document family/household income the following documentation is required:
    - **Most Recent Tax Return**
    - If your are unable to provide a copy of tax return, please complete and attach IRS form 4506T
    - If your income has changed since filing your last tax return, please also include:
      - Current pay stubs, current social security benefit letter, unemployment benefit letter or denial letter, worker's compensation statement
  - If you have no income, in addition to your tax return or IRS form 4506T please also include:
    - A copy of denied unemployment letter,
    - A copy of the letter from the Department of Family Services that shows eligibility for the Wyoming SNAP program,
    - A letter from the Comea Shelter verifying a recent stay at the shelter,
    - Does anyone give you money on a monthly basis to pay your expenses? Please explain.
- **Asset Verification upon Request**
- **Private Insurance Coverage Card, Medicare A or B Card, Medicare Part D card, Medicaid or Equality Care**

CLIENT INFORMATION

What language do you speak? ☐ English ☐Spanish ☐Other ___
What language do you write? ☐English ☐Spanish ☐Other
Did someone complete this form on your behalf? ☐Yes ☐No
Si Ud. necesita este formulario en español, por favor avísenos.

Today's Date:

Social Security #

Agency Use Only:
☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G
☐ H ☐ J ☐ K ☐ L ☐ Z

Legal Last Name	First Name, Middle Initial	Birth Date	Gender M F	Other/Former/Maiden Names
Physical Address	City	State	Zip Code	County
Mailing Address /P.O. Box	City	State	Zip Code	County

Home Phone	Message Phone	Are you a U.S. Citizen? ☐Yes ☐No	Marital Status (check one) ☐Never Married ☐Married ☐Divorced ☐ Legally Separated ☐Widowed ☐Minor Child
Cell Phone	Work Number	Email Address	

Race (check one)	Ethnicity (check one)	Housing Information (check one)	Are you a Veteran?
☐Asian ☐African American ☐ American Indian/Alaska Native ☐ Native Hawaiian / Pacific Islander ☐Other / Multi Racial ☐ White ☐Decline to answer ☐ Unavailable	☐Not-Hispanic ☐Hispanic / Latino ☐ Ethnic Black ☐Decline to answer ☐ Unavailable	☐Own ☐Rent ☐HUD/CHA ☐Homeless ☐Rent Free ☐Group Home	☐No ☐Non-Combat ☐Combat

Employment (check one): ☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Student ☐Disabled ☐Retired	Employer Name	Employer Phone Number
	Employer Address	Date Hired

Emergency Contact Name	Emergency Contact Phone Number	Relationship to patient
(For Dependents Only) Name of Parent/Guardian	Relationship to Patient	Family Size

Recently lost employment? ☐Yes ☐No	Place of Birth (city, county, state)	Client's Mother's first name	Highest Grade Client Completed

If you have not completed a community sliding fee application, would you like more information about it?	☐Yes	☐No
Would you like more information about our payment plan arrangements?	☐Yes	☐No

INSURANCE INFORMATION

Health Insurance ☐Yes ☐No	Medicare if yes please include policy # ☐Yes ☐No	Equality Care/Medicaid if yes please include policy # ☐Yes ☐No	Kid Care if yes please include policy # ☐Yes ☐No	Prescription Coverage ☐Yes ☐No
Prescription coverage from Prescription Drug Assistance Program (PDAP)? ☐Yes ☐No		Medicare Part D ☐Yes ☐No	If unemployed, are you eligible for COBRA benefits? ☐Yes ☐No	

Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Birth Date of Policy Holder ___/___/___	Relationship to Patient	Policy Holder SSN
Billing Claims Address:	Customer Service Phone: (____) _______-________	Employer:	Employer phone: (____) _____-_______

Secondary Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Birth Date of Policy Holder ___/___/___	Relationship to Patient	Policy Holder SSN
Billing Claims Address:	Customer Service Phone: (____) _______-________	Employer:	Employer phone: (____) _____-_______

Are you seeking Medical Care as a result of an accident? ☐Yes ☐No If yes, answer following questions…

Date of accident: / /	Was it a motor vehicle accident? ☐Yes ☐No	Was the accident work related? ☐Yes ☐No	Where did the accident occur?
Workers Compensation number:	If motor vehicle accident, name of auto insurance company and policy number:		Do you have an attorney involved and/or a settlement pending? ☐Yes ☐No

