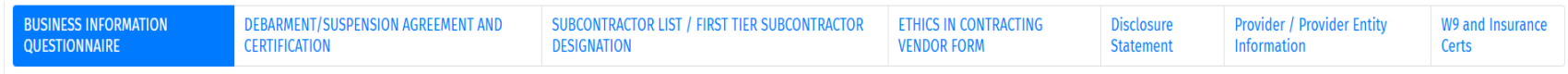
DWIHN
FY 25-26
PRE-CONTRACTING
INSTRUCTION GUIDE

Please note that the Pre-Contracting documents are now automated. You will not be able to move on to the next section of the document until the current section you are working on is completed. See below:



If you need to complete the document later, please follow the directions below:

You can use the [Save] button to the left to save the form so you can return to it to later to continue. Make sure to copy the Link from the following screen so you can return to the form, the e-mail address listed will also recive the link within a day. When you have the form compleate and ready for submission to DWIHN check the "Ready for review" box below then [SAVE] and your PNM will review the form and get back to you if needed. The e-mail listed will recive confimation when your form is compleate and accepted.

Business Questionnaire

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 that any incomplete information could result in a delay in the contracting process or denial of contract renewal.

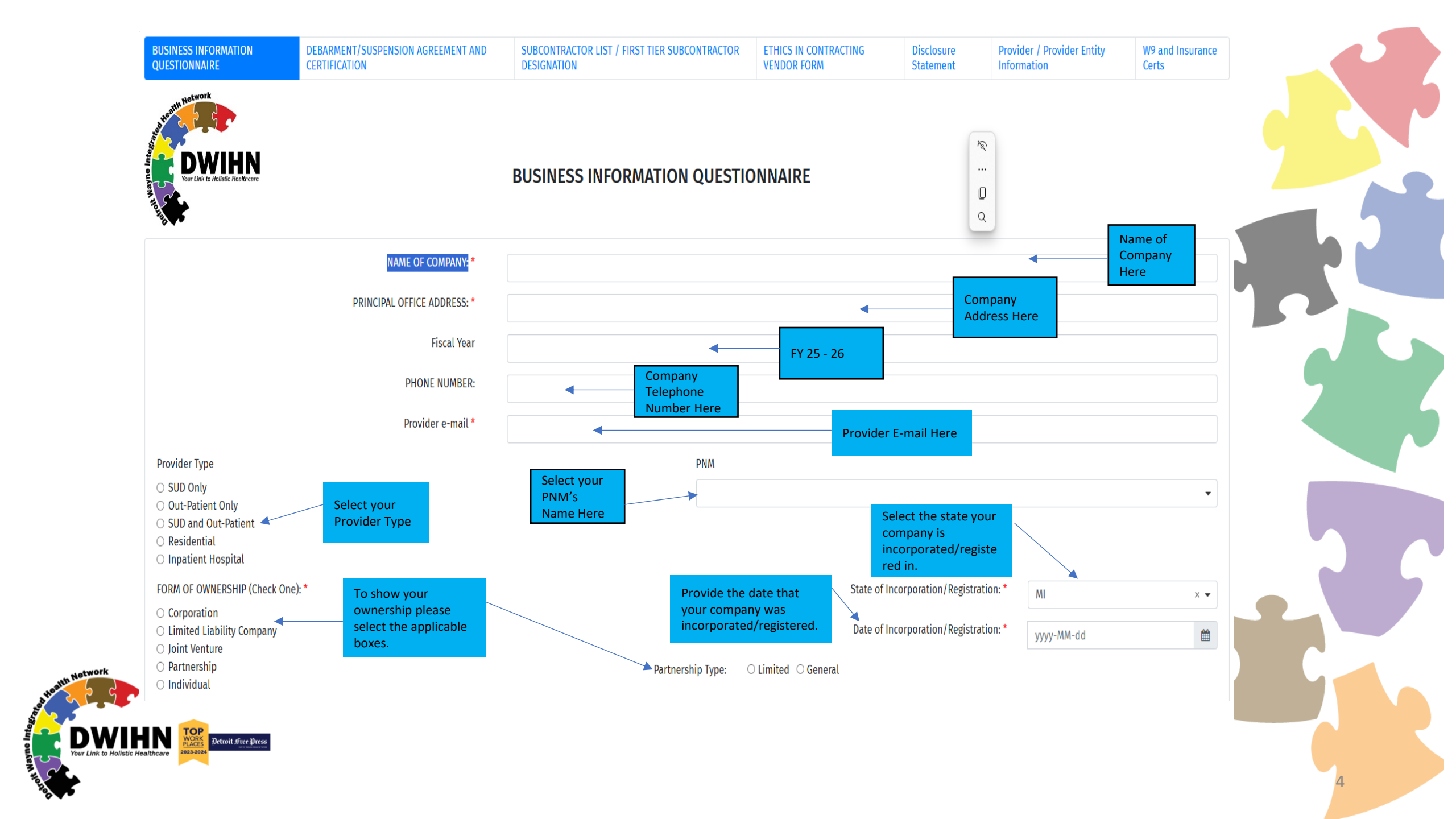
Please fill in the following questionnaire based on the facts of your company.

