Vendor Enrollment Packet

Welcome to self-direction! This packet contains all the forms you need to enroll as a vendor and begin providing services. You will not be paid for services until the following forms are completed and returned:

- ☐ New Vendor Setup Form
- ☐ Vendor Agreement
- ☐ Vendor Payment Request
- ☐ DHS Attestation Form
- ☐ Vendor Transportation Appendix (optional)
- ☐ Vendor Mileage Invoice
- ☐ IRS Form W-9
- ☐ Direct Deposit Agreement
- ☐ Non-Timesheet Invoice
- ☐ Business or Service License

Send completed forms by fax, email, or mail to Conduent at the address below:

Fax: 866.302.6787

Email: mi.via@conduent.com

Mailing Address:
P.O. Box 27460
Albuquerque, NM 87125-7460

To be paid for goods or services rendered, a Vendor Payment Request form must be completed and submitted to Conduent for payment, along with a copy of an invoice, by the program's submission deadline. A copy of the payment schedule can be found in this packet.

As a 1099 tax status agency or independent contractor, vendors will not have any taxes withheld from your payment. Vendors receive an IRS 1099 if they meet the IRS threshold for receiving a 1099, which are mailed out on January 31st. Allow two weeks for delivery.

Should you need any assistance, please contact the Consolidated Customer Service Center at 1.800.283.4465. Due to privacy rules, customer service may be limited on the information we can provide about the participant.

We look forward to serving you!

VENDOR PAYMENT SCHEDULE

New Mexico Self-Direction Program

Payment Request/Invoices MUST be received by Conduent	Payments Made by Palco
SATURDAY	FRIDAY
Deadline	Paid On
January 2, 2021	January 15, 2021
January 16, 2021	January 29, 2021
January 30, 2021	February 12, 2021
February 13, 2021	February 26, 2021
February 27, 2021	March 12, 2021
March 13, 2021	March 26, 2021
March 27, 2021	April 9, 2021
April 10, 2021	April 23, 2021
April 24, 2021	May 7, 2021
May 8, 2021	May 21, 2021
May 22, 2021	June 4, 2021
June 5, 2021	June 18, 2021
June 19, 2021	July 2, 2021
July 3, 2021	July 16, 2021
July 17, 2021	July 30, 2021
July 31, 2021	August 13, 2021
August 14, 2021	August 27, 2021
August 28, 2021	September 10, 2021
September 11, 2021	September 24, 2021
September 25, 2021	October 8, 2021
October 9, 2021	October 22, 2021
October 23, 2021	November 5, 2021
November 6, 2021	November 19, 2021
November 20, 2021	December 3, 2021
December 4, 2021	December 17, 2021
December 18, 2021	December 31, 2021
January 1, 2022	January 14, 2022

2021 Office Closures

New Year's Day – Friday, January 1
Memorial Day - Monday, May 31
Independence Day - Monday, July 5
Labor Day - Monday, September 6
Thanksgiving - Thursday-Friday, November 25-26
Christmas - Friday, December 24

Instructions for Vendor Forms

Please complete the following forms to enroll as a vendor with Palco. Use the instructions and checklist below to guide you through the process. All areas highlighted in yellow on the following forms must be completed.

- The **New Vendor Setup** form is used to setup the vendor for payments from Palco.

  - ☐ Complete all fields in the Vendor Information section.
  - ☐ Select the option for the type of vendor services that will be provided

- The **Vendor Provider Agreement** outlines the responsibilities of the vendor. Complete, sign and date the highlighted fields on the form.

  - ☐ Complete the Vendor Information box at the top of the form.
  - ☐ Consumer/Employer must sign and date at the bottom of the form.
  - ☐ Sign and date at the bottom of the form.

- The **IRS Form W-9** provides Palco with required information, per IRS regulations.

  - ☐ Complete Box 1 with your name as shown on your income tax return.
  - ☐ Write your Business name in Box 2 (if different from Box 1).
  - ☐ Make the appropriate selection in Box 3.
  - ☐ Select Box 4 if appropriate.
  - ☐ Complete Box 5 and Box 6 with your complete address.
  - ☐ Complete Box 7 with your account number (optional).
  - ☐ Write your Taxpayer Identification Number (TIN) in the appropriate boxes of Part 1.
  - ☐ Sign and date the bottom of the form.

