DWIHN FY 23-24 PRE-CONTRACTING INSTRUCTIONS GUIDE

BUSINESS INFORMATION QUESTIONAIRE

The Business Information Questionnaire includes general questions about your goals and ownership/leadership style as well as more specific questions relating to your business. It is important for you to be honest and accurate. Please note any incomplete information could result in a delay in the contracting process or denial of contract renewal.

- Please fill in the following questionnaire on the basis of the facts of your company.
- Please answer all questions.
- If any question is not applicable to your company, please check not applicable.

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BUSINESS INFORMATION QUESTIONNAIRE

NAME OF COMPANY: _____

PRINCIPAL OFFICE ADDRESS: _____

TELEPHONE NUMBER: _____

FORM OF OWNERSHIP (Check One):

☐ Corporation State of Incorporation/Registration: _____

Date of Incorporation/Registration: _____

☐ Limited Liability Company

☐ Joint Venture

☐ Partnership If Partnership, select one of the following:

☐ Limited or ☐ General

☐ Individual

Please Complete Name of Company.

Please Complete the address of your company.

Please complete your company's Telephone Number

To show your ownership please check one of the boxes.. If Limited or General please check one of the boxes below.

Please list the State that your company is incorporated/registered in.

Please list the date your company was incorporated//registered.

☐ Limited or ☐ General

☐ Individual

COMPANY HAS BEEN IN BUSINESS SINCE: _____

How long has your company been in business? Put in the year your business started.

LIST OF PARTNERS, PRINCIPALS, CORPORATE OFFICERS OR OWNERS

Name	Title

List of partners, principals, corporate officers or owners name.

List the title of the partners, principals, corporate officers or owners.

LIST OF CORPORATE DIRECTORS

Name	Other Than Proposer Directorship

List the name of the corporate directors.

List the names other than proposer directorship

Please list if you had any contracts terminated for default or other performance reasons.

HAVE YOU HAD ANY CONTRACTS TERMINATED FOR DEFAULT OR OTHER PERFORMANCE REASONS?

☐ YES ☐ NO If Yes Explain:

REGISTRATION WITH SAM.GOV IS A REQUIREMENT.

PLEASE PROVIDE YOUR SAM Unique Entity ID:

PLEASE PROVIDE YOUR CAGE/NCAGE CODE:

IF YOU ARE NOT REGISTERED WITH SAM.GOV, YOU MUST REGISTER WITHIN 3 DAYS OF COMPLETING THIS DOCUMENT.

ANY ENTITY OR INDIVIDUAL WILL BE CHECKED AGAINST OIG (OFFICE OF INSPECTOR GENERAL) EXCLUSION LIST FOR ANY IMPOSED PENALTIES FOR FEDERAL HEALTHCARE PROGRAMS

ADDITIONAL INFORMATION REQUIRED BY DETROIT WAYNE INTEGRATED HEALTH NETWORK

List of Principal Stockholders (i.e., those holding 5% or more of the outstanding stock)

List the names and addresses of principal stockholders holding 5% or more of outstanding stock.

Name	Address

FINANCIAL DISCLOSURE/CONFLICTS OF INTEREST: Identify any contract(s), including any contract involving an employment or consulting relationship, which the firm, or its partners, principals, corporate officers or owners currently has with Detroit Wayne Integrated Health Network, or with any of its Board Members or Officers.

LATEST CREDIT RATING (SPECIFY IF OTHER THAN DUN AND BRADSTREET)

I hereby certify that the foregoing business information is true, correct and complete to the best of (my/our) knowledge and belief:

Please list the name of your company.

Name of Company

Please have contract signer sign. CEO/President/Executive Directors

Signature: _____

Title: _____ ***Date:*** _____

Please list your title. Ex. CEO/President/Executive Directors

Please list the date that you signed.

DEBARMENT/SUSPENSION AGREEMENT AND CERTIFICATION & LIST OF SUBCONTRACTORS

- The Debarment/Suspension Agreement and Certification & List of Subcontractors process protects the federal government from fraud, waste and abuse by using a number of tools to avoid doing business with non-responsible contractors. Suspensions, Proposals for Debarment, and Debarments are the most widely known tools as these actions are visible to the public via SAM.
- The first page of the Debarment Suspension and Certification should have your name listed as the Provider, the program title and the term.
- The last page of the Debarment Suspension and Certification should have the authorized contract signer's signature and title.

CONTRACT TITLE EXAMPLES

- MI- Health Link (**Outpatient**)
- SUD- Substance Use Disorder (**Prevention and Treatment**)
- Autism- Children (**Outpatient**)
- Specialized Residential (**Residential**)
- Unlicensed Residential Services (SIL) Semi- Independent Living (owner/service provider to members) (**Residential**)
- Financial Management Services: *formerly known as Fiscal Intermediary* (**Fiscal**)
- MH Out-Patient Services (**Outpatient**)
- MH Inpatient Services (**Inpatient**)
- Staffing Agents/ Respite (**Residential**)
- Skill Building/Supported Employment (**Outpatient**)

If you have multiple programs, enter both program titles.

DEBARMENT/SUSPENSION AGREEMENT AND CERTIFICATION & LIST OF SUBCONTRACTORS

List the name of your company.