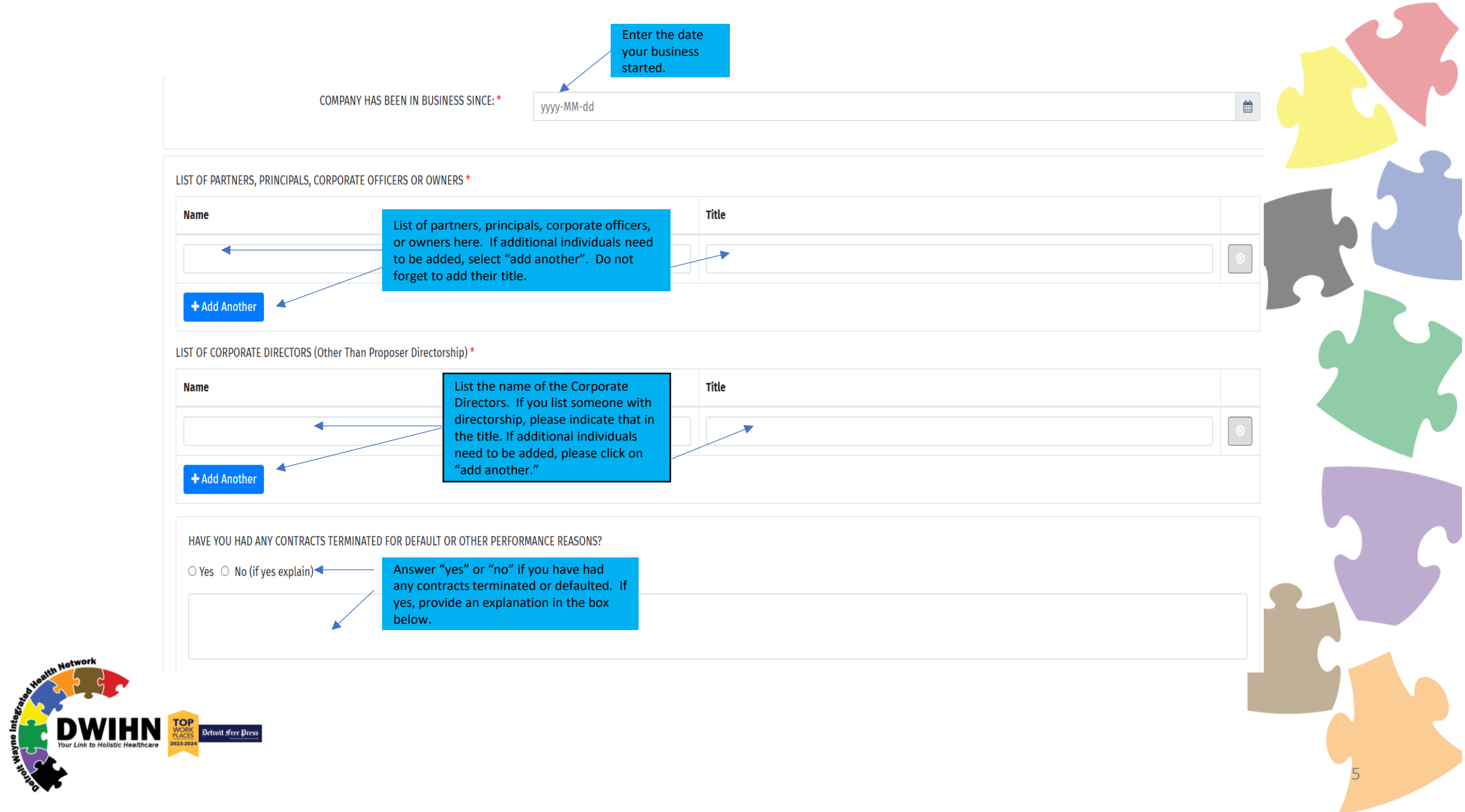
Please answer all questions.

If any question is not applicable to your company, please check not applicable.

BUSINESS INFORMATION QUESTIONNAIRE | DEBARMENT/SUSPENSION AGREEMENT AND CERTIFICATION | SUBCONTRACTOR LIST / FIRST TIER SUBCONTRACTOR DESIGNATION | ETHICS IN CONTRACTING VENDOR FORM | Disclosure Statement | Provider / Provider Entity Information | W9 and Insurance Certs

BUSINESS INFORMATION QUESTIONNAIRE




Enter the date your business started.
COMPANY HAS BEEN IN BUSINESS SINCE: *
yyyy-MM-dd
LIST OF PARTNERS, PRINCIPALS, CORPORATE OFFICERS OR OWNERS *
Name
Title
List of partners, principals, corporate officers, or owners here. If additional individuals need to be added, select "add another". Do not forget to add their title.
+ Add Another
LIST OF CORPORATE DIRECTORS (Other Than Proposer Directorship) *
Name
Title
List the name of the Corporate Directors. If you list someone with directorship, please indicate that in the title. If additional individuals need to be added, please click on "add another."
+ Add Another
HAVE YOU HAD ANY CONTRACTS TERMINATED FOR DEFAULT OR OTHER PERFORMANCE REASONS?
Yes
No (if yes explain)
Answer "yes" or "no" if you have had any contracts terminated or defaulted. If yes, provide an explanation in the box below.

REGISTRATION WITH SAM.GOV IS A REQUIREMENT.