- The **Pay Selection and Direct Deposit Authorization Agreement** gives us the authority to pay you via electronic funds transfer

  - ☐ Select an option for Request Type at the top of the form.
  - ☐ Complete all fields in the Account Information section.
  - ☐ Attach one of the following forms of validating documentation:
    - ✓ A voided check (no temporary checks or deposit slip).
    - ✓ A typed letter from your bank on the bank's letterhead with your name, account number and routing number.
    - ✓ For a pre-paid card, send a statement from the card company showing the card is activated and registered. This statement must have your name printed on the card. Generally, you can log into the card company's website and print this form, or if you purchase your pre-paid card directly from a bank, the bank can provide the necessary documentation. **A copy of your card is NOT valid documentation**.
  - ☐ Sign and date the bottom of the form.

PO Box 242930
Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

New Vendor Setup

VENDOR INFORMATION			
Name		FEIN or SS# of Payee	
Mailing Address	City	State	Zip Code
Phone Number	Email		
Pay Type: ☐ Paper Check ☐ EFT (If this option is selected, attach a direct deposit authorization agreement)			
☐ A W-9 is required for all vendors, a form is attached.			

Please check the services that your agency will be providing and billing.

	TYPE OF AGENCY/VENDOR EXPENSES
☐	Agency-directed Personal Care Attendant
☐	Employment Support (Follow along)
☐	Meal Service
☐	Emergency Monitoring
☐	Emergency Monitoring Installation
☐	Snow Removal/Mowing
☐	Transportation
☐	Other

***Please return this form to Palco via email: accounting@palcofirst.com* or via fax to 1.877.859.8757.**

Vendor Provider Agreement

VENDOR INFORMATION	
Vendor Name	FEIN/SSN/ID
Phone Number	

Please check the appropriate box to indicate the purpose of the submission of this form.

☐ New Vendor
☐ Vendor Pay (Rate) Change

Effective Date of Rate Change _____

The provider agency/vendor/contractor is contracted with the Self-Direction participant/ EOR and works at the participant/EOR's direction. The provider agency/vendor/ contractor and participant/EOR must follow the policies outlined below. This Agreement must be signed and a copy kept by the Self-Direction participant/EOR *and* the provider agency/vendor/ contractor. Please send the signed Agreement to Conduent, the Self-Direction Financial Management Agent (FMA).

PROVIDER/VENDOR/CONTRACTOR RELATIONSHIP WITH MEDICAID

I am a current Medicaid-participating provider. ☐ YES ☐ NO
If Yes, I am a Medicaid-participating provider in good standing. ☐ YES ☐ NO
If No, please explain _____
Provider Medicaid ID number (if applicable) _____

Under 8.314.6.7 NMAC and 8.308.12 K. NMAC, a Legally Responsible Individual (LRI) is defined as any person who has a duty under state law to care for another person. This category typically includes: the parent (biological, legal or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or a spouse. State approval must be obtained in order for an LRI to be paid for providing Self-Direction services.

Participant Name	Vendor Name

FOR ALL VENDORS/CONTRACTORS

Is the vendor/contractor legally responsible for the Self-direction member/participant?

☐ YES ☐ NO

Will the provider agency be hiring or subcontracting with a person who is legally responsible for the member/participant and who will then provide the service(s) to the member/participant? ☐ YES ☐ NO

If you answered yes to any of the questions, please indicate the name of the legally responsible person who will be providing the service(s) to the member/participant and mark the box that best describes the person's relationship to the member/participant.

Name _____

- ☐ Parent (biological, legal or adoptive) of member/participant who is a minor
- ☐ Guardian of member/participant who is a minor
- ☐ Spouse of the member/participant

If the person providing the service(s) is a Legally Responsible Individual (LRI) for the participant, State approval to be a paid provider must be submitted with the Provider Agency/Vendor/Contractor agreement. If the person will be a provider for more than one service, State approval must be submitted for each service.