Name of Provider

Contract Title

Term 10/01/2023 through 09/30/2024

List the Contract Type– Outpatient, Residential, Fiscal, and SUD

As a condition for participation as a service provider or grantee of Detroit Wayne Integrated Health Network ("DWIHN"), the provider or grantee that provides Medicaid services and/or received federal grant money (hereafter known as "Provider") agrees to all terms and conditions of this Debarment/Suspension Agreement and Certification ("Certification").

Provider, by executing this Certification, agrees to all of the following terms and conditions as well as all provisions of the certification:

1. Provider affirmatively warrants and represents that neither Provider, nor any of its principals, are debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any Federal program, including, but not limited to, Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. ' 1320a-7), or Executive Order 12549. Provider must notify DWIHN or its agent immediately upon

- Financial Statements and a Schedule of Expenditures of Federal Awards,
- Summary Schedule of audit findings,
- Auditor's Report, and
- Corrective Action Plans for any audit findings.

11. The words "covered contract", "debarred", "suspended", "ineligible", "lower tier covered transaction", "grantee", "participant", "person", "principal", "proposal", and "voluntarily excluded", as used in this certification have meanings based upon materials in the Definitions and Coverage sections of federal rules implementing Executive Order 12549:45.

Certification Statement Regarding Suspension and Debarment:

I certify that neither the Provider organization named above, nor any of its principals, have been suspended or debarred from any f[illegible]ocurement programs.

Please have contract signer sign. CEO/President/Executive Directors and date form

Signature: _____

Title: _____ ***Date:*** _____

DETROIT WAYNE INTEGRATED HEALTH NETWORK
FIRST TIER SUBCONTRACTOR DESIGNATION FORM

First-Tier Subcontract means a subcontract awarded directly by the contractor for the purpose of acquiring supplies or services for performance of a prime contract.

- ❖ This form must be completed even if you have no subcontractors.
- ❖ #1 the contract number is only applicable if there is a bid announcement.
- ❖ #2 Please check the box to indicate if your contract is over $50,000.

DETROIT WAYNE INTEGRATED HEALTH NETWORK
FIRST TIER SUBCONTRACTOR DESIGNATION FORM (CONTINUATION)

- #3 Please check the box indicating if you will use subcontractors for this contract.
- The box below must be completed in its entirety even if there are no subcontractors being used for this contract.
- Please print your name, add title, authorized contract signer name and date the bottom

DETROIT WAYNE INTEGRATED HEALTH NETWORK
FIRST TIER SUBCONTRACTOR DESIGNATION FORM

To be completed by Prime Contractors for "First Tier" Subcontractors Only

This form must be completed by all prime contractors receiving a contract of more than $50,000 (supply/service)

THIS PAGE MUST BE COMPLETED EVEN IF No SUBCONTRACTORS WILL BE USED

1. CONTRACT NUMBER: _____ (number on bid announcement-If Applicable)

2. CHECK ONE:

Please check if your services are over $50.000.

This is a: SUPPLIES/SERVICES contract **(over$50,000)?** ☐YES ☐ NO

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2. CHECK ONE:

This is a: SUPPLIES/SERVICES contract **(over$50,000)?** ☐YES ☐ NO

This box must be completed even if there are no subcontractors (all fields must be completed)

Please check if you will be using subcontractors.

3. CHECK ONE:

WILL SUBCONTRACTORS BE USED FOR THIS CONTRACT? ☐YES ☐NO

(This page must be completed even if no subcontractors will be used)

Prime Company Name:		Fed Tax ID:	
Address:			
City:	County:	State:	Zip:
Phone: ( )		Fax: ( )	
Authorized Contact Person:		Email:	

I declare that all of the information c[illegible]ete and accurate to the best of my knowledge.

Please print your name and add your title.

Print Name: _____ ***Title:*** _____

(This page must be completed even if no subcontractors will be used)

Prime Company Name:		Fed Tax ID:	
Address:			
City:	County:	State:	Zip:
Phone: ( )		Fax: ( )	
Authorized Contact Person:		Email:	

I declare that all of the information contained in this form is complete and accurate to the best of my knowledge.

Please sign your name and date Here.

Print Name: _____ ***Title:*** _____

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

If you answered "YES" to subcontractors, complete the next page.

SUBCONTRACTOR LIST

- Definition of a Subcontractor: *A "subcontractor" is a company or person whom a prime contractor (or main contractor) hires to perform a specific task as part of an overall project or contract and normally pays the subcontractor directly for services provided.*

- Please make additional copies if you need to list additional subcontractors

- There is a box for each subcontractor that must be completed in its entirety. Including the Fed Tax ID or the last 4 digits of the subcontractor owners Social Security Number.

This form is for you to list the name, address and the purpose of all of your subcontractors

List of Subcontractors

	Name	Address	Purpose
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

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Please list your company nae here.

Please complete each box for each subcontractor. A federal tax ID must be provided or the last 4 digit of their social security number.

SUBCONTRACTOR LIST

Prime Contractor Name_____ **Contract #** _____

Subcontractor#

Company Name		Fed Tax ID:	
Address City:	County:	State	Zip
Authorized contact:	Phone ( )	Fax ( )	
Subcontract Amount: $	% of Contract		
Work to be performed:			

Subcontractor#

Company Name		Fed Tax ID:	
Address City:	County:	State	Zip
Authorized contact:	Phone ( )	Fax ( )	

ETHICS

Ethics form is made up of a series of questions, which aim to help the principal investigator identify whether the project is 'high risk' and requires further formal ethical review.