PLEASE PROVIDE YOUR SAM UNIQUE ENTITY ID: *

PLEASE PROVIDE YOUR CAGE/NCAGE CODE: *

Include your SAM Unique Entity ID and 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)

Enter the name, address, and percentage of ownership of those holding 5% or more of the outstanding stock. If you need to add multiple stockholders, click the "add another button:

Name	Address	% of Ownership	
	Enter a location		

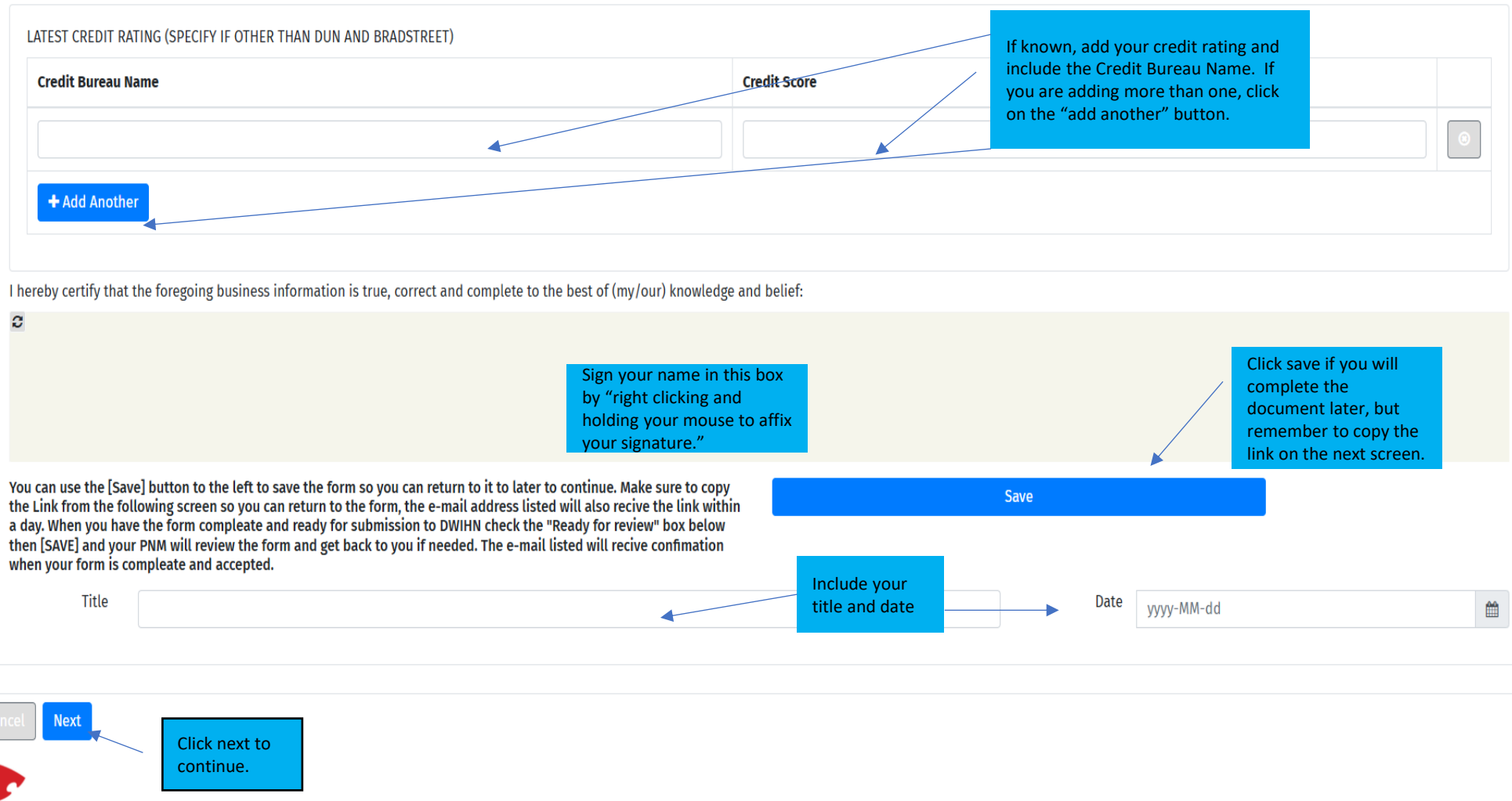
+ Add Another

FINANCIAL DISCLOSURE/CONFLICTSOFINTEREST: 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.

Include any financial disclosure.Conflicts of Interest in this box.

DWIHN Your Link to Holistic Healthcare

TOP WORK PLACES 2023-2024 Detroit Free Press


LATEST CREDIT RATING (SPECIFY IF OTHER THAN DUN AND BRADSTREET)
Credit Bureau Name
Credit Score
+ Add Another
If known, add your credit rating and include the Credit Bureau Name. If you are adding more than one, click on the “add another” button.
I hereby certify that the foregoing business information is true, correct and complete to the best of (my/our) knowledge and belief:
Sign your name in this box by “right clicking and holding your mouse to affix your signature.”
Click save if you will complete the document later, but remember to copy the link on the next screen.
You can use the [Save] button to the left to save the form so you can return to it to later to continue. Make sure to copy the Link from the following screen so you can return to the form, the e-mail address listed will also recive the link within a day. When you have the form compleate and ready for submission to DWIHN check the "Ready for review" box below then [SAVE] and your PNM will review the form and get back to you if needed. The e-mail listed will recive confimation when your form is compleate and accepted.
Save
Include your title and date
Title
Date
yyyy-MM-dd
Cancel
Next
Click next to continue.