ASSIGNMENT AND RELEASE: I authorize Cheyenne Regional Medical Center to disclose medical information as necessary to receive payment and assign all benefits, if any, directly to Cheyenne Regional Medical Center that otherwise might be payable to me for services rendered. I understand that Cheyenne Regional Medical Center may also release medical information about me to physicians or other health care providers who may be involved in my continued care. I understand that this authorization will remain in effect for twelve (12) months. If I choose to seek medical care with another provider, I understand that the treatment and information may still be shared with my insurance or other medical carrier. I understand that Cheyenne Regional Medical Center will file an initial claim with Medicare, Medicaid, insurance, or any other third party, if I have provided and signed the necessary information and/or forms. I understand that I am financially responsible for all of my charges whether or not they are covered by my insurance carrier. I also agree to be responsible for payment of any services rendered if my insurance company takes longer than sixty (60) days from date of service**.** If this occurs, I will be responsible for seeking reimbursement from my insurance company. I authorize the use of this signature on all insurance submissions. I understand that if I fail to make a good faith effort to keep my account current Cheyenne Regional Medical Center reserves the right to refuse non-acute medical services and to engage a collection agency for any outstanding balances.

Signature of Responsible Party:_______________________________________ **Print Name:** _________________________

Relationship to Patient: ____ **Date:** _____________________________

SLIDING FEE DISCOUNT APPLICATION

Tell us about each member of your Household: Please list every household member claimed on your tax return. (**Please use additional pages if needed.**)

Household Member (relationship to applicant)		Insurance Coverage?	Type of Income for Household Member Gross Total Income Per Month (income before taxes and deductions are taken out)	
☐ Self ____________ Last ____________ First MI	**Gender** ☐M ☐F **Birth Date** ____/____/____ **SSN:** ______-_____-______ Can anyone claim you as a **dependent** on their tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ ________	☐ Wages $ ____________ ☐ Self Employment $ ____________ ☐ Worker's Comp $ ____________ ☐ Unemployment $ ____________ ☐ Social Security/SSI $ ____________ ☐ Military/Veteran's Benefits $ ____________ ☐ Pension/ Retirement $ ____________	☐ Trust Fund Monies $ ____________ ☐ Alimony $ ____________ ☐ Child Support $ ____________ ☐ Rental Income $ ____________ ☐ Income from investments $ ____________ ☐ Other $ ____________ ☐ No income See next section
☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: ____________ Last ____________ First MI	**Gender** ☐M ☐F **Birth Date** ____/____/____ **SSN:** ______-_____-______ Is this person is included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ ________	☐ Wages $ ____________ ☐ Self Employment $ ____________ ☐ Worker's Comp $ ____________ ☐ Unemployment $ ____________ ☐ Social Security/SSI $ ____________ ☐ Military/Veteran's Benefits $ ____________ ☐ Pension/ Retirement $ ____________	☐ Trust Fund Monies $ ____________ ☐ Alimony $ ____________ ☐ Child Support $ ____________ ☐ Rental Income $ ____________ ☐ Income from investments $ ____________ ☐ Other $ ____________ ☐ No income See next section
☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: ____________ Last ____________ First MI	**Gender** ☐M ☐F **Birth Date** ____/____/____ **SSN:** ______-_____-______ Is this person is included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ ________	☐ Wages $ ____________ ☐ Self Employment $ ____________ ☐ Worker's Comp $ ____________ ☐ Unemployment $ ____________ ☐ Social Security/SSI $ ____________ ☐ Military/Veteran's Benefits $ ____________ ☐ Pension/ Retirement $ ____________	☐ Trust Fund Monies $ ____________ ☐ Alimony $ ____________ ☐ Child Support $ ____________ ☐ Rental Income $ ____________ ☐ Income from investments $ ____________ ☐ Other $ ____________ ☐ No income See next section

SLIDING FEE DISCOUNT APPLICATION

Tell us about Resources belonging to your Household Members:

Please list every household member claimed on your tax return. (**Please use additional pages if needed.**) Additional Asset documentation may be requested.