- Please answer each question fully and truthfully.
- Please print your name, sign your name, add the date, the company name and the company tax id#

ETHICS IN CONTRACTING VENDOR FORM

(DISCLOSURE OF RELATIONSHIPS WITH DWIHN CONTRACT MANAGERS BY OWNERS AND OFFICERS OF BUSINESS SUBMITTING QUOTE)

- This form must be completed by a person holding a key position in the business, such as, an officer, director, trustee, partner, senior engineer or sales manager and have influence in making this bid or response or in performing the contract if the Detroit Wayne Integrated Health Network (DWIHN) awards it to your business.
- **Please fill out this form to the best of your knowledge and belief.**
- If you are unsure about what to disclose, contact the Purchasing Director at (313) 344-9099.
- **You are not required to question family members beyond what you already know of their affairs.**
- Submit this form with your quote/bid/proposal. A copy will be kept on file by the DWIHN's Purchasing Director.
- If you fail to fully disclose the required information below, the DWIHN may terminate your contract if your business is awarded one.

your contract if your business is awarded one.

This form should be completed to the best of your knowledge.

1. Are you an immediate family member of a DWIHN employee? ☐ YES ☐NO

   If Yes: Name: _____ Relationship: _____

   Department: _____ Title: _____

2. Without any further inquiry, are you aware if your business has employed any immediate family member of a DWIHN employee within the previous twelve (12) months? ☐ YES ☐NO

   If Yes: Name: _____

   Department: _____ Title: _____

3. Without any further inquiry, are you aware if your business has discussed hiring an immediate family member of a contract manager within the previous twelve (12) months? ☐ YES ☐NO

   If Yes: Name: _____

   Department: _____ Title: _____

4. Do you and a contract manager each have a substantial financial interest in one or more of the same business ventures? ☐ YES ☐NO

2. Without any further inquiry, are you aware if your business has employed any immediate family member of a DWIHN employee within the previous twelve (12) months? ☐ YES ☐NO

If Yes:

Name: _____

Department:_____Title: _____

This page should be completed to the best of your knowledge.

3. Without any further inquiry, are you aware if your business has discussed hiring an immediate family member of a contract manager within the previous twelve (12) months? ☐ YES ☐NO

If Yes:

Name: _____

Department:_____Title: _____

You must choose Y or N for each question

4. Do you and a contract manager each have a substantial financial interest in one or more of the same business ventures? ☐ YES ☐NO

If Yes:

Name: _____

Department:_____Title: _____

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Please print, sign your name, date, list your company name and your tax ID #.

ETHICS CERTIFICATION

I certify that I have disclosed all information within my knowledge, which is required by this disclosure form.

Name (Please Print): _____

Signature: _____ Date: _____

Company Name: _____

Company Tax ID#: _____

ETHICS DEFINITIONS

Contract Manager
An elected or appointed DWIHN official identified as having significant discretion over DWIHN contracts.

DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST

The Disclosure of Ownership and Control Interest form is a federal regulation requirement under 42 CFR Part §455, applicable to all providers that participate in state-based health care programs, such as Medicaid & CHIP, and provide services pursuant to a contract between a Medicaid Managed Care Organization.

Please follow instructions in the form to complete

Detroit Wayne
Integrated Health Network
707 W. Milwaukee St.
Detroit, MI 48202-2943
Phone: (313) 833-2500
www.dwihn.org

FAX: (313) 833-2156
TDD: (800) 630-1044 RR/TDD: (888) 339-5588

Disclosure Statement

Detroit Wayne Integrated Health Network (DWIHN) is required to collect disclosure of ownership, controlling interests, and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid program and/or the Pre-paid Inpatient Health Plan (PIHP). This requirement is pursuant to a Medicaid and/or PIHP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455. Required information includes: 1) the identity of all owners and others with a controlling interest of 5% or greater; 2) certain business transactions as described in 42 CFR §455.105; 3) the identity of managers and others in a position of influence or authority; and 4) criminal convictions, sanctions, exclusions, debarment or termination information for the provider, owners or managers. The information required includes, but is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Completion and submission of this Statement is a condition of participating as a credentialed or enrolled provider in the DWIHN provider network for services to members under Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Wavier Program. Failure to submit the requests information may result in a refusal of participation in DWIHN or denial of a claim.

This statement should be submitted at any of the following times: upon the submission of an application; upon execution of an agreement; during re-credentialing or re-contracting; within 35 days after any change in ownership of the disclosing entity. A Statement must be provided to DWIHN within 35 days of a request for information by the US Department of Health and Human Services (HHS) or the State Agency. DWIHN maintains policies and practices that protect the confidentiality of personal information, including Social Security numbers, obtained from its providers and associates in the course of its regular business functions. DWIHN is committed to protecting information about its providers and associates, especially the confidential nature of their personal information.

Detailed instructions and a glossary for capitalized terms can be found at the end of this form. If attachments are included, please indicate to which section those attachments refer.