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 several 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.

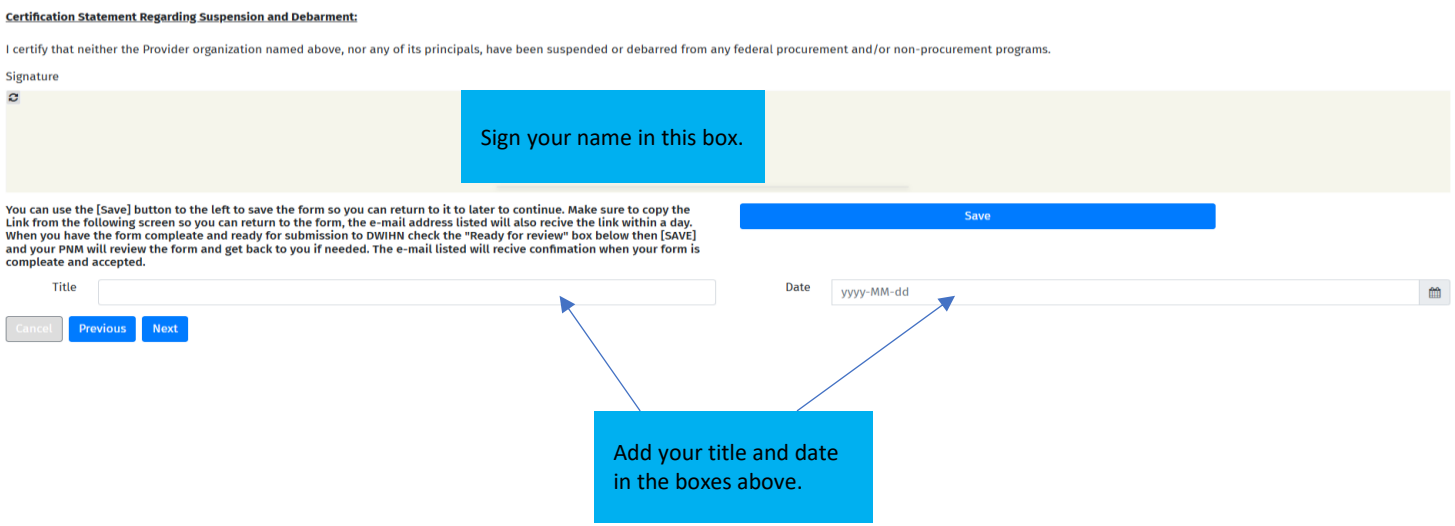
- The last page of the Debarment Suspension and Certification should have the authorized contract signer's signature and title.

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.


The Name of Provider will transfer from the first page, Contract Title, and Term Date: 10/1/2025 through 9/30/2026
Name of Provider
Training Demonstration
Contract Title
Term
yyyy-MM-dd
Through
yyyy-MM-dd


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 federal procurement and/or non-procurement programs.
Signature
Sign your name in this box.
You can use the [Save] button to the left to save the form so you can return to it to later to continue. Make sure to copy the Link from the following screen so you can return to the form, the e-mail address listed will also recive the link within a day. When you have the form compleate and ready for submission to DWIHN check the "Ready for review" box below then [SAVE] and your PNM will review the form and get back to you if needed. The e-mail listed will recive confimation when your form is compleate and accepted.
Save
Title
Date
yyyy-MM-dd
Cancel
Previous
Next
Add your title and date in the boxes above.

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)

Leave contract number blank.

2. CHEK ONE: This is a: SUPPLIES/SERVICES contract (OVER $50,000)? * ○ Yes ○ No

3. CHEK ONE: WILL SUBCONTRACTORS BE USED FOR THIS CONTRACT?? * ○ Yes ○ No

Select "Yes" or "No" if your contract is over $50 K and if your company will use Subcontractors.

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

Prime Company Name: *

Your company name should populate here.

Address *

Add Company Address Here.

County *

Add county here.

Authorized Contact Person: *

Add the person's name who will be signing the contract here.

Fed Tax ID: *

Add your Fed Tax ID here.

Phone Number *

Add Phone Number here.

FAX Number *

Add fax number here if applicable.

E-mail *

Add the email address of the signer here.

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.*

- Click on "Add Another" to add all Subcontractors that will be used. Please include the following information: Name, Fed Tax ID, Address, County, Authorized Contact, Phone Number, Fax Number, E-mail, Subcontract Amount, % of Contract, Purpose/Work to be performed, HTML. Save each submission (subcontractor) before adding the next one.

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

Name

Add the name and title of the person completing the form here.

Title

Signature

Sign your signature in this box and include the date

Date

yyyy-MM-dd

List of Subcontractors

Name
Fed Tax ID
Address
County
Authorized contact:
Phone Number
FAX Number
E-mail
Subcontract Amount:
% of Contract
Purpose / Work to be performed:
HTML

Save

Make sure all applicable areas are completed: Name, Fax, Email, EIN, Email Address, Address, County, Subcontract amount, County %of Contract, Authorized Contact, Purpose/Work to be performed, Phone number and HTML if applicable.

