

**AD WAIVER
MEDICAID
PROVIDER
PACKET**

Where to begin to become a HCBS waiver provider

The Division of Aging (DA) is implementing a hiatus for Assisted Living, Adult Day Service, Adult Family Care and Structured Day Program provider applications through approximately February 28, 2017. During the hiatus, DA will continue to process changes of ownership for providers. The purpose of the hiatus is to allow the DA time to develop a transition plan for Home and Community-Based Services following the March 17, 2014 Centers for Medicare and Medicaid Services (CMS) rule. This CMS rule requires states to ensure that all Medicaid Waiver services are delivered in settings that meet the requirements of a home and community-based setting. For additional details regarding the CMS rule and the DA's implementation please visit <http://www.in.gov/fssa/4917.htm>.

After reviewing the information provided above you will need to complete an application for certification. A table indicating required documents for each waiver service is available for you to review. Any additional questions or inquiries may be submitted to the Waiver Provider Specialist by phone at 317-232-4650 or by email at daproviderapp@fssa.in.gov. The basic Medicaid Waiver Provider application for certification is available to download [here](#) and the required W-9 may be downloaded [here](#). Please submit final application and all required documents at daproviderapp@fssa.in.gov and paper applications will continue to be accepted and may be mailed to the address below.

ATTN: Waiver/Provider Analyst
Family and Social Services Administration
Indiana Health Coverage Programs (IHCP)
DA Home and Community-Based Services Waivers
402 West Washington Street, Room W454, MS 21
P.O. Box 7083
Indianapolis, IN 46027

Once all documentation and forms are received by the Division of Aging, the Waiver Provider Analyst will review your Provider Application packet. There may be some follow-up questions or additional information needed. You may be contacted via email or telephone. It is important that you reply as soon possible in order to avoid any unnecessary delays in processing your application. If the necessary documentation is not submitted in a timely manner, the application may be returned to you with the request to resubmit.

- If you are applying to be an Adult Family Care provider, Assisted Living provider, or an Adult Day Services Provider, you will also need to have an onsite survey conducted by the Division of Aging.
 - [Adult Day Services Survey Tool](#)
 - [Adult Family Care Provider Survey Tool](#)
 - [Assisted Living Service Survey Tool](#)
- If you are applying to be an Assisted Living provider, you must complete a [Disclosure for Housing with Services Establishments form](#), downloadable here.
- If you are applying to be an Adult Family Care provider, you must complete a [Certificate of Liability Insurance](#), downloadable here.
- Upon completion of the application process through the Division of Aging, you will be notified by mail that your certification has been approved or denied. Information regarding the appeal process will also be included, in the event your application is denied.
- If approved, you will then be directed to download your Indiana Health Coverage Programs Waiver Billing Provider Application and Profile Maintenance packet through HP. (See HCBS waiver manual, Section 1. Helpful hints are also included). You will be notified by letter when the

process is complete and your waiver billing number is assigned.

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- NOTE: YOU MUST SUBMIT YOUR APPLICATION TO HP WITHIN 90 DAYS OF RECEIPT OF YOUR WAIVER PROVIDER CERTIFICATION FROM THE DIVISION OF AGING

You may begin providing services when you receive you HP billing number, are activated in the waiver provider database and receive your Notice of Action.

AGED AND DISABLED WAIVER PROGRAMS PROVIDER CERTIFICATION REQUIREMENTS

REQUIRED DOCUMENTS	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI	TBI
15. A written operations manual addressing the requirements in 455 IAC 2 and regularly updated and revised at least annually (455 IAC 2-15-3). Please see page 3 for more information	X	X	X	X	X			X		X		X	X	X	X			
16. Current vehicle registration from the Indiana Bureau of Motor Vehicles; or current registration in the state that the vehicle's owner resides in (455 IAC 2-12-1)(3).																X		
17. Current Professional License, certification or registration (455 IAC 2-14-1)(c)(2), including renewals as applicable. The Provider will be licensed, certified, registered or otherwise properly qualified under federal state or local laws applicable to the particular service that the applicant is performing (e.g., Licensed Architect, PT, OT; Dietician, Plumbers, Electricians, Construction Licenses)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
18. Documented requirement that direct care staff have a negative TB test or negative chest X-Ray, updated yearly (455 IAC 2-6-3)(4); (455 IAC 2-14-1)(b)(1).	X	X	X	X				X		X				X		X		X
19. Licensed health professionals are checked for findings through the Indiana Professional Licensing agency (455 IAC 2-6-3)(2)(C))			X					X		X				X		X		X

*All services that require written personnel policies and a written operations manual must also include additional items within the manuals in order to become a certified provider (see below).