Payment (service code, rate and quantity must be approved in the participant's budget.) The provider agency/vendor/contractor shall be compensated for services at the following rate:

Service Code (from Self-Direction budget) _____
Rate per billing unit (please specify billing unit) $_____ per _____

Additional Service Code (if necessary) _____
Rate per billing unit (please specify billing unit) $_____ per _____

***Please note this agreement must be resubmitted for any change in rate or service code.**
Activities (Describe exactly what duties will be performed):

_____

_____

_____

Participant Name	Vendor Name

Duration of Agreement
This Agreement will be effective when both parties sign it. Either party may end this Agreement for the services planned herein at any time and without liability for doing so, by giving the other party at least five (5) days prior notice, except in an emergency situation. Notice may be provided either orally or in writing. It is the responsibility of the vendor and the Member/ Participant/EOR (or their authorized representative) to provide notice of this termination by reporting it to the Conduent Call Center at 1-800-286-4465.

Modification of Agreement
This Agreement may be changed by agreement of both parties. Modification of the Agreement will require that you submit a new Agreement to Conduent, and must include prior approval to ensure that the budget can support the proposed changes. *Signed copies of all new agreements must be provided to Conduent before any changes in rates, units, and so on, can be made.* Changes in rates will NOT be done retroactively. Conduent must receive the Vendor Agreement at least 15 days before the effective date of any rate change. If there is an increase in the rate, the new rate must be approved in the member/participant's budget.

Scheduling of Provider Agency/Vendor/Contractor
If the provider agency/vendor/contractor is **unable** to provide services at the scheduled time, they shall provide at least _____ hours advance notice to the Self-Direction member/participant/EOR. A **change** in time by the provider agency/vendor/contractor or Self-Direction member/participant/EOR must be scheduled at least hours in advance. In case of emergency, the provider agency/vendor/contractor will notify the Self-Direction member/participant/EOR or another designated person. Such person shall be identified in advance, in writing. If the provider agency/vendor/contractor is knowingly going to be late, they shall notify the Self-Direction member/participant, EOR, or designated representative by telephone.

Provider Agency/Vendor/Contractor Qualifications, Duties and Policies.
Provider agency/vendor/contractor hereby agrees to the duties and policies as specified below. Qualifications, duties and policies of the provider agency/vendor/contractor include, but are not limited to, the following:

1. The provider agency/vendor/contractor attests (*confirms*) that it and/or its staff/workers meet the minimum qualifications, including a current license or certificate, as applicable, for providing services as required by the Self-Direction Program and described in the Self-Direction Program regulations (8.314.6 NMAC or 8.308.12 NMAC and 8.314.7 Supports Waiver NMAC) and the Self- Direction Program Service Standards.
   a. The provider agency/vendor/contractor attests that its staff/workers hold valid social security numbers and are authorized to work in the United States.
   b. All provider agency and independent contractor licenses, credentials and other required documents must be available for review by Conduent or the state as requested, for the duration of this agreement.
   c. Provider Agencies and independent contractors must maintain a copy of current professional and/or business licenses and/or professional credentials on file at all times.

Participant Name	Vendor Name

d. The provider agency/vendor/contractor attest that its staff/workers have and will complete the required program training documented in the standards and participant specific training documented in the Supports Waiver Individual Service Plan (ISP), or Mi Via Service and Support Plan (SSP) within the required time frames.

