TNTFI
TNT Fiscal Intermediary Services, Inc.

TNT Fiscal Intermediary Services, Inc.
Fiscal Agent

VENDOR INFORMATION FORM

Member Name: _____
Required (Last) (First) (MI)

Responsible Party's Name: _____
Required (Last) (First) (MI)

Vendor Name: _____
(Vendor Legal Name)

Vendor Assumed Business Name (if any): _____

Taxpayer Identification Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

County: _____

Business Phone: (_____) _____ Cell Phone: (_____) _____

Fax Number: (_____) _____ Email Address: _____

What types of goods or services will be provided to the participant? _____

_____

If providing services, what type of business is this? (please check one) This information will help us determine if additional documentation is required.

____ Corporation ____ LLC (multi-member) ____ LLC (single member) ____ LLP

____ Partnership ____ Sole Proprietorship ____ Government ____ Non-profit

---

Responsible Party/
Member Signature: _____ **Date:** _____

Vendor Signature: _____ **Date:** _____

PROVIDER AGENCY/VENDOR/CONTRACTOR AGREEMENT

Between Self-Direction Member/Participant/Employer of Record (EOR) and Provider

Self-Direction Medicaid Waiver

This signed agreement must be received by CONDUENT (formerly Xerox) before any payments can be issued to the provider agency/vendor/contractor for SERVICES. This agreement may not be required for certain services (for example, phone or internet services) and is not necessary for the purchase of most goods.

Please contact CONDUENT if you are not clear about when this agreement is necessary.

Please check the appropriate checkbox to indicate the purpose 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 member/participant/ EOR and works at the member/participant/EOR's direction. The provider agency/vendor/ contractor and member/participant/EOR must follow the policies outlined below. This Agreement must be signed and a copy kept by the Self-Direction member/participant/EOR *and* the provider agency/vendor/ contractor. Please send the signed Agreement to CONDUENT (formerly Xerox), 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 applies) _____

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.

FOR MI VIA VENDORS/CONTRACTORS ONLY

Is the vendor/contractor legally responsible for the Mi Via 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 member/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.

Parties to Agreement

This Agreement is made on

(Date) _____, by and between

(Vendor name) _____, hereinafter called "provider agency"/ "vendor"/"contractor" and

(Member/Participant/EOR name) _____, hereinafter called "Member/Participant/EOR."

This Agreement will establish the rates for specific services and the responsibilities of the parties to each other.

Payment (service code, rate and quantity must be approved in the member/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 _____

This agreement must be resubmitted for any change in rate or service code.

Activities (describe exactly what duties will be performed):

_____

_____

_____

_____

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 1-866-916-0310.

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 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.

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 Service and Support Plan.

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 Service and Support Plan and budget.

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 contactor 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).

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 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.

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.

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.

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.

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 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.

PROVIDER AGENCY/VENDOR/CONTRACTOR AGREEMENT

Please complete and sign in ink.

Member/Participant/EOR Signature: _____

Date: _____

(if Guardian) Relationship to Member/Participant: _____

Date: _____

Provider Agency/Vendor/Contractor Signature _____

Date: _____

Provider Agency/Vendor/Contractor Telephone Number _____

HUMAN SERVICES DEPARTMENT

ENTENNIALCARE

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 provider who offers self-directed HCBS in a setting where individuals live and/or receive HCBS must comply with the provider setting requirements. A HCBS setting is provider-owned or controlled when the setting in which the individual resides is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS.

The CMS Final Rule requirements for residential and non-residential HCBS settings include:

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 resources available for room and board.

3) Providers must ensure an individual's rights of 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) Additional HCBS Final Rule requirements relate to ensuring 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 get the full details on 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 and attest that my organization/provider setting is in compliance 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: _____

Signature:_____ Date:_____

SELF-DIRECTION PAYMENT REQUEST FORM (PRF)

The requested item and amount must be approved in your Support Plan and Budget.
DO NOT use your own money to pay vendors. Conduent-FMA CANNOT reimburse you.
Initial PRFs must be submitted for payment within ninety (90) days from date of service to meet timely filing requirements. Initial PRFs submitted past ninety (90) days from date of service will deny for failure to meet Medicaid timely-filing requirements.