**For additional information on solo providers, see below

- *All services that require written personnel policies and a written operations manual must also include the following items within the manuals in order to become a certified provider. Written personnel policies must be reviewed annually, and updated as needed (455 IAC 2-15-2)(a)(2). A written operations manual addressing the requirements in 455 IAC 2 must be regularly updated and revised at least annually (455 IAC 2-15-3).
 - 11A. A procedure for conducting reference and employment, and criminal background on each prospective employee or agent (455 IAC 2-15-2)(b)(1).
 - 11B. A prohibition against employing or contracting with a person convicted of: Sex Crime; Exploitation of an endangered adult; Abuse or Neglect of a child; Failure to report battery; Neglect or Exploitation of an adult or child; Theft; Murder; Voluntary or Involuntary Manslaughter; and Battery (455 IAC 2-15-2)(b)(2).
 - 11C. Job descriptions for each position including minimum qualifications and major job duties of the position (455 IAC 2-15-2)(b)(4).
 - 11D. A process for evaluation of job performance at the end of a training period and, annually, and including a process from individuals receiving services to give feedback on an employee or agent (455 IAC 2-15-2)(b)(3).
 - 11F. Disciplinary procedures (455 IAC 2-15-2)(b)(4).
 - 11G. Description of grounds for disciplinary action or dismissal of employee of Agent (455 IAC 2-15-2)(b)(5).
 - 11H. Description of an employee's right and responsibilities, including responsibilities of administrators and supervisors (2-15-2)(b)(6).
 - 11I. A provider shall maintain in the provider's office, files for each employee or agent of the provider (455 IAC 2-14-1)(a).
 - 11K. A system in place for the transfer of information to and from each provider listed on the individual's plan (455 IAC 2-16-2)(b).
 - 11L. Maintain a current organization chart to include Parent organization and subsidiary organization (455 IAC 2-9-1)
 - 11M. A written quality assurance and quality improvement system, updated annually, that :
 - 11M.1. Is focused on the individual (455 IAC 2-9-5)(a)(1).
 - 11M.2. Is appropriate for services being provided (455 IAC 2-9-5)(a)(2)
 - 11M.3. Includes a process for analyzing data for reportable incidents, developing and reviewing recommendations to reduce risk of future incidents (455 IAC 2-9-5)(b) and .
 - 11M.4. Will include documentation of efforts to improve services based on survey feedback (455 IAC 2-9-5)(b)(3)
 - 11M.5. Is on-going and updated at least annually
 - 11M.6. Will include an annual survey of individual satisfaction (455 IAC 2-9-5)(b)(1).
 - 11M.7. Will include a record of findings of the annual satisfaction survey (455 IAC 2-9-5)(b)(2)
 - 15A. For incident filing and review (455 IAC 2-8-1, 455 IAC 2-8-2, Waiver Assurance G-1). A written procedure for filing within 24 hours, any suspected Abuse, Neglect or Exploitation, or Death of a participant with APS, or CPS and DA's Incident Reporting website consistent with provider requirements.
 - 15B. A procedure in place for filing within 48 hours of any unusual occurrence via DA's Incident Reporting website consistent with provider requirements (455 IAC 2-8-2).
- **The solo provider classification refers to an individual (as opposed to an agency) operating under their SSN and operating without employees. For solo providers, additional documents may be required. Requirements for solo providers not indicated on page one also include:
- 11M and all of its subsections (see above)
 - 15A & 15B(see above)



**APPLICATION FOR PROVIDER CERTIFICATION
AGED AND DISABLED WAIVER (A&D)
TRAUMATIC BRAIN INJURY WAIVER (TBI)**

State Form 55512 (R / 7-14)

Attention: Waiver / Provider Analyst
FAMILY AND SOCIAL SERVICES ADMINISTRATION
INDIANA HEALTH COVERAGE PROGRAMS (IHCP)
DA Home and Community-Based Services Waivers
402 West Washington Street, Room W382, MS 07
P.O. Box 7083
Indianapolis, IN 46207-7083

- INSTRUCTIONS:**
1. Mail the completed, signed and dated documents to the FSSA Division of Aging at the above address, or e-mail them to daproviderapp@fssa.in.gov.
 2. Retain copies of all documents mailed to the FSSA Division of Aging.
 3. If you have any questions regarding the completion of the packet, please visit the website at <http://www.in.gov/fssa/da/3476.htm> or contact a waiver provider specialist in the FSSA Division of Aging at (317) 232-4650 or e-mail daproviderapp@fssa.in.gov.

