Reset Form

Vendor Address Change Request Form

Fill Out Completely and Submit To:
ResourceDevelopment@nlacrc.org

Vendor Name:			current vendor #:
Effective Date of Address Change: (must provide 60 days notice)			
Contact Information			
Phone:			Fax:
Cell Phone:			Email:
Old Address	☐ **Service/Office**	☐ **Mailing**	☐ **Both**
Street:			
City:	State:		Zip Code:
New Address	☐ **Service/Office**	☐ **Mailing**	☐ **Both**
Street:			
City:	State:		Zip Code:

Required Forms

The following are required to complete the address change process.

- ❒ DS 1890 Vendor Application / Profile
- ❒ Home and Community Based Services Provider
- ❒ W-9 Form (n/a for mailing address change)
- ❒ Electronic Billing Agreement (n/a for mailing address change)

By signing below, I certify that the above information is accurate and that I am authorized to sign on behalf of the aforementioned vendor.

Authorized Signature	Title
Name (please print)	Date

For Regional Center use only:		
Address in NLACRC catchment area?	❒ Yes	❒ No
Residential Vendor? *If yes, refer to Resource Development.*	❒ Yes	❒ No
❒ SANDIS address change complete	❒ VSN Comment	❒ VSN Printed
❒ Documents sent to vendor file	Date:	
❒ E-billing and W-9 Forms to Accounting	Date:	
❒ Address change tracker updated	Date:	

VENDOR APPLICATION

DS 1890 (Rev. 07/2011) (Electronic Version)

Applicant Name	Federal Tax ID or SSN * _ _ _
Name of Governing Body or Management Organization	

Mailing Address (Street)	(City)	(State)	(Zip)	(County)

Service Address *(If different than mailing address)* (Street)	(City)	(State)	(Zip)	(County)

Applicant *(owner or executive director)*	Telephone number ( )
Type of Service to be Provided	Facility Capacity

Identification of the type of consultants, subcontractors and community resources to be used by the vendor as part of its service

CERTIFICATION

I hereby certify to the best of my knowledge and belief, this information is true, correct, and complies with Title 17, Section 54310(a).

Applicant's Signature ▶	Date

INSTRUCTIONS

Please read the Department of Developmental Services California Code of Regulations, available from the regional centers, prior to completing this form. Type or print this form. Mail to the regional center serving your area.

Attach applicable information outlined in Title 17, Section 54310(a)(10)

(A) Any license, credential, registration or permit required for the performance of the service or operation of the program, or proof of application for such document;

(B) Any academic degree required for performance or operation of the service;

(C) Any waiver from licensure, registration, certification, credential, or permit from the responsible controlling agency;

(D) The proposed or existing program design as required in Section 56712 and Section 56762, if applicable, for applicants seeking vendorization as community-based day programs;

(E) The proposed or existing staff qualifications and duty statements as required in Sections 56722 and 56724 for applicants seeking vendorization as community-based day programs;

(F) The proposed or existing design as required in Section 56780 for applicants seeking vendorization as in-home respite services agencies;

(G) The proposed or existing staff qualifications and duty statements as required in Section 56792 for applicants seeking vendorization as in-home respite services agencies;

(H) The signed Home and Community-Based Services Provider Agreement with the Department of Health Services, if required.

** "Except for the Federal Tax ID or Social Security Number, all information provided by you on this form may be released to a member of the public pursuant to the Public Records Act, Section 6250 et seq. of the California Government Code."*

VENDOR APPLICANT PROFILE (please only submit either tax ID or SSN)

Federal Tax ID: ____–_____
or SSN: _____–__–_____

Applicant Name: (Agency or Individual)

Name of any governing body or management organization: **Type of Service to be provided:**

Mailing Address: (Street) (City) (State) (Zip)

Service Address: (Street) (City) (State) (Zip)

Telephone Number **Fax Number** **Emergency Telephone** **Facility Capacity:**

Contact Name: **Email Address:** **Languages Spoken by Staff:**

Type of Consultants, subcontractors and community services to be used (if not listed in service description):

Do you accept: MediCal? *Yes* ◯ *No* ◯ MediCare? *Yes* ◯ *No* ◯ Other insurance? *Yes* ◯ *No* ◯

How did you hear about the regional center?