_____ _____

Acknowledgement Signature Date

Provider/Provider Entity Information

*Please fill out the entire section. Every field must be complete. If fields are left blank, the form will be returned for corrections/completeness. *These fields cannot be left blank; check appropriate box or use 'N/A'.*

Please choose appropriate category:	**Name of Provider/Provider Entity:**
☐ Provider Entity	
☐ Licensed Independent Practitioner	**Name of Person Completing this Form:**
☐ Managing Employee	**Title:**
☐ HCBS Provider	**Phone Number:**
☐ Other:	**Fax:**
Group Affiliation? ☐ Yes ☐ No	**Email:**
If yes, do you have a private practice as well? ☐ Yes ☐ No	**In which state(s) do you participate in Medicaid?**
Additional Addresses (list all Practice Locations)	**Attaching list?** ☐ Yes ☐ No

***SSN (if Individual Provider):**	***Medicaid ID#:**	***NPI#:**
☐ N/A	☐ *Applied for Medicaid ID	☐ *Applied for NPI#
***Federal Tax ID# (if Entity):**	☐ *Not applicable	☐ *Not applicable
☐ N/A		

Section I: Individual Provider Ownership Information

1. Are there any individuals or organizations with a Direct or Indirect Ownership Interest of 5% or more in your entity/practice? ☐ Yes ☐ *No-Skip to #2* ☐ *N/A-Skip to #2*

   If an organization with Direct or Indirect ownership in the disclosing entity is a nonstock or non-member entity, each individual serving on the governing board of directors or trustees must be disclosed below.

See instructions for more information and examples

If yes, list the name, primary address, date of birth (DOB), and Social Security Number (SSN) for each person having an Ownership Interest in the disclosing entity of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership Interest of 5% or greater. (42 CFR §455.104). Attach additional sheets as necessary - ☐ Yes ☐ No

Name of Owner	**DOB (mm/dd/yyyy)**	**Complete Address (Street/City/State/Zip)**	****SSN or TIN or both as applicable**	**% Interest**
		Street: C: S: Z:		
		Street: C: S: Z:		
		Street: C: S: Z:		

***SSN and TIN required under §455.104; See Sect 4313 of the Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No 22*

Section II: Ownership in Other Providers & Entities

2. Does the *Owner identified in Section I* have an Ownership or Controlling Interest in *any other* provider or entity?
☐ Yes ☐ *No-Skip to #3* ☐ *N/A-Skip to #3*

If yes, list the name and the SSN or TIN of the other provider or entity in which the *Owner identified in Section I* also has an Ownership or Controlling Interest (42 CFR §455.104(b)(3)). Attach additional sheets as necessary - ☐ Yes ☐ No

Name of Owner from Section I	Name of Other Provider or Entity	Other Provider or Entity's SSN (individual) or TIN (entity)

Section III: Subcontractor Ownership

3. Do you, as the Provider Entity, have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor? ☐ Yes ☐ *No-Skip to #4* ☐ *N/A-Skip to #4*

If yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor?
☐ Yes ☐ No

If yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you *also have* Direct or Indirect Ownership Interest of 5% or more (42 CFR §455.104).
Attach additional sheets as necessary - ☐ Yes ☐ No

Legal Name of Subcontractor:		
Name of Subcontractors *Other Owner*:		***Other Owner's*:**
***Other Owner's* Address:**		**City, State, Zip:**
***Other Owner's* TIN:**	***Other Owner's* SSN:**	**% Interest:**

Section IV: Familial Relationships of All Owners

4. Are any of the individuals identified in Sections I, II, or III related to each other? ☐ Yes ☐ *No – Skip to #5* ☐ *N/A-Skip to #5*

If yes, list the individuals identified and the relationship to each other (e.g. spouse, domestic partner, sibling, parent, child) (42 CFR §455.104(b)(2). Attach additional sheets as necessary - ☐ Yes ☐ No

Name of Owner 1	Name of Owner 2	Relationship

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment, or Terminations

5. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Provider Entity ever been indicted or convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, CHIP or Title XX program?
☐ Yes ☐ *No-Skip to #6* ☐ *N/A-Skip to #6*

If yes, list those persons and the required information below. (42 CFR §455.106). Attach additional

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**State and Date of Conviction:**
Matter of the Offense:	**Date of Reinstatement:**

6. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Provider Entity ever been sanctioned, excluded, or debarred from Medicaid, Medicare, CHIP or Title XX program? ☐ Yes ☐ *No-Skip to #7* ☐ *N/A-Skip to #7*

If yes, list those persons and the required information below. (42 CFR §455.436). Attach additional sheets as necessary - ☐ Yes ☐ No

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**List all States where currently excluded:**
Reason for Sanction, Exclusion, or Debarment:	
Date(s) of Sanctions, Exclusions, or Debarments:	**Date of Reinstatement:**

7. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? ☐ Yes ☐ *No-Skip to #8* ☐ *N/A-Skip to #8*

If yes, list those person and the requirement information below. (42 CFR §455.416). Attach additional sheets as necessary - ☐ Yes ☐ No

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**Terminated from Medicare?** ☐ Yes ☐ No
Reason for Termination:	**Date of Termination:**
State that originated Termination:	**Date of Reinstatement:**

**At any time during the Contract period, it is the responsibility of the Provider/Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (see Fed. Register, Vol. 44, No. 138)*

Section VI: Business Transaction Information

8. **Business Transactions – Subcontractors:** Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? ☐ Yes ☐ *No-Skip to #9* ☐ *N/A-Skip to #9*