Date of application (month, day, year)		Type of application (check one) <input type="checkbox"/> New application <input type="checkbox"/> Change of ownership <input type="checkbox"/> Add service(s)	
Name of applicant			
Telephone number ()	Fax number ()	E-mail address	
Legal business name of applicant			
Doing business as (DBA) name of applicant			
Legal status of provider (check one) <input type="checkbox"/> Individual / sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership			
Indiana State Department of Health (ISDH) license number		Name license issued to	
Name of Chief Executive Officer (CEO) / administrator / owner			
Name of contact person		Title	
Physical location (number and street, city, state, and ZIP code)			
Mailing address (if different from above) (number and street or Post Office box, city, state, and ZIP code)			
Type of waiver in which you wish to provide services (check all that apply) <input type="checkbox"/> Aged and Disabled (A&D) (** only) <input type="checkbox"/> Traumatic Brain Injury (TBI) (* only)			
Service(s) you plan to provide (check all that apply)			
<input type="checkbox"/> Adult Day Services	<input type="checkbox"/> Environmental Modifications	<input type="checkbox"/> Specialized Medical Equipment and Supplies	
<input type="checkbox"/> Adult Family Care	<input type="checkbox"/> Healthcare Coordination	<input type="checkbox"/> Structured Day Program*	
<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Home Delivered Meals	<input type="checkbox"/> Structured Family Caregiving**	
<input type="checkbox"/> Attendant Care	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Supported Employment*	
<input type="checkbox"/> Behavior Management*	<input type="checkbox"/> Personal Emergency Response System	<input type="checkbox"/> Transportation	
<input type="checkbox"/> Case Management	<input type="checkbox"/> Residential Based Habilitation*	<input type="checkbox"/> Vehicle Modifications	
<input type="checkbox"/> Environment Modification Assessment**	<input type="checkbox"/> Respite		
County(ies) in which you plan to provide service(s) (check all that apply)			
<input type="checkbox"/> 01 Adams	<input type="checkbox"/> 15 Dearborn	<input type="checkbox"/> 29 Hamilton	<input type="checkbox"/> 43 Kosciusko
<input type="checkbox"/> 02 Allen	<input type="checkbox"/> 16 Decatur	<input type="checkbox"/> 30 Hancock	<input type="checkbox"/> 44 LaGrange
<input type="checkbox"/> 03 Bartholomew	<input type="checkbox"/> 17 DeKalb	<input type="checkbox"/> 31 Harrison	<input type="checkbox"/> 45 Lake
<input type="checkbox"/> 04 Benton	<input type="checkbox"/> 18 Delaware	<input type="checkbox"/> 32 Hendricks	<input type="checkbox"/> 46 LaPorte
<input type="checkbox"/> 05 Blackford	<input type="checkbox"/> 19 Dubois	<input type="checkbox"/> 33 Henry	<input type="checkbox"/> 47 Lawrence
<input type="checkbox"/> 06 Boone	<input type="checkbox"/> 20 Elkhart	<input type="checkbox"/> 34 Howard	<input type="checkbox"/> 48 Madison
<input type="checkbox"/> 07 Brown	<input type="checkbox"/> 21 Fayette	<input type="checkbox"/> 35 Huntington	<input type="checkbox"/> 49 Marion
<input type="checkbox"/> 08 Carroll	<input type="checkbox"/> 22 Floyd	<input type="checkbox"/> 36 Jackson	<input type="checkbox"/> 50 Marshall
<input type="checkbox"/> 09 Cass	<input type="checkbox"/> 23 Fountain	<input type="checkbox"/> 37 Jasper	<input type="checkbox"/> 51 Martin