Household Member	Resources Belonging to this Household Member	Please list amount or current value	Resources Belonging to this Household Member	Please list amount or current value
	☐ Cash on Hand	$ _______________	☐ Automobile Make___________ Model ____________ Year _____	$ _______________
	☐ Checking Account	$ _______________	☐ Automobile Make___________ Model ____________ Year _____	$ _______________
______________________________ Last	☐ Checking Account	$ _______________	☐ Recreational Vehicle Make________ Model__________Year ____	$ _______________
	☐ Savings Account	$ _______________	☐ Crops/Equipment/Livestock	$ _______________
______________________________	☐ Savings Account	$ _______________	☐Property/Real Estate – Attach Assessment Schedule	$ _______________
First MI	☐Certificate of Deposit	$ _______________	☐Property/Real Estate – Attach Assessment Schedule	$ _______________
	☐ Stocks/Bonds/Annuities	$ _______________	☐Life Estate	$ _______________
	☐ IRA/401/Keogh/Pension	$ _______________	☐Burial Space	$ _______________
	☐ Burial Funds/Trusts	$ _______________	☐ Safety Deposit Box	$ _______________
	☐ Life Insurance	$ _______________	☐ Contract for Deed	$ _______________
	☐ Trust Funds	$ _______________	☐ Promissory Note	$ _______________
	☐Settlements	$ _______________	☐ Other Resources	$ _______________
	☐ Cash on Hand	$ _______________	☐ Automobile Make___________ Model ____________ Year _____	$ _______________
	☐ Checking Account	$ _______________	☐ Automobile Make___________ Model ____________ Year _____	$ _______________
______________________________ Last	☐ Checking Account	$ _______________	☐ Recreational Vehicle Make________ Model__________Year ____	$ _______________
	☐ Savings Account	$ _______________	☐ Crops/Equipment/Livestock	$ _______________
______________________________	☐ Savings Account	$ _______________	☐Property/Real Estate – Attach Assessment Schedule	$ _______________
First MI	☐Certificate of Deposit	$ _______________	☐Property/Real Estate – Attach Assessment Schedule	$ _______________
	☐ Stocks/Bonds/Annuities	$ _______________	☐Life Estate	$ _______________
	☐ IRA/401/Keogh/Pension	$ _______________	☐Burial Space	$ _______________
	☐ Burial Funds/Trusts	$ _______________	☐ Safety Deposit Box	$ _______________
	☐ Life Insurance	$ _______________	☐ Contract for Deed	$ _______________
	☐ Trust Funds	$ _______________	☐ Promissory Note	$ _______________
	☐Settlements	$ _______________	☐ Other Resources	$ _______________
	☐ Cash on Hand	$ _______________	☐ Automobile Make___________ Model ____________ Year _____	$ _______________
	☐ Checking Account	$ _______________	☐ Automobile Make___________ Model ____________ Year _____	$ _______________
______________________________ Last	☐ Checking Account	$ _______________	☐ Recreational Vehicle Make________ Model__________Year ____	$ _______________
	☐ Savings Account	$ _______________	☐ Crops/Equipment/Livestock	$ _______________
______________________________	☐ Savings Account	$ _______________	☐Property/Real Estate – Attach Assessment Schedule	$ _______________
First MI	☐Certificate of Deposit	$ _______________	☐Property/Real Estate – Attach Assessment Schedule	$ _______________
	☐ Stocks/Bonds/Annuities	$ _______________	☐Life Estate	$ _______________
	☐ IRA/401/Keogh/Pension	$ _______________	☐Burial Space	$ _______________
	☐ Burial Funds/Trusts	$ _______________	☐ Safety Deposit Box	$ _______________
	☐ Life Insurance	$ _______________	☐ Contract for Deed	$ _______________
	☐ Trust Funds	$ _______________	☐ Promissory Note	$ _______________
	☐Settlements	$ _______________	☐ Other Resources	$ _______________

SLIDING FEE DISCOUNT APPLICATION (Continued)

IF NO INCOME IS INDICATED

If you have no income, please indicate which of the following you can provide as documentation:

☐ A copy of denied unemployment letter,

☐ A copy of the letter from the Department of Family Services that shows eligibility for the Wyoming SNAP program,

☐ A letter from the Comea Shelter or Safehouse verifying a recent stay at the shelter,

☐ Does anyone give you money on a monthly basis to pay your expenses? ☐ No ☐ Yes, Amount of monthly payment provided $ _____________

Can we provide information about payment arrangements for you?	☐Yes	☐No
Have you recently lost employment? Are you eligible for COBRA benefits? Please list employer _________________________________	☐Yes ☐Yes	☐No ☐No
Have you ever filed for bankruptcy or do you intend to? If yes, what State? ____________ Case #? _____________File date? ________ Discharge date? _________ Is the reason for the filing due to medical bills?	☐Yes ☐Yes	☐No ☐No

My signature indicates that all of the information I have provided is true and correct. I hereby grant permission to this agency to obtain and share the information I have provided for the purpose of determining eligibility for assistance. I understand that failure to disclose insurance coverage for services provided or any household income will exclude me from receiving discounts and the agencies in which I applied for discounts have the right to full legal recourse to collect full billed charges.

Signature of Responsible Party:____ **Print Name:** _______________________________

Relationship to Patient: ____ **Date:** ____________________________________

For Agency Use Only:

Agency Representative : ____ **Date:** ____________________________________

Summary

In order to serve you better, Cheyenne Regional Medical Center and Cheyenne Regional Medical Group participate in the Laramie County GoalConnect Collaborative. GoalConnect is linking multiple agencies together to better serve clients, reduce duplication of efforts and decrease gaps in access to the most needed services.

