

Ohio Department of Medicaid  
**Affidavit of Tax Payment Compliance**  
**For Non-Agency**  
**ODM-Administered Waiver Service Providers**

1. I \_\_\_\_\_ am a Non-Agency Provider pursuant to Rule 5160-45-01 of the Ohio Administrative Code.
2. As a Non-Agency Provider, I am an independent contractor and am responsible for payment of all applicable federal, state and local income taxes and employment taxes in compliance with federal, state and local requirements.
3. I understand that federal employment taxes include Medicare and Social Security taxes.
4. I am submitting this affidavit pursuant to the requirements of Rule 5160-45-10 of the Ohio Administrative Code.
5. I hereby attest that for the year \_\_\_\_\_ I have paid all applicable federal, state and local income and employment taxes.

\_\_\_\_\_  
Affiant/Provider

\_\_\_\_\_  
Ohio Medicaid Provider Number

\_\_\_\_\_  
National Provider Identifier Number

\_\_\_\_\_  
Provider's Address

Sworn before me and signed in my presence (enter date): \_\_\_\_\_

\_\_\_\_\_  
Notary Public

Commission Expires (enter date) \_\_\_\_\_