+ Add Another

If subcontractors will be used, click on the “Add Another” button to add all contractors. The form will expand.

Cancel | Previous | Next

Click next to move to the next section.

ETHICS

The ethics form consists of a series of questions that 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 #

(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.

1. Are you an immediate family member of a DWIHN employee? *

Add the Name, Relationship, Department, and Title of the DWIHN Employee who is your immediate family member.

Answer "Yes or No"

◉ 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

Add the name of any immediate family member of DWIHN who has been employed with your business within the previous twelve (12) months. Provide the Name, Department and 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

Have there been any discussions to hire an immediate family member of a contract manager within the previous twelve (12) months? Provide the Name, Department, and 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 ○

If Yes: Name

Department

Title

Do you and a contract manager have a substantial financial interest in a business venture? Provide the Name, Department, and Title

Ethics Certification

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

Print Name

Signature

Date

yyyy-MM-dd

Add the name of the person completing the form and today's date. Add your signature in the box below. Include the Company Name and Company Tax ID.

Company Name

Company Tax ID

Ethics Definitions

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

Immediate Family
Your Father, Mother, Son, Daughter, Brother, Sister, Uncle, Aunt, Great Aunt, Great Uncle, First Cousin, Nephew, Niece, Husband, Wife, Grandfather, Grandmother, Grandson, Granddaughter, Father-In-Law, Mother-In-Law, Son-in-Law, Daughter-In-Law, Brother-In- Law, Sister-In-Law, Stepfather, Stepmother, Stepson, Stepdaughter, Stepbrother, Stepsister, Half Brother, Half Sister, and including the Grandfather or Grandmother of an individual's Spouse. It shall also include a former spouse or an individual with whom the public servant has had a child in common.

Substantial Financial Interest

- Ownership of any interest or involvement in any relationship, which results in the receipt of $500 or more per year. Exceptions: Market-rate from a financial institution; income from the ownership of less than $10,000 of stocks and bonds traded on the national stock exchanges.

- Holding a key position in a business such as officer, director, trustee, partner or sales manager. Exceptions: Officers who serve without compensation on the boards of charitable organizations.

You can use the [Save] button to the left to save the form so you can return to it to later to continue. Make sure to copy the Link from the following screen so you can return to the form, the e-mail address listed will also recive the link within a day. When you have the form compleate and ready for submission to DWIHN check the "Ready for review" box below then [SAVE] and your PNM will review the form and get back to you if needed. The e-mail listed will recive confimation when your form is compleate and accepted.

Save

Cancel | Previous | Next

You can either "Save" the document to complete it later or, select "Next" to move to the next set of documents.

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 and CHIP, and provide services pursuant to a contract with a Medicaid Managed Care Organization.

Please follow the instructions in the form, then complete the acknowledgement below:

Acknowledgement

Type Name *

Type the Name of the person completing the form. Add signature in the box below, and date of completion.

Signature *

Date *

yyyy-MM-dd

You can use the [Save] button to the left to save the form so you can return to it to later to continue. Make sure to copy the Link from the following screen so you can return to the form, the e-mail address listed will also recive the link within a day. When you have the form compleate and ready for submission to DWIHN check the "Ready for review" box below then [SAVE] and your PNM will review the form and get back to you if needed. The e-mail listed will recive confimation when your form is compleate and accepted.

Save

Cancel Previous Next

Click “Next” to go to the next set of documents, or “Save” to complete later. Make sure to copy the link.

*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: *

- ○ Provider Entity
- ○ Licensed Independent Practitioner
- ○ Managing Employee
- ○ HCBS Provider
- ○ Other (enter below)

Choose one of the appropriate categories.

Group Affiliation?

○ Yes ○ No

Does your group have an affiliation? Select "yes or no." If "Yes" is selected, an additional question will populate to be answered.

Name of Provider/Provider Entity: *

Name of Person Completing this Form: *

Title *

Phone Number *

FAX Number *

E-mail *

In which state(s) do you participate in Medicaid? *

Add the name of the Provider/Provider Entity, Name of Person Completing this Form, Title, Phone Number, Fax Number (If Applicable), E-mail, and the State(s) that your company participates in Medicaid.

Additional Addresses (list all Practice Locations)

+ Add Another

Click "Add Another" for additional addresses (practice locations)

Section I: Individual Provider Ownership Information

Answer, “Yes”, No, or NA. If “Yes”, answer the questions below: Name of Owner, DOB, SSN, TIN or both as applicable, Complete Address, Interest. If additional owners need to be disclosed, click the “Add Another” button to continue. If “No” skip to Section II.

1. Are there any individuals or organizations with a Direct or Indirect Ownership Interest of 5% or more in your entity/practice?

◉ Yes ○ No ○ N/A

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

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).

Name of owner	DOB
	yyyy-MM-dd
Complete Address	SSN, TIN or both as applicable *
% Interest	**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

+ Add Another

Answer “Yes or No”. If “Yes”, complete the section below: Name of Other Provider or Entity; Other Provider or Entity SSN or TIN; Other Provider or Entity SSN or TIN. If additional disclosures are needed, click “Add Another”. If “No” Skip to Section III

Section II: Ownership in Other Providers & Entities

Does the Owner identified in Section I have an Ownership or Controlling Interest in any other provider or entity?