<input type="checkbox"/> 10 Clark	<input type="checkbox"/> 24 Franklin	<input type="checkbox"/> 38 Jay	<input type="checkbox"/> 52 Miami
<input type="checkbox"/> 11 Clay	<input type="checkbox"/> 25 Fulton	<input type="checkbox"/> 39 Jefferson	<input type="checkbox"/> 53 Monroe
<input type="checkbox"/> 12 Clinton	<input type="checkbox"/> 26 Gibson	<input type="checkbox"/> 40 Jennings	<input type="checkbox"/> 54 Montgomery
<input type="checkbox"/> 13 Crawford	<input type="checkbox"/> 27 Grant	<input type="checkbox"/> 41 Johnson	<input type="checkbox"/> 55 Morgan
<input type="checkbox"/> 14 Daviess	<input type="checkbox"/> 28 Greene	<input type="checkbox"/> 42 Knox	<input type="checkbox"/> 56 Newton
<input type="checkbox"/> 57 Noble	<input type="checkbox"/> 71 St. Joseph	<input type="checkbox"/> 85 Wabash	
<input type="checkbox"/> 58 Ohio	<input type="checkbox"/> 72 Scott	<input type="checkbox"/> 86 Warren	
<input type="checkbox"/> 59 Orange	<input type="checkbox"/> 73 Shelby	<input type="checkbox"/> 87 Warrick	
<input type="checkbox"/> 60 Owen	<input type="checkbox"/> 74 Spencer	<input type="checkbox"/> 88 Washington	
<input type="checkbox"/> 61 Parke	<input type="checkbox"/> 75 Starke	<input type="checkbox"/> 89 Wayne	
<input type="checkbox"/> 62 Perry	<input type="checkbox"/> 76 Steuben	<input type="checkbox"/> 90 Wells	
<input type="checkbox"/> 63 Pike	<input type="checkbox"/> 77 Sullivan	<input type="checkbox"/> 91 White	
<input type="checkbox"/> 64 Porter	<input type="checkbox"/> 78 Switzerland	<input type="checkbox"/> 92 Whitley	
<input type="checkbox"/> 65 Posey	<input type="checkbox"/> 79 Tippecanoe		
<input type="checkbox"/> 66 Pulaski	<input type="checkbox"/> 80 Tipton		
<input type="checkbox"/> 67 Putnam	<input type="checkbox"/> 81 Union		
<input type="checkbox"/> 68 Randolph	<input type="checkbox"/> 82 Vanderburgh	<input type="checkbox"/> State Wide	
<input type="checkbox"/> 69 Ripley	<input type="checkbox"/> 83 Vermillion		
<input type="checkbox"/> 70 Rush	<input type="checkbox"/> 84 Vigo		
Please attach the following documents:			
<input type="checkbox"/> 1. W-9 Tax Identification Number			
<input type="checkbox"/> 2. Secretary of State letter of authorization to conduct business in Indiana (agencies only)			
<input type="checkbox"/> 3. Verification of liability insurance as required by 455 IAC 2-6-2, 455 IAC 2-12-1(4) (vehicle insurance), and 455 IAC 2-11-1 (property and personal Liability insurance)			
<input type="checkbox"/> 4. Organizational Chart (agencies only)			
<input type="checkbox"/> 5. Copy of Home Health Aide Agency License or Personal Services Agency License (if applicable)			
<input type="checkbox"/> 6. All required documents as specified in the provider requirements table located at http://www.in.gov/fssa/da/3476.htm#jump_provider			
Have you read the following documents?			
<input type="checkbox"/> 1. DA HCBS Waiver Provider Manual: http://provider.indianamedicaid.com/general-provider-services/manuals.aspx <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> 2. The Aging Rule: http://www.in.gov/legislative/iac/T04550/A00020.PDF <input type="checkbox"/> Yes <input type="checkbox"/> No			
Signature of authorized representative		Date (month, day, year)	
Typed or printed name of authorized representative		Title	

