



Vendor/Provider Welcome

Thank you for participating in the Chanda Center for Health Remote Service Program, in collaboration with PALCO. Through this program, participants will receive access to therapies that would otherwise not be available. To get started, Palco will need to collect some enrollment documents from you. Once everything is processed, Palco will send you and the participant a notification that services can begin. Services cannot be delivered until approval. This packet will provide you with all the necessary enrollment forms and instructions for reimbursement. Please read all the enclosed information carefully and speak to Palco or the participant seeking your enrollment if you have questions.

Process Flow:

1. Complete Enrollment with Palco - Complete the enclosed forms and submit to Palco for processing.

The following forms are required:

- ☐ Vendor/Provider Information Form with License and Insurance Attachments
- ☐ IRS Form W-9
- ☐ Direct Deposit Agreement
- ☐ Participant and Vendor/Provider Services Agreement Form
- ☐ Consent to Provider Disability Competent

2. Review the Participants authorized services - Participants on this program are authorized for a specific number of services for the year. For example, acupuncture 1x/week and massage 1x every other week. Every participant's authorization will vary. It is important and the responsibility of each participant to monitor their utilization and not exceed the authorized amount of services given. If a participant were to exceed the authorized amount and program funds were depleted prematurely, they would be responsible for paying for the services out of pocket. The Participant Services Agreement Form will dictate the exact authorized amount of services that are approved and serve as an agreement between you and the Participant for how services will be scheduled. It will also dictate the exact reimbursement rate available for each modality based on Medicaid's allocated funding. This program does not pay for any missed or canceled appointments that necessitate a cancellation fee per your practice policies. Participants are aware of this, but please ensure you and the participant develop an agreement as last minute cancellations do occur when working with individuals with disabilities.

3. Receive approval from Palco and begin providing services - Once you have approval from Palco (via email), services can be provided. You will find enclosed instructions for submitting completed services to Palco for payment. You can also find the payment schedule enclosed.

4. Monitor utilization and payments - Palco will provide you access to the online portal for monitoring the amount of services a participant has remaining and to monitor your payments. At the end of the year, Palco will issue you a 1099 Form for tax purposes. Please ensure Palco is kept up to date if your contact details change at any time.

Once Palco receives all required forms from participant and vendor/provider, we'll send an effective start date, which is the date that treatments may begin. **DO NOT BEGIN TREATMENTS UNDER THE CHANDA CENTER FOR HEALTH/PALCO UNTIL YOU'VE RECEIVED AN EFFECTIVE START DATE FROM US.** An effective start date will be provided to you by email.

Vendor/Provider Information Form with License and Insurance Attachments

Complete this form entirely to begin the enrollment process as a Vendor/Provider in the Chanda Center for Health / Palco Remote Services Program.

PARTICIPANT INFORMATION		
Full Name	Palco ID	Program
		CHANDA CENTER

VENDOR/PROVIDER INFORMATION			
Name	FEIN or SS# of Payee		Date of Birth (mm/dd/yyyy)
Mailing Address (Street Address, Including Apt. #) – <i>if different than the physical address</i>			
City	State	Zip	County
Phone		Email	

VENDOR/PROVIDER QUESTIONS
What service(s) will you be providing? ☐ Acupuncture ☐ Chiropractic ☐ Massage Therapy
Would you like your information to be added to a provider directory maintained by Palco for the benefit of other clients seeking providers on this program? <i>(This does not necessitate a requirement to provide services.)</i> ☐ Yes ☐ No
To enroll in this program, you must submit the following documents for qualification. Please check off each document listed below to indicate it is attached. ☐ Copy of license to practice ☐ Proof of Liability Insurance with "Chanda Center for Health" added as additionally insured As your license and insurance renews, we will need a copy of the updated documents in order for you to remain an active vendor/provider. Please ensure this is done timely to avoid any delays in payment and/or termination of enrollment.

Note: Once enrollment is complete, you can provide services to other eligible program participants easily without a full re-enrollment. All that will be required is a Participant Services Agreement form on file for every participant you serve. Said agreement is required to be in place prior to rendering services.

BACKGROUND CHECKS

As part of program enrollment, Palco will run the following checks listed below to ensure you meet the requirements of being a vendor/provider of this program. By signing below, you give permission for Palco to run the below listed checks and to share the results with the Chanda Center for Health and program administrators if necessary. You understand that eligibility to become an approved vendor/provider is based on the outcome of these checks and that you cannot provide services, nor receive payment, until Palco has notified you that you have been cleared to do so. You hereby release the participant, Chanda Center, Palco, and his/her agents from any and all liability, claims and/or demands, of whatever kind, related to the compilation or preparation of the checks hereby authorized.

- ☒ Colorado Bureau of Investigation Criminal History Check
- ☒ Office of Inspector General Medicaid exclusion check.
- ☒ Colorado Board of Nursing (DORA) check

I understand and agree with my responsibilities as a vendor/provider in this program and enrolling with Palco. I consent to the required background checks as listed above and agree to keep Palco up to date with any license and insurance renewals within a timely manner.

Vendor Name

Vendor Signature

Date

Please return this form to Palco via email: enrollment@palcofirst.com or via fax to Toll free: 877.859.8757 local: 501.821.0045

Request for Taxpayer Identification Number and Certification

Give Form to the
requester. Do not
send to the IRS.