(•) Yes ( ) No ( ) N/A

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)).

Name of Other Provider or Entity	Other Provider or Entity's SSN (individual) or TIN (entity)	Other Provider or Entity's SSN (individual) or TIN (entity)

+ Add Another

Section III: Subcontractor Ownership

If you answered “Yes” for the Subcontractor Ownership, complete the section below: Legal Name of Subcontractor, Name of Subcontractor's Other Owner, Other Owners, Other Owners' Address, Other Owners' TIN, Other Owners' SSN, %Interest. If there are additional Owners, select “Add Another”. If “No,” go to Section IV.

Do you, as the Provider Entity, have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor?

(●) Yes ( ) No ( ) N/A

Does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor?

(●) Yes ( ) No

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).

Legal Name of Subcontractor:	Name of Subcontractors Other Owner
Other Owner’s :	Other Owner’s Address:
Other Owner’s TIN:	Other Owner’s SSN:
% Interest:	

+ Add Another

Section IV: Familial Relationships of All Owners

Are any of the individuals identified in Sections I, II, or III related to each other?

◉ Yes ○ No ○ N/A

If “No”” go to the next section.

List the individuals identified and the relationship to each other (e.g. spouse, domestic partner, sibling, parent, child) (42 CFR §455.104(b)(2).

Name of Owner 1	Name of Owner 2	Relationship	

+ Add Another

Click “Add Another” for additional Disclosures

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

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 ○ N/A

If no, go to Section VI.

List those persons and required information below. (42 CFR $455.436). Attach additional sheets necessary.

Name	DOB
	yyyy-MM-dd
Address	**SSN(Indiv.) or TIN(Entity)**
State of conviction	**Date of Conviction**
	yyyy-MM-dd
Matter of the offense	**Date of Reinstatement**
	yyyy-MM-dd

+ Add Another

Click "Add Another" for additional Disclosures

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 ○ N/A

If "No" go to the next question.

List those person and requirement information below. (42 CFR $455.436)

Name	DOB
	yyyy-MM-dd
Address	**SSN(Indiv.) or TIN(Entity)**
City, State, Zip	**List all states where currently excluded**
Reason for sanction exclusion or debarments:	**Date of Reinstatement**
	yyyy-MM-dd
Date(s) of sanctions exclusions or debarments	
yyyy-MM-dd	

+ Add Another

Click "Add Another" for additional Disclosures

Has the provider entity or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of the Provider Entity ever been terminated from participation in Medicaid, Medicare, CHIP or Title XX program?

◉ Yes ○ No ○ N/A

If "No" go to Section VI

List those person and requirement information below. (42 CFR $455.436)

Name	DOB
	yyyy-MM-dd
Address	SSN(Indiv.) or TIN(Entity)
City, State, Zip	Terminated from Medicare ○ Yes ○ No
Reason for termination:	Date of termination:
	yyyy-MM-dd
State that originated Termination:	Date of Re-instatement:
	yyyy-MM-dd

+ Add Another

Click "Add Another" for additional Disclosures

Section VI: Business Transaction Information

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
- ( ) N/A

If “No” go to the next question

List Of Sub-contractors

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

+ Add Another

Click “Add Another” for additional Disclosures

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
- ( ) N/A

If "No" go to the next section.

list the information for any Wholly Owned Supplier

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

+ Add Another

Click "Add Another" for additional Disclosures

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
- ( ) N/A

If “No” go to Section VII

list the information for Subcontractors

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

+ Add Another

Click “Add Another” for additional Disclosures

Section VII: Management and Control

Managing Employees: Does the Provider Entity have any Managing Employees?

- (•) Yes
- ( ) No
- ( ) N/A

If “No” go to the next question.

list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-dayoperations of Provider Entity (general manager, business manager, administrator or director)

