Fiscal Assistance, Inc.
4646 S. Biltmore Lane
Madison, WI 53718
Phone (855) 201-4320
Fax: (844) 650-1968

Vendor Service Provider Checklist

All new Vendor Service Providers must fill out each form, sign, date, and return all forms to FA, Inc. **before** a start date can be established and any payments can be made.

Please complete and return the following forms at your earliest convenience:

- ❑ Vendor Service Provider Agreement
- ❑ Background Information Disclosure
- ❑ W-9 Request for Taxpayer Identification Number
- ❑ Wisconsin Medicaid Program Provider Agreement
- ❑ Vendor Direct Deposit Authorization
- ❑ Driver Compliance and Insurance Form

Your packet also includes a sample vendor check request form for you to keep. You will be notified when all paperwork is complete and you are an active vendor service provider. Once approved, you will receive blank copies of the vendor check request form to submit for payment.

** Please wait for confirmation of your active status **before** you begin billing. **

If you have questions, please contact:

Renae Huffman	Scarlett Russell	Theresa Chard
Enrollment and Outreach Director	Enrollment and Outreach Assistant Director	Enrollment and Outreach Coordinator
Direct Phone: 608-819-7748	Direct Phone: 608-733-6237	Direct Phone: 608-733-6243
RenaeH@fiscalassistance.org	ScarlettR@fiscalassistance.org	TheresaC@fiscalassistance.org

Return Packet to:

Fiscal Assistance, Inc.
4646 S. Biltmore Lane
Madison, WI 53718
Phone: 1-855-201-4230
General Fax: 1-844-650-1968
Email: enrollment@fiscalassistance.org

Vendor Service Provider Agreement

Vendor Information

Vendor Name:

Contact Name _____

Address_____
Street Apt City State ZIP

Phone Number (_____) _____ Alt. Number (_____) _____

Email Address_____

Provider FEIN_____

Service Recipient Information- member receiving services or products:

Member Name:

Address: _____

Member phone (____)_____

Vendor Service Provider Acknowledgment

Vendor has accurately completed and submitted W-9 form to become a vendor with Fiscal Assistance and the member named above.

The vendor agrees to supply goods or services as authorized by the MCO to the member with Fiscal assistance acting as fiscal conduit for services.

Vendor/member agrees to submit invoice and signed vendor payment request for the authorized amount.

Vendor agrees to submit invoices within 30 days of goods or service delivery.

Vendor agrees to payment disbursement according to payment schedule from Fiscal Assistance.

I understand I am responsible for maintaining program integrity by preventing and reporting fraud.

Vendor Signature_____ Date_____

BACKGROUND INFORMATION DISCLOSURE (BID)

- **PENALTY: Knowingly providing false information or omitting information may result in a forfeiture of up to $1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).**
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- Refer to DQA form F-82064A, *BID Instructions,* for additional information.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- **PRINT OR TYPE YOUR ANSWERS.**

Check the box that applies to you.

☒ Employee / Contractor (including new applicant)
☐ Household member (lives on premises, but is not a client)
☐ Applicant for a license, certification, or registration (including continuation or renewal)
☐ Other – Specify:

NOTE: If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Full Legal Name – *First*	*Middle*	*Last*

Position Title (Complete only if a prospective or current employee or contractor.)	Birth Date *(MM/dd/yyyy)*	Sex
NOT APPLICABLE		☐ Male ☐ Female

Any Other Names By Which You Have Been Known (Including Maiden Name)

Race / Ethnicity (Check ONLY one.)	Social Security Number
☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown	

Home Address	City	State	Zip Code

Business Name and Address – Employer or Care Provider (Entity)
N/A

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

   Yes ☐ No ☐

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.
   You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.

   Yes ☐ No ☐

3. **IMPORTANT: Read before completing item 3.**

Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. "All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential." Reports and records may be disclosed only to the persons identified in this section.

☐ **If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.**

Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? Yes ☐ No ☐

If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? Yes ☐ No ☐

If **Yes,** explain, including when and where it happened.

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? Yes ☐ No ☐

If **Yes**, explain, including when and where it happened.

6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person**? Yes ☐ No ☐

If **Yes**, explain, including when and where it happened.

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? Yes ☐ No ☐

If **Yes**, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes ☐ No ☐

   If **Yes,** explain, including when and where it happened.

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? Yes ☐ No ☐

   If **Yes,** explain, including when and where it happened and the reason.

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? Yes ☐ No ☐

   If **Yes**, indicate the year of discharge: _____

   Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. Have you resided outside of Wisconsin in the last three (3) years? Yes ☐ No ☐

   If **Yes**, list each state and the dates you resided there.