If yes, list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) Attaching additional sheets as necessary - ☐ Yes ☐ No

Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

9. **Significant Business Transactions – Wholly Owned Suppliers:** Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? ☐ Yes ☐ *No-Skip to #10* ☐ *N/A-Skip to #10*

If yes, list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past five (5) year period (43 CFR §455.105(b)(2)). Attach additional sheets as necessary - ☐ Yes ☐ No *See Glossary for definition.*

Name of Supplier:	**Suppliers SSN or TIN:**
Suppliers Address:	**City, State, Zip:**

10. **Significant Business Transactions – Subcontractors:** Has the Provider Entity had any Significant Business Transactions with a Subcontractor totaling more than $25,000 in the past five (5) year period?
☐ Yes ☐ *No-Skip to #11* ☐ *N/A-Skip to #11*

If yes, list the information for Subcontractors with whom the Provider Entity had any Significant Business Transactions exceeding the $25,000 during the past five (5) year period (42 CFR §455.105(b)(2)).
Attach additional sheets as necessary - ☐ Yes ☐ No

Name of Subcontractor:	**Subcontractor's SSN or TIN:**
Subcontractor Address:	**City, State, Zip:**
Subcontractors Owner (SO):	**SO's SSN or TIN:**
SO's Address:	**City, State, Zip:**

This information must be provided and/or updated within 35 days of a request. Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received (42 CFR §455.105)

Section VII: Management and Control

11. **Managing Employees:** Does the Provider Entity have any Managing Employees?
☐ Yes ☐ *No-Skip to #12* ☐ *N/A-Skip to #12*

If yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of Provider Entity (general manager, business manager, administrator or director), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104). Attach additional sheets as necessary - ☐ Yes ☐ No

Name	DOB mm/dd/yyyy	Complete Address	SSN	Title

12. **Agents:** Does the Provider Entity have any Agents? ☐ Yes ☐ *No* ☐ *N/A*

If yes, list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity, including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104).

Attach additional sheets as necessary - ☐ Yes ☐ No

Name	DOB mm/dd/yyyy	Complete Address	SSN

Through signature below, I hereby certify that any employees or contractors providing services pursuant to a contract with Detroit Wayne Integrated Health Network are screened with the applicable background check including, but not limited to, verification against the OIG's List of Excluded Individuals & Entities (https://oig.hhs.gov/exclusions/index/asp) and the System for Award Management (SAM) www.sam.gov and any applicable state, federal or other governmental exclusion or sanction database and that the information provided herein is true, accurate, and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of a claim and/or termination of the contract.

Signature_____ Title_____

Print Name_____ Date_____

_____ _____ _____

Phone Number Fax Number Email Address

SERVICE AGENCY PROFILE

IMPORTANT

This form is to be completed by the Community Mental Health Services Program {CMHSP) for each service agency which provides services to recipients as part of CMHSPs array of service. A service agency is the CMHSP itself, or contract agencies which provide services to recipients. A form must be completed for each service agency under contract with the CMHSP as well as the CMHSP.

This form must be resubmitted if there is a change in type of service provided at a site, or if services are provided at a site not listed on a previously submitted form, or if services are no longer provided at a previously reported site. It must be completed if a new service agency begins services as part of CMHSPs array of services.

1. General Information: 3. Address Change

2. Desired Effective Date for Addition or Change: *Sunday, December 18, 2018*

3. PIHP *Choose an item.*		4. Service Agency Name *Click here to enter text.*
5. Service Agency Address *Click here to enter text.*		
6. City *Click here to enter text.*	7. Zip *Click here to enter text.*	8. Telephone Number *Click here to enter text.*
9. Service Agency Administrator Name *Click here to enter text.*		10a. Accreditation Type *Click here to enter text.* 10b. Expiration Date *Click here to enter a date .*

Service Agency Sites (for multiple locations of the provider listed in #3 above)

*** Services which require approval from DCH for enrollment**

11. Program Name, Address, City, ZIP *Click here to enter text.* Telephone *Click here to enter number .*	12. Services (click on and select either I, II, 111, IV, or V) *I.* * I. Supports and Services for Adults with Mental Illness and Children with Emotional Disturbances - Psycho-Social Rehabilation Programs *III.* ***IV.*** ***V.***

11. Program Name, Address, City, ZIP *Click here to enter text.* **Telephone** *Click here to enter num ber.*	**12. Services (click on and select either I, II, III, IV, or V)** *I.* *II.* *III.* ***IV.*** ***V.***
11. **Program Name, Address, City, ZIP** *Click here to enter text.* **Telephone** *Click here to enter num ber.*	**12. Services {click on and select either I, 11, 111, IV, or V)** *I.* *II.* ***III.*** ***IV.*** ***V.***
11. Program Name, Address, City, ZIP *Click here to enter text.* **Telephone** *Click here to enter num ber.*	**12. Services (click on and select either I, II, III, IV, or V)** *I.* *II.* *III.* ***IV.*** ***V.***

W9

❖ Line 1 – Name

This should be your full name. It should match the name on your individual tax return.

❖ Line 2 – Business name

If you have a business name, trade name, DBA name or disregarded entity name, fill it in here. If you do not have a business, you can leave this line blank.