Name	DOB
	yyyy-MM-dd
Complete Address	SSN
Title	

+ Add Another

Click “Add Another” for additional disclosures

Agents: Does the Provider Entity have any Agents

- (●) Yes
- ( ) No
- ( ) N/A

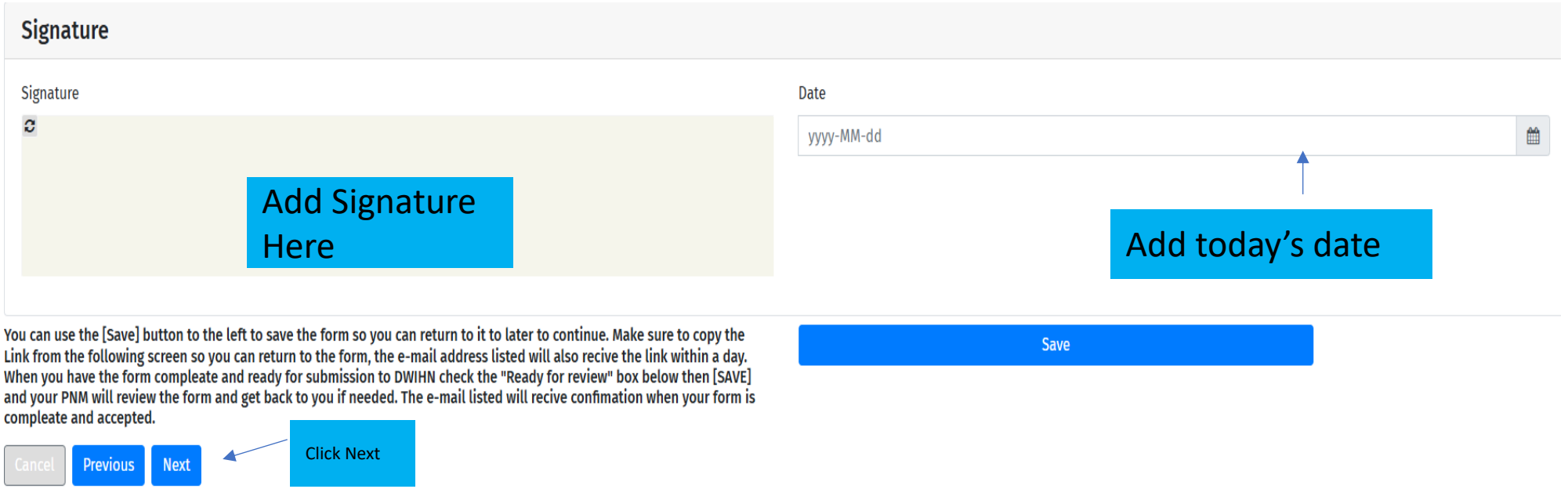
If “No” go to the Signature Section.

list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity

Name	DOB
	yyyy-MM-dd
SSN	Complete Address

+ Add Another

Click “Add Another” for additional disclosures


Signature
Signature
Add Signature Here
Date
yyyy-MM-dd
Add today's date
You can use the [Save] button to the left to save the form so you can return to it to later to continue. Make sure to copy the Link from the following screen so you can return to the form, the e-mail address listed will also recive the link within a day. When you have the form compleate and ready for submission to DWIHN check the "Ready for review" box below then [SAVE] and your PNM will review the form and get back to you if needed. The e-mail listed will recive confimation when your form is compleate and accepted.
Save
Cancel
Previous
Next
Click Next

Upload W9

File Name	Size
Drop files to attach, or browse	

Upload W9

Click here to download a fillable copy of the W9 from the IRS

Upload Liability Ins Cert

File Name	Size
Drop files to attach, or browse	

Upload COI, if there are separate Certificates, upload to the applicable tabs.

Upload Auto Ins Cert

File Name	Size
Drop files to attach, or browse	

additional insurance

You can use the [Save] button to the left to save the form so you can return to it to later to continue. Make sure to copy the Link from the following screen so you can return to the form, the e-mail address listed will also recive the link within a day. When you have the form compleate and ready for submission to DWIHN check the "Ready for review" box below then [SAVE] and your PNM will review the form and get back to you if needed. The e-mail listed will recive confimation when your form is compleate and accepted.

Save

☐ Ready for Review

Now that all the sections have been completed, click "Ready for Review" and "Save"

Your PNM will receive the document and provide feedback within 24 – 48 hours. If there are revisions needed, you will receive an email outlining the revisions that are needed. Or, you will receive an approval if all the documents are correct.

Instructions for Provider:

Please **do not click the Submit button** at the bottom of this page. The form will be submitted by your Provider Network Manager (PNM).

Once your form is ready for review, check the *Ready for Review* box and click the **Save** button.

Important: Once the Submit button is clicked, no further changes can be made. If revisions are needed after submission, you will need to start a new form.

The Submit button is for **PNM use only**.

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 a 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 the 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 that 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.

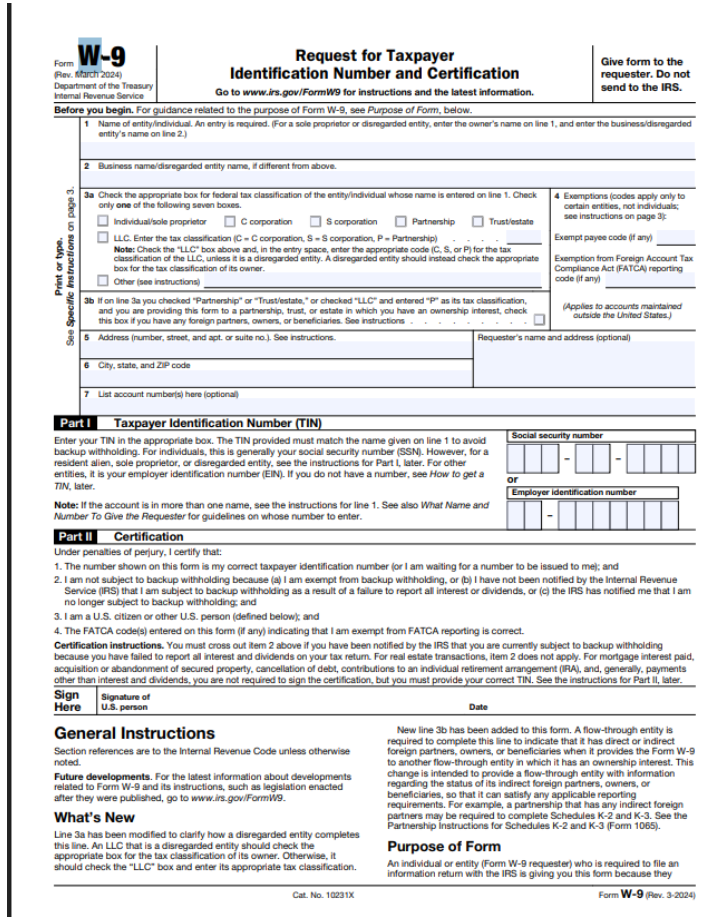
W9 (Continuation)

- 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.
- 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.