2. The provider agency/vendor/contractor agrees to assist the Self-Direction member/participant by providing the services and performing the activities agreed upon with the Self-Direction member/participant/EOR, according to his/her approved budget, and Supports Waiver Individual Service Plan (ISP), or Mi Via Service and Support Plan (SSP).
3. Provider agency/vendor/contractor staff have the required skills to provide the services and perform the activities agreed upon with the Self-Direction member/participant/EOR, according to his/her approved budget, and Supports Waiver Individual Service Plan (ISP), or Mi Via Service and Support Plan (SSP).
4. Provider agency/vendor/contractor staff that provides direct services will have completed and passed a criminal record check in accordance with Department of Health/Division of Health Improvement DOH/DHI regulations. **Criminal background checks are mandatory.**
   a. Provider agencies are responsible for completing background checks on all of their staff. All staff must have passed such a screening before providing direct services to the member/participant. Confirmation must be available to Conduent and the state for review as requested, for the duration of this agreement.
   b. If the agency staff or independent contractor has a professional license, like a registered nurse or therapist, their licensing board has already completed a background check. They do not need to do another one for Self-Direction.
   c. If a vendor or independent contractor is not a licensed practitioner and is subject to the Caregivers Criminal History Screening Act, they will need to complete a background check through Conduent. The background check for vendors is exactly the same as the process for employees. These vendors/contractors must receive clearance from Conduent before they can begin to provide services to the member/participant.
   d. Any agency, vendor or contractor staff that has not completed a criminal background check must be employed or contracted on a provisional (*temporary*) basis pending the results of the criminal background check. A Consolidated Online Registry (COR) background check must be completed before any direct service is provided (even if on a provisional or temporary basis). Proof that a criminal records check is in process must be on file with the agency prior to the staff person providing any direct services, and must be available to Conduent and the state for review as requested.
5. All qualification documentation (*required information*) must be completed by the provider agency/vendor/contractor and be on file with the provider agency/vendor/contractor prior to and while providing services. Licenses and/or other qualification requirements must be verified before services are provided and payment made. Additional information such as a Nature of Services Questionnaire may be requested by Conduent in order to determine whether a proposed vendor/contractor meets the classification criteria.
6. Provider agency/vendor/contractor acknowledges and understands that funds available for payment are authorized by the Self-Direction New Mexico Medicaid Self-Directed Waiver in advance of services being provided. Payment to the provider agency/vendor/contractor shall only be made as authorized by Self-Direction and upon submitting a **complete Payment Request Form** and invoice to Conduent (according to payment procedures).

Participant Name	Vendor Name

7. Provider agency/vendor/contractor staff shall only perform services within the authorized payment amount, quantity and duration, as they will not be paid by the State of New Mexico for services provided in excess of (over) the authorized amount.
8. The member/participant will pay any services provided over the authorized amount (as documented in the approved budget) to the provider agency/vendor/contractor.
9. The provider agency/vendor/contractor will not be paid for services not provided.
10. Payment for services may be in the form of a check or via direct deposit. The provider agency/vendor/contractor can change their preference of payment at any time, subject to the processes and timelines outlined in the Direct Deposit Agreement and associated instructions.
11. Provider agency/vendor/contractor agrees that it will withhold, as applicable, and pay all required federal income, Medicare, Social Security, New Mexico state and local taxes (as applicable) that are owed in regard to service(s) provided.
12. Payment for services provided by the provider agency/vendor/contractor is from federal and state funds. Any false claims, statements, documents or concealment of material facts will be prosecuted under applicable federal and state laws.
13. A provider agency/vendor/contractor that provides services is considered a Medicaid provider and must document services and maintain documentation as set forth in the Self-Direction Program Regulations (8.314.6.12 NMAC, 8.314.7 Supports Waiver NMAC, or 8.308.12 NMAC).
14. In the event of illness, emergency, or incident preventing the provider agency/vendor/contractor from providing scheduled services to the Self-Direction member/participant, the provider agency/vendor/contractor agrees to notify the member/participant/EOR as soon as possible and in the manner agreed upon by both parties as described in this Agreement.
15. The provider agency/vendor/contractor agrees to participate in training and/or orientation, if requested by the Self-Direction member/participant/EOR, in providing the services that are the subject of this agreement.
16. The provider agency/vendor/contractor agrees to keep all information regarding the Self-Direction member/participant confidential in compliance with HIPAA and other federal and state laws, and to respect the Self-Direction member/participant's privacy.
17. The provider agency/vendor/contractor understands that it is engaged by the Self-Direction member/participant/EOR and *not* the State of New Mexico or Conduent.
18. The provider agency/vendor/contractor, its employees, customers' employees, officers, directors, shareholders, sub-contractors and agents are not employees of the member/participant/EOR, the State of New Mexico, Conduent or its subcontractors. The provider agency/vendor/contractor agrees that it provides services to the member/participant as an independent contractor of the member/participant/EOR, and that no employer/employee relationship shall exist between the member/participant/EOR, Conduent or its subcontractors and the provider agency/vendor/contractor related to the services being rendered under this agreement.
19. Misrepresentation of time worked, services provided, and/or other related information is considered fraud. If the Self-Direction member/participant/EOR or the provider agency/vendor/contractor willfully or intentionally misrepresents information, this agreement may be terminated (*ended*) and the Self-Direction member/participant/EOR or provider will be referred to the HSD Medicaid Fraud Unit.