Request for Taxpayer Identification Number and Certification

Give Form to the
requester. Do not
send to the IRS.

Print or type See Specific instructions on page 2.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification; check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner. <input type="checkbox"/> Other (see instructions) ▶ _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	6 City, state, and ZIP code	
7 List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number										
				-				-		
or										
Employer identification number										
				-						

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

**AGED AND DISABLED WAIVER PROGRAMS
PROVIDER CERTIFICATION REQUIREMENTS**

[illegible]

12/11/2019

[illegible][illegible]

As the vast majority of the respondents in the survey were not currently employed, we were unable to determine the respondents' current employment status. However, the respondents were asked to indicate their current employment status at the time of the survey. The majority of the respondents (55%) indicated that they were currently employed, while 45% indicated that they were not currently employed. The respondents who were currently employed were asked to indicate their current employer. The majority of the respondents (55%) indicated that they were currently employed by a private company, while 45% indicated that they were currently employed by a government agency or a non-profit organization.

2-1. A review was for information and interest being provided on each prospective employee's report (455 JAC 2-15-21)(3)(A).

[illegible]

and, lastly, a secondary position, such as deputy (455 A.C.2.15-2) (b) (4).

[illegible][illegible]

116. Description of grounds for disciplinary action or dismissal of employee of Agent (SSA) (25-579)(b)(5).

114. Description of an employee's right and responsibilities, including responsibilities of administrators and supervisors [2-15-2] [6] [9]

[illegible]

The system in place to disseminate information to and from each member listed on the individual system (55-162-16-2)(b)

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1. The Government of India has decided to grant a 10% increase in the minimum wages of the unskilled labour in the public sector.

6. 17/5/2019 ರಿಂದ 19/5/2019 ರವರೆಗೆ

9. 11/16/16 NYPL Inc filed an annual statement of financial information (455 IAC 2-5-5) (b) (3)

1. 12. 2017. URL: <https://www.gutenberg.org/files/45514/45514-h/45514-h.htm> [22]

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CRS and DCS Independent Reporting: Veterans' experiences with reporting their requirements

156 A. J. WOODWARD AND D. LEE FOR THE UNITED STATES OF AMERICA

For sole providers and dual documents may be required. Requirements for so

אברהם בן יצחק

- **11th and 12th grades (senior level)**
 11th and 12th grades are the final years of high school. Students in these grades are typically 17-18 years old. They are required to take more advanced courses, including AP or IB classes, and are preparing for college or career. The curriculum is more rigorous and focused on preparing students for higher education or the workforce.

- **15A.2.5B (Serbanova)**

Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100																																																																																																																																																																																												
Population (millions)	5.3	5.4	5.5	5.6	5.7	5.8	5.9	6.0	6.1	6.2	6.3	6.4	6.5	6.6	6.7	6.8	6.9	7.0	7.1	7.2	7.3	7.4	7.5	7.6	7.7	7.8	7.9	8.0	8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8	8.9	9.0	9.1	9.2	9.3	9.4	9.5	9.6	9.7	9.8	9.9	10.0	10.1	10.2	10.3	10.4	10.5	10.6	10.7	10.8	10.9	11.0	11.1	11.2	11.3	11.4	11.5	11.6	11.7	11.8	11.9	12.0	12.1	12.2	12.3	12.4	12.5	12.6	12.7	12.8	12.9	13.0	13.1	13.2	13.3	13.4	13.5	13.6	13.7	13.8	13.9	14.0	14.1	14.2	14.3	14.4	14.5	14.6	14.7	14.8	14.9	15.0	15.1	15.2	15.3	15.4	15.5	15.6	15.7	15.8	15.9	16.0	16.1	16.2	16.3	16.4	16.5	16.6	16.7	16.8	16.9	17.0	17.1	17.2	17.3	17.4	17.5	17.6	17.7	17.8	17.9	18.0	18.1	18.2	18.3	18.4	18.5	18.6	18.7	18.8	18.9	19.0	19.1	19.2	19.3	19.4	19.5	19.6	19.7	19.8	19.9	20.0	20.1	20.2	20.3	20.4	20.5	20.6	20.7	20.8	20.9	21.0	21.1	21.2	21.3	21.4	21.5	21.6	21.7	21.8	21.9	22.0	22.1	22.2	22.3	22.4	22.5	22.6	22.7	22.8	22.9	23.0	23.1	23.2	23.3	23.4	23.5	23.6	23.7	23.8	23.9	24.0	24.1	24.2	24.3	24.4	24.5	24.6	24.7	24.8	24.9	25.0	25.1	25.2	25.3	25.4	25.5	25.6	25.7	25.8	25.9	26.0	26.1	26.2	26.3	26.4	26.5	26.6	26.7	26.8	26.9	27.0	27.1	27.2	27.3	27.4	27.5	27.6	27.7	27.8	27.9	28.0	28.1	28.2	28.3	28.4	28.5	28.6	28.7	28.8	28.9	29.0	29.1	29.2	29.3	29.4	29.5	29.6	29.7	29.8	29.9	30.0	30.1	30.2	30.3	30.4	30.5	30.6	30.7	30.8	30.9	31.0	31.1	31.2	31.3	31.4	31.5	31.6	31.7	31.8	31.9	32.0	32.1	32.2	32.3	32.4	32.5	32.6	32.7	32.8	32.9	33.0	33.1	33.2	33.3	33.4	33.5	33.6	33.7	33.8	33.9	34.0	34.1	34.2	34.3	34.4	34.5	34.6	34.7	34.8	34.9	35.0	35.1

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