W9 (Continuation)

- 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.
- 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 business(es) 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.

W9



Form **W-9** (Rev. March 2024)
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.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

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

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead 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 Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____

(Applies to accounts maintained outside the United States.)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions ☐

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. See also *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*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

Cat. No. 10231X — Form **W-9** (Rev. 3-2024)

This form should be completed in its entirety. The correct form has the 2024 year on it.

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

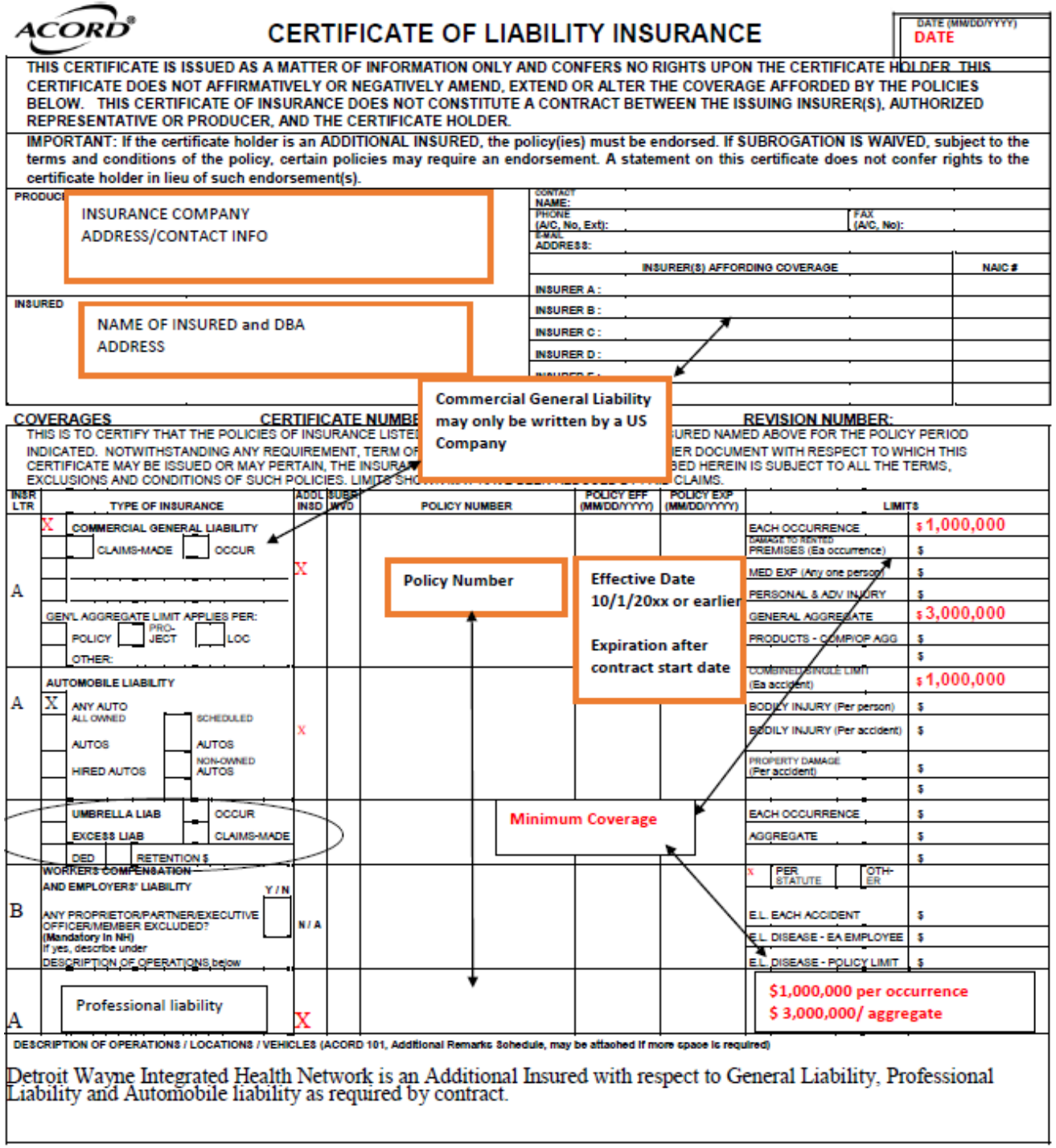
Workers Compensation	Provider shall maintain workers compensation insurance including Employer's Liability.	DWIHN	N/A – DWIHN is not an additional insured. In the certificate, Limits here should be 500,000 500,000 500,000 Or per statute
Property	If Provider has furnishings or equipment provided by or 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.



ACORD

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 NUMBE REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTE 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 BED 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 ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N If yes, describe under DESCRIPTION OF OPERATIONS below		N / A				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

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
- 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.