Participant Name	Vendor Name

20. The provider agency/vendor/contractor attests (confirms) they have reviewed the Mi Via Service Standards and Regulations, or Centennial Care Managed Care Policy Manual, as they apply to the services they are providing and agrees to provide these services in accordance with program rules.
21. The provider agency/vendor/contractor attests they are in compliance with the reporting requirements set forth in the ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING, AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS REGULATIONS (7.1.14 NMAC)
22. If providing Customized Community Supports and/or Employment Supports, the vendor attests (confirms) that services and supports are provided in a community based integrated setting which supports and provides opportunities for participants to access and engage with community resources and activities with others in their community.
23. The provider agency/vendor/contractor acknowledges that they are required to comply with audits conducted by the State of New Mexico.

Self-Direction Member/Participant/EOR Responsibilities

1. The Self-Direction member/participant, EOR or their representative agrees to provide orientation to the provider agency/vendor/contractor in providing the services requested by the Self-Direction member/participant/EOR and authorized in the member/participant's approved Service and Support Plan and budget, as well as training and budget monitoring.
2. The Self-Direction member/participant, EOR, or their representative agrees to establish a mutually agreeable schedule for the provider agency/vendor/contractor services, either orally or in writing.
3. The Self-Direction member/participant, EOR, or their representative, agrees to provide adequate (fair) notice of changes to the scheduled services to the provider agency/ vendor/contractor in the event of unforeseen circumstances or emergencies, but such notice cannot be guaranteed.
4. Misrepresentation of time, services, individuals and/or other information is forbidden. If the Self-Direction member/participant/EOR or provider agency/vendor/contractor knowingly misrepresents information, the member/participant may lose the option of participating in Self-Direction.
5. The Self-Direction member/participant/EOR, or their representative is responsible to ensure payments are made to provider agencies/vendors/contractors for services provided.
6. The Self-Direction member/participant/EOR understands that at any time, the provider agency/vendor/contractor can change their preference of payment from check to direct deposit subject to the processes and timelines outlined in the Direct Deposit Agreement and associated instructions.
7. The Self-Direction member/participant, EOR or their representative understands that if there is a conflict about the services provided, including but not limited to type, quantity or duration, it is the responsibility of the Self-Direction member/participant/EOR to resolve this directly with the provider of service following New Mexico laws governing such conflicts.

Participant Name	Vendor Name

Initials _____

8. The Self-Direction member/participant, EOR or their representative, may not receive cash, rebate money, or return goods for cash for any service or goods paid for through the Self- Direction New Mexico Self-Directed Medicaid Waiver. Member/Participants who arrange to receive rebates or refunds on the unauthorized return of goods or services may be terminated from the Self-Direction Waiver program.

Mutual Responsibilities

The parties agree to follow the regulations, policies and procedures of the Self-Direction New Mexico Self-Directed Medicaid Waiver, including the enrollment and payment processes established by Conduent, the Self-Direction FMA, the Self-Direction Regulations (8.314.6 NMAC, 8.314.7 Supports Waiver NMAC, or 8.308.12 NMAC) and the Service Standards or Centennial Care Managed Care Policy. The provider agency/vendor/contractor and Self-Direction member/ participant/EOR agree to hold harmless, release, and forever discharge the State of New Mexico, Conduent and its subcontractors from any claims and/or damages that might arise out of any action or omissions by the provider agency/vendor/contractor or Self-Direction member/participant/EOR.

The member/participant/EOR and provider agency/vendor/contractor must sign below to begin a service relationship through this program. By signing, the provider agency/vendor/contractor and the member/participant/EOR listed herein verify all qualifications and agree to the duties, responsibilities and policies as outlined in this Agreement.