❖ Line 3 – Federal tax classification

This section defines how you, the independent contractor, is classified when it comes to federal taxes. You will check the first box if you are filing as an individual, sole proprietor or single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes. A sole proprietor business operates under the owner's Social Security number and hasn't been registered as another type of business. Taxes apply to single-member LLCs in the same way.

W9 (CONTINUATION)

- Line 4 – Exemptions
- You do not need to fill in this section as an individual. Only certain businesses or entities with any reason for exemption need to fill out these spaces. If this applies to you, you'll need to provide a number or letter code that indicates that reason.
- If your entity is exempt from backup withholding, you'll fill in the first line with your code. This should apply to most entities. However, if your business is not, the company who hired you for your services will need to withhold income tax from your pay at a flat rate of 24% and send it to the IRS. This is known as backup withholding.
- If you are exempt from reporting required by the Foreign Account Tax Compliance Act (FACTA), you will fill in the second line. The latter only applies if you hold your accounts outside the United States. If you maintain your account in the U.S., you can leave the second line blank or write "N/A." If you're unsure about your exemptions, Page 3 of the form outlines situations that would make you exempt.

W9 (CONTINUATION)

- Lines 5 & 6 – Address, city, state, and ZIP code
- Line 5 requires the address (number, street, and apartment or suite number) where your employer will mail your information returns. The following line, Line 6, leaves a space for you to enter the city, state and ZIP code of this address.
- Line 7 – Account number(s)
- This is an optional line where you can fill in any account numbers your employer may need. Most individuals can leave this blank.

W9 (CONTINUATION)

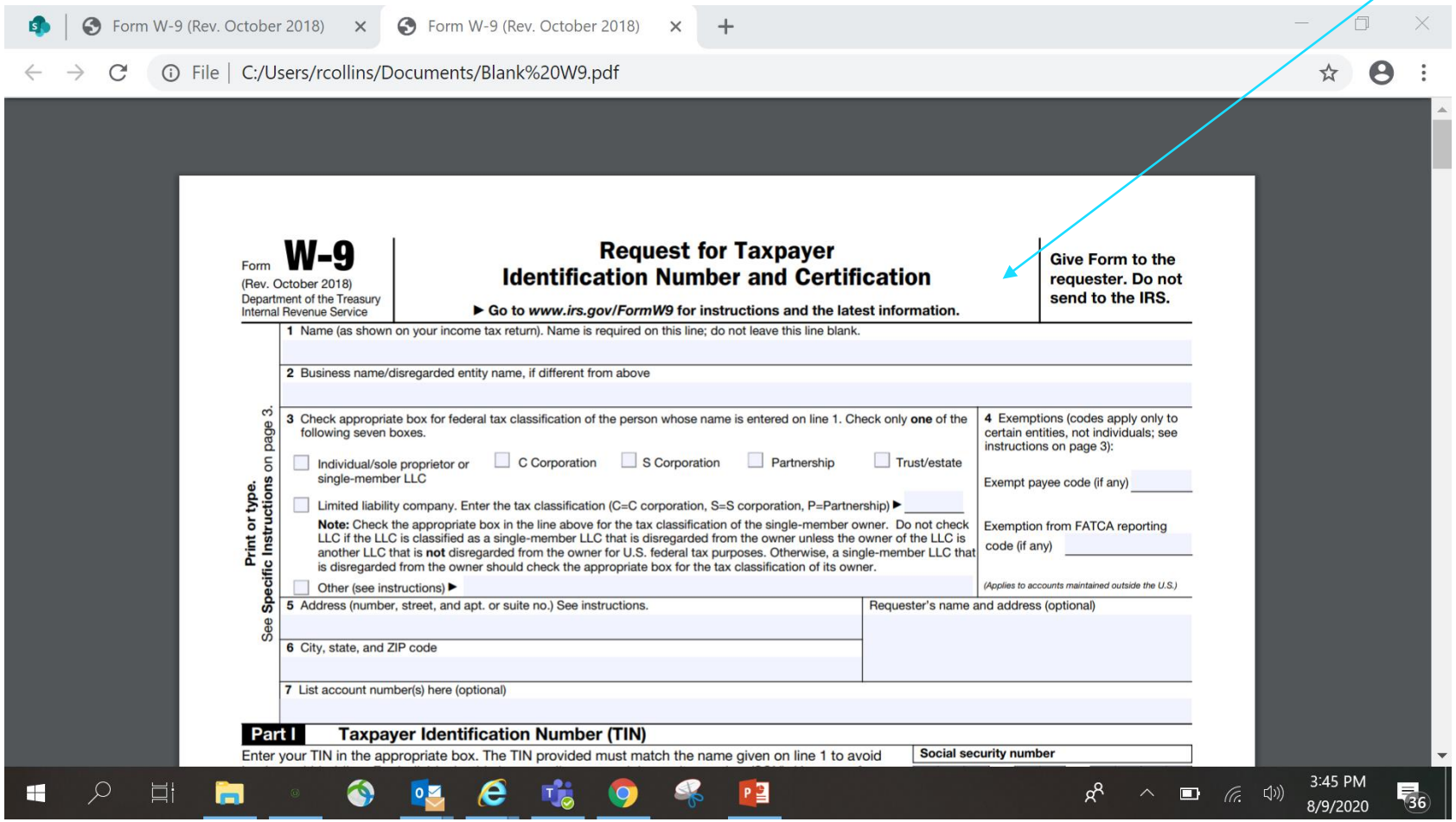
- Part I – Taxpayer Identification Number (TIN)
- You have two options in this section. You can enter either your Social Security number (SSN) or your employer identification number (EIN). Typically, you provide your SSN if you file as an individual or single-member LLC. Use your EIN if you file as a multi-member LLC classified as a corporation or partnership. If you are a sole proprietor, you could use either number, but your SSN is preferable.
- If you are a resident alien and you are not eligible for a SSN, you should use your IRS individual taxpayer identification number (ITIN).
- Again, you may want to check with your tax advisor or contact the IRS directly to double check your information. Providing an incorrect TIN can cause issues with your payments or tax return. It can also lead to future backup withholding.