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. ☐ Individual/sole proprietor or single-member LLC ☐ 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) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
	6 City, state, and ZIP code	
	7 List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number										
				-				-		
or										
Employer identification number										
				-						

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ►	Date ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

Participant and Vendor/Provider Services Agreement Form

Participant Name: _____ **Palco ID:** _____

Vendor/Provider Name: _____

The Participant authorization for services is as follows for Adults on the CIH waiver:

Service	Authorized Frequency	Price Per Session
Acupuncture (97810 U1 SC)		\$68.95 per 60 minutes (4 units)
Massage Therapy (97124 U1 SC)		\$71.33 per 60 minutes (4 units)
Chiropractic (98942 U1 SC)		\$44.37 per 30 minutes (2 units)

The Participant authorization for services is as follows for Children on the CwCHN and CES waivers:

Service	Authorized Frequency	Price Per Session
Massage Therapy (97124 U1 SC)		\$71.33 per 60 minutes (4 units) Eligible for 24 hours or a max of 96 units per service plan year

Participant must complete the authorized frequency column based on the case manager's authorization for services. If a service listed here is not approved or is not applicable to this provider, write "N/A."

As a Participant of the Chanda Center for Health Remote Services program, I understand that I am responsible for recruiting and engaging all Vendors/Providers providing services to me. I understand I must manage scheduling in collaboration with my chosen vendor/provider and receive services in accordance with the authorized frequency set by my Case Manager and documented via my care plan.

Funds to pay for services provided by the worker are from public sources, and financial accountability and liability apply to the use of the funds. Both the Participant and Vendor/Provider have individual and joint responsibilities to be accountable for the funds spent through the program and understand that submitting false or fraudulent invoices or submitting requests for payment of goods or services provided, other than those approved and authorized will be reported to the appropriate authorities for investigation and possible prosecution as fraud. The vendor/provider agrees to be paid the "Price Per Session, based on the current approved reimbursement rates. As rates increase or decrease, both the participant and vendor/provider will be informed in advance of any change. In the case of insufficient funds to cover program expenses, the participant will be responsible for payment to the vendor/provider under state and federal laws. The participant must maintain accurate records

and provide such records to authorized parties as requested, as well as adhere to all program rules and regulations, including Chanda Center & Palco's Privacy Policies.

The program cannot pay for missed sessions, so all parties should review and communicate individualized cancelation policies. The Chanda Center for Health/Palco will not pay for any treatments received by the provider(s) or facilitate any collection of payments between the participant and vendor/provider after allocated funds have been depleted. The best way to avoid this is to follow the authorized frequency of services as outlined above. Any balance due for payment will be the responsibility of the participant.

The Provider agrees to the following:

- Participate in a fee for service system which results in a list of providers qualified to render support and services to individuals with individualized authorization service allocations for self-directed supports ("the recipient") this remote program. Chanda Center for Health/Palco will process payments in accordance with the service recipient's budget, funds, and authorized services for the program. Chanda Center for Health/Palco is not authorized to pay any request that exceeds the service recipient's budget and funds for the program.
- Maintain status as a qualified vendor/provider of services and by complying with all applicable federal, state, and local laws, rules and regulations regarding licenses, certifications, accreditations and/or other credentialing entities. Should any credentials be suspended or placed on probation, or experiences changes in contact person or business information, Palco will be notified within five (5) days. Qualification does not guarantee a contract, funding, or a particular fee for the provision of services to the recipient or others.
- Comply with fraud and mandatory abuse provisions of the state, as well as the False Claims Act and the Anti-Kickback Statute.
- Not subcontract any of the services committed to the recipient, as this agreement is not transferrable or assignable.
- Provide only the service outlined in the service description as well as adhere to the specified start date, end date, and unit of service as noted in the request for payment.
- Accept the reimbursement schedule for services rendered as set forth by the program as payment in full.
- Submit invoices/payment requests within 6 months of the date of service.
- Follow Chanda Center for Health/Palco instructions for submission of invoices and requests for payment.
- Maintain adequate financial, medical, and administrative records to fully justify and describe the nature and extent of all goods and services provided to the recipient for a minimum of seven (7) years and make available to Chanda Center/Palco when requested and protect confidentiality and security of all information in accordance with HIPAA and HITECH.
- Hold Chanda Center for Health/Palco harmless for all negligent acts of the provider and its agents, representatives, and assignees.
- Understand and acknowledge that Palco is NOT the vendor/provider's employer or contract holder and you are a contractor of the Chanda Center for Health.

By signing below, all parties attest that they have read, understand, agree, and attest to the above.

Printed Participant Name

Vendor Name

Participant/Legal Guardian Signature

Vendor Signature

Date

Date

Direct Deposit Authorization Agreement

Request Type (check one):

- ☐ New Account Setup ☐ Change in Existing Account ☐ Cancellation

Please allow up to five (5) business days for your request to be processed. The change will be effective on the on the next scheduled service period following the date the request is processed.

DIRECT DEPOSIT ACCOUNT INFORMATION		
Vendor/Provider Name		Program CHANDA CENTER
Financial Institution	Routing Number	Account Number
Type of Account (select one): ☐ Checking ☐ Savings ☐ Pre-paid card		

REQUIRED. The following validating documentation is attached:

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

OR

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

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

Printed Name

Signature

Date

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

Vendor/Provider Competency Requirements

Vendor/Provider Name: _____

As a Vendor/Provider of the Chanda Center for Health Remote Services Program, I understand that I am responsible for reviewing and completing training as it relates to

- Disability Etiquette
- Transfers
- Accommodations

The Chanda Center for Health in partnership with Palco has created a training library with resources on these topics. Please navigate to www.palcofirst.com/chanda-training to review the required materials. The password to enter the site is "chanda1". All vendors/providers must complete the review of the training modules before enrolling. Materials should be reviewed by all individuals within the vendor's organization or independent providers who will interact with program participants.

By signing below, I attest that as a vendor/provider of this program I have completed the required training modules and I understand, agree, and attest to the above information.

Vendor Name

Vendor Signature

Date