_____ _____

Participant/Employer Signature **Date**

_____ _____

Provider Agency/Vendor/Contractor Signature **Date**

Participant Name	Vendor Name

Initials _____

Vendor Payment Request

Complete all relevant fields below for payment to be sent to a vendor for authorized services in the Individual Support Plan (ISP). DO NOT use your own money to pay vendors, Conduent CANNOT reimburse you. Payment will be generated on the next payroll cycle according to the Payroll Schedule, after Conduent has processed this form, which may take up to five (5) business days. Please make sure the below vendor has properly submitted all paperwork to enroll with Conduent prior to submitting this request. Initial Vendor Payment Request forms must be submitted for payment within ninety (90) days from date of service to meet timely filing requirements. Initial VPRs submitted past ninety (90) days from date of service will be denied for failure to meet Medicaid timely requirements.

PARTICIPANT INFORMATION		
Full Name	Medicaid ID	Approved Budget Period
VENDOR INFORMATION		
Full Name		FEIN or SS# of Payee
Vendor Address	City, State, Zip Code:	

A W-9 is required for all Vendors. All Vendors require a W-9 to be submitted with the Vendor Payment Request form. This form must be filled out and signed by the vendor.

PAYMENT INFORMATION				
Date of Service	Procedure Code	Service Description & Explanation	Amount (Including all taxes)	Invoice Attached*
			$	☐
			$	☐
			$	☐
		TOTAL	**$**	

An itemized invoice MUST be attached. Invoices should only include items included in requests for waiver reimbursement.

Is this a correction to a PRIOR VPR? ☐ YES ☐ NO

Special instructions:

By signing this form, I attest that the vendor is qualified to render this service. I also attest that services were delivered and received consistent with the Individual Support Plan.

Employer Signature _____ **Date** _____

ATTACH A VENDOR INVOICE WITH THIS PAYMENT REQUEST FORM.
FUTURE DATED INVOICES WILL NOT BE ACCEPTED.

Phone: 1.800.283.4465 Fax: 1.866.302.6787
Email: mi.via@conduent.com
CONDUENT
P.O. Box 27460
Albuquerque, NM 87125-7460

HUMAN SERVICES DEPARTMENT

SELF-DIRECTED PROVIDER ATTESTATION FORM
CMS FINAL RULE FOR HCBS

Please read the following summary of the Centers for Medicare and Medicaid Services (CMS) Final Rule Requirements for Home and Community Based Services (HCBS) Providers.

Any residential or non-residential HCBS provider, who offers self-directed services in a setting where individuals live and/or receive HCBS, must comply with the following CMS Final Rule requirements:

1) Providers must ensure that settings are integrated in and support full access of individuals to the greater community including:

- Providing opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources; and
- Ensuring that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS.

2) Providers must ensure that the individual selects from among setting options including non-disability specific settings and options for a private unit in a residential setting. The provider setting must have person-centered service plans that document the options based on the individual's needs and preferences. For residential settings, the person centered plan must document options available for room and board.

3) Providers must ensure an individual's rights to privacy, dignity and respect, and freedom from coercion and restraint.

4) Providers must ensure settings optimize individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.

5) Provider must ensure settings facilitate individual choice regarding services and supports, and choice regarding who provides them.

6) Providers must ensure tenant protections, privacy, and autonomy for individuals receiving HCBS who do not reside in their own private (or family) home.

As a Medicaid enrolled HCBS provider you are required to ensure all aspects of the Final Rule are followed. **HSD/MAD recommends that you read the CMS Final Rule in the Federal Register at the following link to review the details of the CMS Final Rule requirements:**

https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=emailZ

I certify that I have carefully read the summary requirements for the Home and Community Based Services above and the CMS Final Rule Requirements in the Federal Register at the link provided above. I attest that my organization/provider setting is in compliance or will be in compliance by March 17, 2022 with the CMS Final Rule Requirements published in the Federal Register.

Additionally, I certify that my organization/provider setting will remain in compliance with the CMS Final Rule Requirements published in the Federal Register.

(THE APPLYING PROVIDER MUST SIGN AND DATE THIS ATTESTATION FORM).