W9 (CONTINUATION)

- The other boxes correspond to C corporation, S corporation, Partnership and Trust/estate businesses.
- The Limited liability company box is for a Partnership or LLC businesses with multiple members. You can check this box if you own an LLC treated as a partnership for federal taxes (fill in “P” in the adjacent space), an LLC that has filed Form 8832 or 2553 and is taxed as a corporation (fill in “C” or “S” in the adjacent space depending on the type) or an LLC whose owner is another LLC not disregarded for federal tax purposes (fill in the appropriate letter in the adjacent space). If your LLC has not filed a request to be taxed as a C or S corporation, it is taxed as a Partnership. The “Note” on the form clarifies the LLC-specific rules. You can always seek your attorney’s or tax advisor’s help to ensure you complete your form(s) correctly

W-9

This form should be completed in its entirety.



Form 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.

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.)

Print or type. See Specific Instructions on page 3.

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

Social security number

Form W-9 (Rev. October 2018)

File | C:/Users/rcollins/Documents/Blank%20W9.pdf

5 City, state, and ZIP code

7 List account number(s) here (optional)

This form should be complete entirety.

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

- 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)

3:51 PM
8/9/2020

CERTIFICATE OF INSURANCE

A Certificate of Insurance (COI) is a statement of coverage issued by the company that insures your business. Usually no more than one page, a (COI) provides a summary of your business coverage. It serves as verification that your business is indeed insured.

- Please provide a copy of your ***current Certificate of Insurance*** for your company.

DWIHN Outpatient and Residential Provider Insurance Requirements

Insurance Requirement	Required Insurance Limit	Certificate Holder	Additional Insured
General / Commercial Liability	1,000,000 per occurrence and 3,000,000 in annual aggregate	Detroit Wayne Integrated Health Network (DWIHN)	Detroit Wayne Integrated Health Network (DWIHN)
Professional also commonly referred to as Errors and Omissions	1,000,000 per occurrence and 3,000,000 in annual aggregate	Detroit Wayne Integrated Health Network (DWIHN)	Detroit Wayne Integrated Health Network (DWIHN)
Auto	If Provider or its employees owns, leases or uses in the transportation of members or provision of services, provider must maintain motor vehicle insurance in the minimum amount of 1,000,000 per occurrence. If no vehicle are owned or leased, non-owned and hired	DWIHN	DWIHN (only applies to the extent that they use car to perform services

Workers Compensation	Provider shall maintain workers compensation insurance including Employer's Liability.	DWIHN	N/A – DWIHN is not an additional insured. In the certificate, Limits here should be 500,000 500,000 500,000 Or per statute
Property	If Provider has furnishings or equipment provided by or purchased by DWIHN or the State funds, Provider must procure and maintain replacement cost Property Insurance inclusive of personal property of members under provider's care	DWIHN	DWIHN

Note: Providers are required to maintain the required insurance requirements at all times as well as include DWIHN as certificate holder and additional insured accordance with the Section 10 of the Residential and Outpatient Provider Agreements.

- **Where the provider's insurance policies do not meet the minimum policy limit requirements, Provider may use an umbrella policy to make up the difference. E.g. if Provider only has $1**

million per occurrence/ $2million annual aggregate of GL the provider can use coverage of $1million from their policy to cover the gap in coverage.

- Auto Coverage: Coverage type can be “hired” or “owned” auto.
- DWIHN cannot be named as an additional insured because workers’ compensation can only cover your direct employees.
- Property coverage may only be applicable in residential settings.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
DATE

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER

INSURANCE COMPANY
ADDRESS/CONTACT INFO

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A :	
INSURER B :	
INSURER C :	
INSURER D :	

INSURED

NAME OF INSURED and DBA
ADDRESS

Commercial General Liability may only be written by a US Company

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED ...URED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OF ...ER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURA...ED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SH... CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC OTHER:	X		Policy Number	Effective Date 10/1/20xx or earlier	Expiration after contract start date	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$
								$
A	X AUTOMOBILE LIABILITY ANY AUTO / ALL OWNED AUTOS / SCHEDULED AUTOS / HIRED AUTOS / NON-OWNED AUTOS	X					COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $			Minimum Coverage			EACH OCCURRENCE	$
							AGGREGATE	$
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N / A If yes, describe under DESCRIPTION OF OPERATIONS below						X PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional liability	X					$1,000,000 per occurrence $ 3,000,000/ aggregate	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Detroit Wayne Integrated Health Network is an Additional Insured with respect to General Liability, Professional Liability and Automobile liability as required by contract.

