Vendor Packet

Date of Completion: _____

Welcome to IRIS Self-Direction Services of Wisconsin!

A Participant Employer who participates in the IRIS program has chosen you to provide them services. As the participant employer's Fiscal Employer Agency (FEA), we will ensure you are paid for the services you provide. As a vendor, we will require paperwork to ensure you are properly setup in our payment software system. Please fill out the attached paperwork. When services have been provided, we require an invoice along with the Vendor Form. An example invoice is included in this packet for reference. However, you can submit your own invoice so as long as it has the needed/required information.

If you have questions on how to fill out any of the forms, please contact us so we can help.**Our toll-free phone number is 877-901-5826.** Forms must be complete to process your payment. The calendar that is included shows when invoices are due and when payment is made. We encourage you to submit the invoice before the due date listed, allowing enough time to make corrections.

After completing all of the forms, please email or fax them to:
wivendor@outreachfiscalagent.com, or by fax: 800-687-3121 (ensure the invoice is also sent).

We look forward to working with you!

Vendor Packet Checklist

_____W9

_____Provider Application

_____MA Provider Agreement

Vendor Schedule

Sample Invoice

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.*

ELECTRONIC FUNDS TRANSFER FORM
VENDOR PAYMENTS

Attach a **voided check** for verification of the checking account number. Any changes to the account must be submitted immediately! The initial request and any subsequent changes will **not** be direct deposited to your account until the account is authorized by your Financial Institution. Authorization will take effect not less than 10 days after acceptance by the Financial Institution. Paper checks will be mailed to your address of record until the account is authorized.

☐ **New Account** ☐ **Change of Account** ☐ **Cancellation**

Financial Institution Name

Branch Name and Phone Number

Address

City

State

Zip

Account Routing Number

Account Number

I hereby authorize my Participant's FEA (Fiscal Employer Agent), hereinafter called Company, to initiate credit entries and, if necessary, debit entries for the purpose of correcting an erroneous credit previously initiated to the business account indicated above. I further authorize the Financial Institution named above to accept such entries and to credit or debit the amount thereof to such account.

This authority is to remain in full force and effect until Company and Financial Institution have received written notification from me of its termination in such time and manner as to afford Company and Financial Institution a reasonable opportunity to act upon it.

Print Business Name

EIN

Print Name and Title of Individual Authorizing EFT

Phone Number

Email Address

Signature

Date

Mail: 204 3rd. Ave., Suite 110, Osceola, WI 54020
Phone: 877-901-5826
Fax: 800-687-3121
Email: outreach.wi@outreachfiscalagent.com

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01312 (03/2017)

STATE OF WISCONSIN

IRIS PROVIDER APPLICATION

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. Applicants will not be considered as IRIS program service providers until all necessary paperwork is completed, submitted, and verified.

Personally identifiable information on this form is collected to verify that the application is complete and accurate, and will be used only for this purpose.

PROVIDER DEMOGRAPHICS

Organization Name

Provider's Name (Last, First, MI)	Telephone Number	Email Address ☐ *May be published in Provider Directory*

Title

Are you applying as (choose one): ☐ Agency ☐ Individual Practitioner

Type of Application: ☐ Initial Application ☐ Reinstatement

W-9 Name (as shown on income tax return)	W-9 Business Name (if different from W-9 name)
W-9 Exempt: ☐ Yes ☐ No	State of Wisconsin Department of Financial Institutions ID Number:

BILLING AND CLAIMS CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable):	Wisconsin Provider Management Identifier (if applicable):
Tax Identification Number:	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name

Name – Contact Person	Telephone Number	Email Address ☐ *May be published in Provider Directory*
Fax Number		Internet Address ☐ *May be published in Provider Directory*

Address	City	State	Zip Code	County

RENDERING PROVIDER CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable):	Wisconsin Provider Management Identifier (if applicable):
Tax Identification Number:	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name

Name – Contact Person	Telephone Number	Email Address ☐ *May be published in Provider Directory*
Fax Number		Internet Address ☐ *May be published in Provider Directory*

Address	City	State	Zip Code	County

DAILY OPERATIONS CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable):	Wisconsin Provider Management Identifier (if applicable):
Tax Identification Number:	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name

Name – Contact Person	Telephone Number	Email Address ☐ *May be published in Provider Directory*

Fax Number		Internet Address ☐ *May be published in Provider Directory*		
Address	City	State	Zip Code	County

SERVICES TO BE PROVIDED: List the service(s) you wish to provide. Please reference the IRIS Service Definition Manual for a complete list of allowable services.

Services	**Does this service require a license or certification?**

LICENSING / CERTIFICATION: List all current licenses and certificates (if applicable). A copy of each is required with this application.

Title of Licensure/Certification	Type of Licensure/Certification	Licensure/Certification Number	State in which Licensure/Certification Obtained	Expiration Date

By signing below, I certify that background checks on all employees have been completed in accordance with the Wisconsin Caregiver Program.

If I am to provide specialized transportation, I certify that the vehicle used is and will be mechanically sound, has properly functioning lighting, safety, ventilation, and braking systems, and properly inflated tires without excessive wear. I further certify that proper licensing and insurance has been verified and is attached.

I understand and agree that this application will not be processed until it is deemed complete by DHS. It is my responsibility to provide a complete application. I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility.

I certify that the information in this document and all attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after provider approval has been awarded, may lead to suspension or termination of provider approval.

SIGNATURE – Provider	Date Signed

Please submit this application to your Fiscal Employer Agent (FEA) using ONE of the following methods:

AGENCY	FAX	EMAIL	GROUND MAIL
GT Independence	888-972-3891	customerservice@gtindependence.com	215 Broadus St. Sturgis, MI 49091
iLIFE	414-918-4463	IRIS.Vendor@iLIFEfms.com	6100 North Baker Road Glendale, WI 53209
Outreach Health Services	877-901-5826	wivendor@outreachfiscalagent.com	204 3rd Avenue, Suite 110 P.O. Box 945 Osceola, WI 54020
Premier Financial Management Services	888-302-3607	vendorpaperwork@premier-fms.com	10425 W North Ave, Suite 345 Milwaukee, WI 53226

Information contained in email messages may be privileged and confidential. There is some risk that any information in an email you send may be disclosed to, or intercepted by, unauthorized third parties. By agreeing to allow the use of email as a method of communication to WI DHS, this indicates that you acknowledge and accept the possible risks associated with such communication.

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.

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