Member/Participant Information

Member/Participant Name: _____

Member/Participant Date of Birth: _____

Member/Participant Employer of Record: _____

Provider Information (Vendor or Employee)

Printed Name: _____

Title/Position: _____

Social Security Number/Tax ID: _____

Signature: _____ Date: _____

APPENDIX TO VENDOR AGREEMENT
CHECKLIST FOR PROVIDERS OF TRANSPORTATION SERVICES
Self-Direction Medicaid Waiver

<u>This form is ONLY required if driving the member is your job function or part of your assigned tasks.</u>

VENDOR INFORMATION	
Full Name	ID/Last 4 of SSN

All individuals who provide transportation services of any sort to a Self-Direction participant must possess the following qualifications:

- **Possess a valid New Mexico driver's license**
- **Be at least 18 years of age**
- **Be free of physical or mental impairment that would adversely affect driving performance**
- **Have no driving while intoxicated (DWI) convictions or chargeable (at fault) accidents within the previous two years**
- **Possess a current insurance policy and vehicle registration**

I attest that I have verified that my transportation provider possesses each of these qualifications. (Please complete and sign in ink.)

_____ _____

Employer Printed Name **Employee Signature**

_____

Date

Please attach copies to this form of the following documents from the provider (vendor) listed above:

- Valid New Mexico driver's license
- Current Insurance Policy
- Current Vehicle Registration

These documents are necessary in order to verify if the provider is qualified to perform transportation services within Self-Direction. Without these documents, transportation cannot be provided.

Vendor Mileage Invoice

Is this a correction to a PRIOR Mileage Invoice? ☐ YES ☐ NO

PARTICIPANT INFORMATION		
Full Name	ID	Program/Plan
VENDOR INFORMATION		
Full Name	Driver's License #	License Plate #
Vehicle Year	Vehicle Model	Service Code:

PAYMENT INFORMATION			
Date	Destination (From/To)	Purpose of Trip	Odometer Miles
			Start _____ End _____ Miles _____
			Start _____ End _____ Miles _____
			Start _____ End _____ Miles _____
			Start _____ End _____ Miles _____
			Start _____ End _____ Miles _____
			Start _____ End _____ Miles _____
		SUBTOTAL (miles)	
		TOTAL MILES x $ _____ (per mile)	**$**

I certify that this invoice is true and correct.

_____ _____

Driver Signature Date

I certify that the travel requested is approved on the member/participant's Service & Support Plan/Budget, and proper driver's license, insurance and vehicle registration have been verified.

_____ _____

Employer Signature **Date**

Please note, according to Medicaid timely-filing requirements, requests for payment must be submitted within 90 days of service.

Please send this completed form to Conduent

Fax: 866.302.6787
Email: mi.via@conduent.com

Mailing Address:
P.O. Box 27460
Albuquerque, NM 87125-7460

Form **W-9**
(Rev. October 2018)
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.*

Pay Selection and Direct Deposit Authorization Agreement

HOW WOULD YOU LIKE TO BE PAID?
Payment Selection: (please check only one box) ☐ Direct Deposit ☐ Money Network Services* *If you choose the Money Network Services Option, Palco will enroll you with our partners at First Data: Money Network Services.

Request Type (check one):
☐ New Account Setup ☐ Change in Existing Account ☐ Cancellation

DIRECT DEPOSIT ACCOUNT INFORMATION		
Account Holder's Full Name		ID or Last 4 of SSN
Financial Institution	Routing Number	Account Number
Type of Account (select one): ☐ Checking ☐ Savings ☐ Pre-paid card		

REQUIRED The following validating documentation is attached:

☐ Voided check with account holder name printed on the check.
Check cannot be a temporary check.

OR

☐ Official documentation from financial institution listing account holder name, account, and routing number. This includes letters from banks and paperwork from pre-paid cards.

I authorize Palco, Inc. to initiate deposits and debit entries for the purpose of correcting an erroneous deposit to the account indicated herein. In the event Palco is unable to initiate debit entries, I authorize the repayment to Palco from future amounts owed to me. I understand Palco is not responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. I understand that it is my responsibility to verify the crediting of funds by my financial institution prior to initiating debits against my account. I understand the risks of sharing an account with others, including my employer or worker. Palco is not responsible for any charges I incur from my financial institution. Any changes to my account must be submitted to Palco immediately. This authorization will remain in full force and effect until Palco has received written cancellation in such time and in such manner as to afford Palco and all appropriate financial institutions a reasonable opportunity to act on it.

_____
Printed Name

_____ _____
Signature **Date**