CERTIFICATE HOLDER	CANCELLATION
DETROIT WAYNE INTEGRATED HEALTH NETWORK 707 W. Milwaukee Detroit MI 48202	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE

DETROIT WAYNE INTEGRATED HEALTH NETWORK

MOVE TO ELECTRONIC FUNDS PAYMENTS

OVERVIEW

Electronic Funds Transfer (EFT) is a fast and efficient way for businesses to exchange money. EFT payments are also known as ACH transactions for the Automated Clearing House (ACH). The Automated Clearing House is a nationwide electronic payment network that facilitates the clearing of electronic payments and payment-related information between financial institutions. By accepting EFT payments, businesses gain faster and more reliable access to the funds due them.

FREQUENTLY ASKED QUESTIONS

1. What will it cost?
   There is no cost associated with switching from receiving paper checks to EFT payments.

2. Do I need to create a new bank account?
   No. Your existing bank account can be used. You will just need to provide your bank's routing number, along with your bank account number.

3. Is it secure?
   EFT payments are more secure than paper checks. DWMHA safeguards your bank account information with our enterprise resource planning (ERP) system security which functions to protect our data behind our network firewalls.

4. How long does it take for an EFT payment to be deposited?
   EFT payments can be deposited into the payee's bank account in as little as 24 hours. The funds will be deposited on the next non-holiday business day.

5. Can I continue to get paid by check?
   No. The use of paper checks is being discontinued.

6. Will I receive notification when a payment is made?
   A remittance will be sent to the email address(es) that we have on file for you.

7. When will this change be implemented?
   Effective July 1, 2017 paper checks will no longer be issued.

NEXT STEPS

Complete the DWIHN Electronic Funds Transfer Enrollment form and email it to the Accounts Payable Manager, Tyreesse Omani at tomani@dwihn.org.

ELECTRONIC FUNDS TRANSFER ENROLLMENT FORM

This form is used to initiate Electronic Funds Transfers (EFTs) for the specified vendor. Please complete all fields, putting N/A if not applicable. A separate document, such as a confirmation letter from your bank, or a voided check with bank information, must be provided as validation of the banking information as listed on this form.

DWIHN Vendor ID:_____ **DWIHN Contact Person:**_____

Note: Your Vendor ID will be listed on your most recent payment stub or remittance.

Company Information

Business Name:		
Tax ID/EIN:		
Street Address:		
City:	State:	Zip Code:
Contact Name:		Phone:
Email Address for Remittance:		

Bank Information

Bank Name:	
Bank Routing #:	Bank Account #:

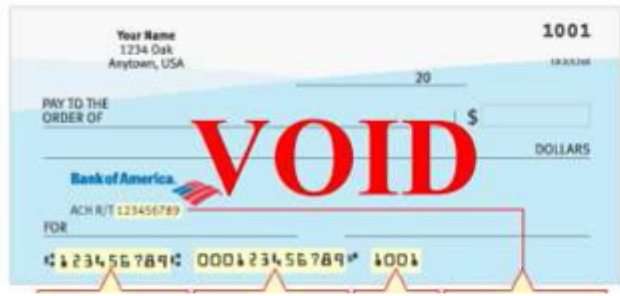
I, authorized signed on the account above, hereby authorize Detroit Wayne Integrated Health Network to originate Automated Clearinghouse(ACH) credits to this account for invoice payments for debts owe by DWIHN.

Authorized Signature:_____ Date:_____

Authorized Signature:_____ Date:_____

Printed Name/Title:

BE SURE TO INCLUDE A VOIDED CHECK OR BANK CONFIRMATION LETTER WITH YOUR SUBMISSION.



For questions, please email or call Accounts Payable at tomani@dwihn.org, 313-344-9099 ext 3267.

SAM.GOV

- The System for Award Management (SAM) is an official website of the U.S. government. There is no cost to use SAM. You can use this site for FREE to:
- Register to do business with the U.S. government
- Update or renew your entity registration
- Check status of an entity registration
- Search for entity registration and exclusion records

OIG

- Your Provider Network Manager will check OIG for Provider Status prior to contracting
- Office of Inspector General(OIG) maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals/Entities (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP). To avoid CMP liability, health care entities should check the list monthly to ensure that new hires and current employees are not on it.

PRE-CONTRACTING PACKET CHECKLIST:

- Business Information Questionnaire
- Debarment/Suspension Agreement and Certification & List of Subcontractors
- Ethics in Contracting Vendor Form
- Disclosure of Ownership/ Statement
- SAP Form
- W9 **(new provider or if changes have occurred)*
- Certificate of Insurance *(ensure proper limits/DWIHN named as additional insured)*
- EFT Form - **(new providers or if changes have occurred)*

Note: before submitting the pre-contracting packet please review, the email address and CEO/Authorized signer name for accuracy. All signatures are electronic and the provider will get a copy of the contract sent to them once all signatures are finalized by email.

CONTRACT TIMELINE

- Pre-contracting paperwork—
  - Training/ Submission dates
    - Providers--- Tuesday, May 4, 2021 and Friday, May, 7, 2021 from 10:00 am to 11:30 am
    - Pre-contracting paperwork sent to providers May 10, 2021
    - Return of pre-contracting paperwork by Monday, May 24, 2021