Have you / Are you currently vendored with the regional center? (Please circle) *Yes* *No*
If yes, other services for which you are vendored:

Service/Program:	Vendor # and Service Code	Vendoring Regional Center
	—	Please click here to select one:
	—	Please click here to select one:
	—	Please click here to select one:
	—	Please click here to select one:
	—	Please click here to select one:

CERTIFICATION:

I hereby certify to the best of my knowledge and belief, this information is true, correct and complies with Title 17, Section 54310(a).

Applicant's Signature:_____ **Date**: _____

Print Name: _____ **Title**: _____

Reset Form Save As

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)

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 . . . . . ☐

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.)

5 Address (number, street, and apt. or suite no.). See instructions.

6 City, state, and ZIP code

Requester's name and address (optional)
North Los Angele County Regional Center
9200 Oakdale Avenue, Suite 100
Chatsworth, CA 91311

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

HOME AND COMMUNITY BASED-SERVICES PROVIDER AGREEMENT

Name of Service Provider *(Please type or print)*

Address

Telephone	Vendor Number	To be completed by Regional Center only.	Service Code	To be completed by Regional Center only.

CERTIFICATION STATEMENT

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center clients have been provided to the clients by the Provider. The services were, to the best of the Provider's knowledge, provided in accordance with the client's written Individual Program Plan. The Provider shall also certify that all information submitted to the regional center is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

THE PROVIDER AGREES TO INCLUDE WITH EACH CLAIM SUBMITTED TO THE REGIONAL CENTER A CERTIFICATION STATEMENT TO THE ABOVE TERMS AND CONDITIONS WHICH SHALL BE PRINTED ON THE REVERSE SIDE OF EACH PROVIDER OF CARE CLAIM FORM.

I certify that the undersigned will be A PARTICIPATING provider of Medi-Cal home and community-based services upon SUBMISSION OF THIS AGREEMENT TO THE REGIONAL CENTER and satisfaction of all vendorization requirements pursuant to Title 17, California Code of Regulations, and compliance with the requirements for providers of service set out in Welfare and Institutions Code, Division 9, Part 3, and in California Code of Regulations, Title 22.

Department of Health Services

This form does not indicate that you are a Medi-Cal provider, but that you are aware regional center receives reimbursement from Medi-Cal for specific services.
YOUR SIGNATURE IS MANDATORY.

Signature of Service Provider	Date

(Rev. 6/99)

ENROLLMENT PROCESS

eBilling, eAttendance & EFT Payment Processing Agreement

Form Instructions

Every service provider organization must appoint a representative who will administer user accounts for those employees requiring access to the eBilling web based application, and that representative must complete the agreement form in its entirety and submit it to the appropriate regional center for registration and access. Each service provider organization will be responsible for maintaining security agreements with those employees accessing the eBilling application.

The Provider must sign the agreement form and return it to the regional center to complete the enrollment process before the representative will be granted administrative access to the eBilling application. All pages must be returned.

Upon termination of a service provider organization's employee, it is the responsibility of the service provider representative to terminate access for that user account. When the service provider representative is voluntarily or involuntarily terminated from employment, the service provider organization must notify the regional center of this termination within 24 hours to have access removed.

A copy of the entire provider enrollment form must be kept on file at the regional center. Copies may be made if necessary.

ENROLLMENT PROCESS

Regional Center Provider Electronic Billing Agreement Form

A separate agreement form must be completed for each Service Provider Number (SPN).

Service Provider Name | Service Provider Number

To be completed by Regional Center only.

Name of Governing Body or Management Organization

Mailing Address (Street) (City) (State) (Zip)

Service Address (Street) (City) (State) (Zip)
(If different than Mailing Address)

Telephone Number

Email Address

To be completed by Regional Center Staff

Service Code | Sub-Code | Checkbox Calendar(Y/N) | Type (Y/N/I/P) ★

To be completed by Regional Center, please leave blank.

ENROLLMENT PROCESS

Provider EFT/EB/EA Information

Provider Name	Service Provider Number To be completed by Regional Center only.
Bank Name (Primary Account)	Bank Name (P & I Account)*
Bank Routing Number (Primary Account)	Bank Routing Number (P & I Account)
Account Number (Primary Account)	Account Number (P & I Account)
Account Type (Checking or Savings: Primary Account) Please select one:	Account Type (Checking or Savings: P & I Account) Please select one:
Mail check remittance advice? (Yes or No)** ○ ○	Mail check remittance advice? (Yes or No)** ○ ○
Starting date for EFT processing	Start date for EB Processing
Approved at Regional Center by To be completed by Regional Center only.	Date

Only for Residential Facilities to receive P & I funds.