Purpose and Benefits to Your Care

GoalConnect Partners want to better serve your needs through coordinating services. Sharing your individual information may reduce referrals you do not need or connect you to public programs and community service groups that may help you. It may tell providers about your health history, allergies and prescription drugs to coordinate your care. Finally, being in the system can reduce repeated paperwork.

You Choose to Participate

We ask you to sign this form to include you in the GoalConnect system. It is your choice to sign. No Provider may refuse to treat you if you do not sign. If you do not sign the form, Providers will not share your information through the database. You may cancel your authorization at any time.

Security & Privacy of Information

Federal and state laws protect the privacy of your information. GoalConnect protects your information by strictly limiting who can access the system. We require all Participating Partners their employees, agents and business associates to sign confidentiality agreements to maintain the security of your information. You will receive the HIPAA Notice of Privacy Practices, which gives you additional information about the providers' respective confidentiality policies.

Current Participating Partners of GoalConnect are:

- Cheyenne Regional Medical Center
- Cheyenne Health & Wellness Center
- Peak Wellness Center, Inc.
- Needs, Inc.
- Comea
- Adelante
- Connections Corner/Circles Wyoming
- Wyoming Interfaith Health Ministries (Faith Nurses)
- Community Action of Laramie County – Interfaith Family Support Services
- Community Action of Laramie County – Heath Care for Homeless
- Community Action of Laramie County – Kinship Support Services
- University of Wyoming Family Practice

Consent Form

- I understand that by signing this form, I give permission for my provider, a GoalConnect Participating Partner, to enter my individually identifiable information in the GoalConnect system.
- I understand that my individual information could include participation in an Agency program, demographic information to include name, birth date, gender, race, social security number, address, phone number, household members, financial information, employment status, residential, health and treatment history and/or personal or family needs information.
- I have reviewed the list of current GoalConnect Partners, and I know that others may be added later. A list of Partners is available to me upon my request.
- I have received a copy of this form.
- I understand that this form will be effective unless I cancel it or GoalConnect ends. I can cancel this authorization at any time by completing a Cancellation Form, which I can get from any Participating Provider.
- I understand if I sign on behalf of someone else, I am certifying that I have authority under Wyoming law to make health care and social services decisions for that person.
- I understand I am allowing GoalConnect to share my individually identifiable information and that no Partner may access my information unless I go to that Participating Provider for services.
- I understand that it is my choice to sign and that no Provider may refuse to treat me if I do not sign.

I have read and understand the above.

Your Name (PRINT)	Authorized Representative Relationship to Client (if applicable)
Your Signature (or Signature of Representative)	Date
Facility	Client DOB:
Witness	Date

Form **4506-T**
(Rev. September 2013)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▸ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Return or Account Transcript" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Cheyenne Regional Medical Center, PO Box 1649, Cheyenne, WY 82003 (307) 633-3000

Caution. *If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.*

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▸ ______________

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution. *If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.*

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. ______ ______ ______ ______

Check this box if you have notified the IRS or the IRS has notified you that one of the years for which you are requesting a transcript involved **identity theft** on your federal tax return . . . . ☐

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

Phone number of taxpayer on line 1a or 2a

Sign Here

▸ **Signature** (see instructions) Date

▸ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▸ **Spouse's signature** Date

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506-T and its instructions, go to *www.irs.gov/form4506t.* Information about any recent developments affecting Form 4506-T (such as legislation enacted after we released it) will be posted on that page.

General Instructions

CAUTION. *Do not sign this form unless all applicable lines have been completed.*

Purpose of form. Use Form 4506-T to request tax return information. You can also designate (on line 5) a third party to receive the information. Taxpayers using a tax year beginning in one calendar year and ending in the following year (fiscal tax year) must file Form 4506-T to request a return transcript.

Note. If you are unsure of which type of transcript you need, request the Record of Account, as it provides the most detailed information.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Return or Account Transcript" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Chart for individual transcripts (Form 1040 series and Form W-2 and Form 1099)

If you filed an individual return and lived in:	Mail or fax to:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301 512-460-2272
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	Internal Revenue Service RAIVS Team Stop 37106 Fresno, CA 93888 559-456-5876
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	Internal Revenue Service RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 816-292-6102

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 801-620-6922
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250 859-669-3592

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P. O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party—Business.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506-T for a taxpayer only if the taxpayer has specifically delegated this authority to the representative on Form 2848, line 5. The representative must attach Form 2848 showing the delegation to Form 4506-T.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 12 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.