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? Yes ☐ No ☐

   If **Yes**, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years? Yes ☐ No ☐

   If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? Yes ☐ No ☐

If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

_____ I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

Name – Person Completing This Form	Date Submitted

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See **Specific Instructions** on page 3.

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 of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ 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) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

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 instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* 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 for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

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, *later.*

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

(PROVIDER IS EMPLOYEE)

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Phone Number	
Address – Street	City	State	Zip Code

The above-referenced provider of home and community-based waiver services under Wisconsin's Medicaid program, hereinafter referred to as the provider, hereby agrees and acknowledges as follows:

1. To provide only the items or services authorized by the managed care organization or IRIS program.
2. To accept the payment issued by the managed care organization or IRIS program as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the managed care organization or IRIS program.
5. To keep any records necessary to disclose the extent of services provided consistent with the provider's business type.
6. To provide, upon request by the managed care organization, the IRIS program, or the Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program including the caregiver background check law.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants **for a period of ten (10) years** and to furnish upon request to the DHS, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. This requirement includes retaining all records and documents according to the terms provided by Wis. Admin. Code § DHS 106.02(a)-(d); (f)-(g).
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the managed care organization and upon request, to the Department in writing:

    a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

    b) The names and addresses of all persons who have a controlling interest in the provider;

c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;

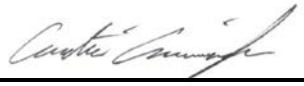
d) The names and addresses of any subcontractors who have had business transactions with the provider;

e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.

12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.
13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.
14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

Modifications to this agreement cannot and will not be agreed to. Altering this agreement in any way voids the Department of Health Services' signature. This agreement is not transferable or assignable.

Name – Provider (Typed or Printed)	
SIGNATURE – Provider	Date Signed

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)	
SIGNATURE – Department of Health Services	Date Signed
	8/14/17

Direct Deposit Authorization

Legal Name: _____

Bank Name: _____

Fiscal Assistance, Inc. requires all vendors/employees to select a direct deposit option, either an account/s you specify **or** a Bank Corp Rapid pay debit card. If account verification information (voided check or bank letter) isn't provided at the time of employment, a Rapid Pay Card will be issued to you and will be used until other account information/verification is provided.

Please select **at least one** direct deposit option, and indicate the percentage of earnings you would like deposited to each account. *You need to provide verification information for each account you choose.*

❑ **Checking**: _____**%** Attach either a **voided check** or **a letter from the bank**
- Letter must be printed on bank letterhead
- Must have the routing and account numbers for the account
- Must be typed with name/s of the account holder/s
- Starter checks may not be used

❑ **Savings:** _____**%** Attach a **letter from the bank**.
- Must be printed on bank letterhead
- Must have the routing and account numbers for the account
- Must be typed with name/s of the account holder/s

❑ **WEX Rapid Pay Card**: I authorize Fiscal Assistance, Inc. to issue me a Bank Corp Rapid Pay debit card using my identifying information and initiate payroll deposits to this card account. (You will receive your card in approximately 2 weeks)

I hereby authorize Fiscal Assistance, Inc. to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries in error to my bank account at the financial institution noted above. This authorization is to remain in full force and affect until Fiscal Assistance, Inc. receives written notice from me of its termination, in such time and manner as to allow Fiscal Assistance, Inc. and the financial institution a reasonable opportunity to act on it.

Signature: _____ ***Date:*** _____

Please attach a copy of a voided check and/or a verification letter from your bank – If this information isn't attached you will be issued a Rapid Pay Card until account verification information is received

Fiscal Assistance, Inc.
4646 S. Biltmore Lane
Madison, WI 53718
Phone: (855) 201-4230
Fax: (844) 650-1968

Verification of Driver Standards
Provider's Compliance with Specialized Transportation

Driver Name:

Participant Name (who will receive transportation):

Providers (Employees/Drivers) are required to have a **current driver's license** issued by the Department of Transportation and **current insurance at all times**. Vehicles used to provide transportation must be insured and in good repair, with all operating and safety systems functioning.

I hold a valid driver's license #: _____

License is from the State of:_____

License expiration date (MM/DD/YYYY):_____

I carry vehicle liability insurance with (company name):_____

Driver's Signature:_____ **Date:**_____

Note: It is the responsibility of the driver to notify Fiscal Assistance Inc. if there is a change in insurance. If you transport multiple participants, you will complete a separate driver verification for each participant.

If you have questions, please contact:

Renae Huffman	Scarlett Russell	Theresa Chard
Enrollment and Outreach Director	Enrollment and Outreach Assistant Director	Enrollment and Outreach Coordinator
Direct Phone: 608-819-7748	Direct Phone: 608-733-6237	Direct Phone: 608-733-6243
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