ATTACH A VENDOR COST QUOTE OR VALID INVOICE WITH THIS PAYMENT REQUEST FORM

Conduent, Inc.
P.O. Box 27460
Albuquerque, NM 87125

Phone: 1-866-916-0310
FAX: 1-866-302-6787

Print Member/Participant Name	
Member/Participant Medicaid Card Number	
Approved Budget Period	
Waiver Service Procedure Code/Modifier	
Describe Item Being Purchased	
Full Payment Amount (including all taxes)	
Is the item being purchased an EMOD?	___ Yes ____No
For Environmental Modifications (EMOD) Only	___ First Installment ___ Second Installment ___ Job Completed
Request Date (within budget to be paid)	
Print Name of Person Authorized to Sign the PRF	
Signature of Person Authorized to Sign the PRF	

BY SIGNING THE PRF, I ATTEST THAT I AM THE PERSON AUTHORIZED TO SIGN THE PRF. IF I AM THE PARTICIPANT, I ATTEST THAT I DO NOT HAVE AN AUTHORIZED REPRESENTATIVE OVER FINANCIAL MATTERS. IF I AM THE PARTICIPANT'S EMPLOYER OF RECORD (EOR) AND/OR AUTHORIZED REPRESENTATIVE, I ATTEST THAT I DO NOT RECEIVE PAYMENT FOR PROVIDING SELF-DIRECTED SERVICES TO THE PARTICIPANT.

Payee Name (Vendor Name) _____ Vendor Federal Tax ID# _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip _____

CHECKS WILL BE MAILED TO THE PERSON AUTHORIZED TO SIGN THE PRF

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

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:

☐ 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. 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.

☐ 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.)

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** ▶

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.

Vendor Direct Deposit Authorization

ATTACH A VOIDED CHECK FOR A NEW ACCOUNT SETUP OR CHANGE IN ACCOUNT

TRANSACTION TYPE

SECTION 1

☐ New setup	(Sections 2, 3 & 4)	☐ Change financial institution	(Sections 2, 3 & 4)
☐ Cancellation	(Sections 2, 3 & 4)	☐ Change account number	(Sections 2, 3 & 4)
		☐ Change account type	(Sections 2, 3 & 4)

PAYEE IDENTIFICATION

SECTION 2

Social Security or Employer Identification Number (EIN) |__|__|__|__|__|__|__|__|__|__|__|			
Name		Phone number ( )	
Mailing Address	City	State	Zip

AUTHORIZATION FOR SETUP, CHANGES OR CANCELLATION

SECTION 3

I (Company) authorize TNT Management Resources, Inc (TNT) to deposit my vendor or contractor payments to my financial institution electronically. I further authorize TNT to initiate debit entries as adjustments for credit entries made in error. Also I acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law and the rules set forth by the National Automated Clearing House Association (NACHA). This authorization is to remain in full force and affect until TNT has received notification from me, or a company representative, of its termination in writing by mail to 4935 Indian School Rd NE, Salem, Oregon 97305. This notification must be received at least three (3) business days prior to the proposed effective date of the termination of authorization to afford TNT and DEPOSITORY a reasonable opportunity to act on it. I understand that I (we) will be charged a $10.00 fee for any check that is unable to be processed due to the fact that I (we) have given wrong information to TNT or my bank information changes and I (we) fail to notify TNT.

Will these payments be forwarded to a financial institution outside the United States? ☐ YES ☐ NO

Authorized Signature (Applicant or authorized agent – Required)	Phone Number (Required)	Date (Required)
Vendor /Contractor Name		Vendor ID #
Comments		

FINANCIAL INSTITUTION

SECTION 4

Name		City	State
Routing Transit Number |_|_|_|_|_|_|-|_|_|_|_|_|_|-|_|	Customer Account Number |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|		Type of Account ☐ **Checking** ☐ **Savings**
Representative Name (Please Print)		Title	
Bank Representative Signature (Optional)		Phone Number ( )	Date

TNT Version 13.9 Date 10/29/2013