*Second Bank Account, for P & I, should be used by Residential Facilities for the purpose of receiving Personal & Incidental funds for the customers.

**If you want a printed copy of your detail EFT transactions, answer yes to Mail Check Remittance Advice.

Please submit a voided check and a W-9 form with this request.

Residential facilities need to submit 2 voided checks to confirm both the primary and P&I bank accounts.

Reset Form Save As

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)

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 . . . . . ☐

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.)

5 Address (number, street, and apt. or suite no.). See instructions.

6 City, state, and ZIP code

Requester's name and address (optional)
North Los Angele County Regional Center
9200 Oakdale Avenue, Suite 100
Chatsworth, CA 91311

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

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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

ENROLLMENT PROCESS

Service Provider Administrator User Security Information

Provider Name | Service Provider Number

To be completed by Regional Center only.

User Name (First) (Last) (MI)

User ID | User Password (at least 6 characters in length, numbers and characters ok) *

* Note – Password must be reset upon initial logon to eBilling

Original signature here.

Provider Signature | Telephone | Date

To be completed by Regional Center, please leave blank.

ENROLLMENT PROCESS

Regional Center Provider Electronic Billing Agreement Form

1. CLAIMS ACCEPTANCE AND PROCESSING

The regional center agrees to accept from the enrolled Provider electronic invoices. The Provider hereby acknowledges that he or she has received and read and understands and agrees to abide by the EB provider manual and its contents, and agrees to read and comply with all EB provider manual updates and provider bulletins relating to electronic billing.

2. CLAIMS CERTIFICATION

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center consumers have been provided to the consumers by the Provider. The services were, to the best of Provider's knowledge, provided in accordance with the consumer's written Individual Program Plan. The Provider shall certify that all information submitted to the regional center is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of five years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the consumer. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

I certify that the consumer(s) submitted through the electronic process were provided the services as authorized for the stated periods, and that no additional charges were made to other parties. These claims are submitted under penalty of perjury in accordance with the Medi-Cal program Provider Agreement Claim Certification.

3. VERIFICATION OF CLAIMS WITH SOURCE DOCUMENTS

The Provider agrees to retain personal responsibility for the development, transcription, data entry, and transmittal of all invoice information for payment. The Provider shall also assume personal responsibility for verification of submitted invoices with source documents. The Provider agrees that no invoice shall be submitted until the required source documentation is completed and made readily retrievable in accordance with Medi-Cal statutes and regulations. Failure to make, maintain, or produce source documents shall be cause for immediate termination of electronic billing privileges.

4. CHANGE IN ELECTRONIC BILLING STATUS

The Provider and the Regional Center agree that any changes in Provider status which might affect eligibility to participate in electronic billing pursuant to federal and state law shall be promptly communicated to each party.

5. PROVIDER REVIEWS

The Provider agrees that agents of the Regional Center, the Department of Developmental Services, the Department of Health Services, the Office of the State Controller, the Department of Justice, or any other authorized agent or representative of the State of California or any authorized representative of the U.S. Department of Health and Human Services may, from time to time, conduct such reviews as are necessary to ensure compliance with state and federal law and with this agreement. In particular, the Provider agrees to make available to such agent or representative

all source documents necessary to verify the accuracy and completeness of invoices submitted electronically.

6. EFFECTIVE DATE
This agreement shall become effective upon approval of the Regional Center.

7. TERMINATION
The Department, Regional Center or Provider may terminate this agreement with or without cause by giving seven days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department or Regional Center. The Department or Regional Center may, however, terminate this agreement immediately upon determination that the Provider has failed or refused to produce or retain source documents in accordance with federal and state laws or this agreement or has violated other provisions of the provider agreement.

8. PROVIDER TO HOLD REGIONAL CENTER AND STATE OF CALIFORNIA HARMLESS
The provider agrees to hold the Regional Center and the State of California harmless for any and all failures performed by billing software, or other features of electronic billing which do not occur with (hard copy) paper billing. The provider agrees that the provider is assuming any and all risks that accompany electronic billing and that the provider is not relying upon the evaluation, if any, that the State of California or Regional Center has made of the electronic billing system or software the provider is using.

9. CONFIDENTIALITY OF RECORD
The Provider agrees to provide adequate precautions to protect the confidentiality of Consumer information in accordance with Welfare and Institutions Code section 4514, Health Insurance Portability and Accountability Act (HIPAA), and all other applicable state and federal statutes and regulations regarding confidentiality of consumer information.

Provider Signature Information

Full Printed Name | Title

Provider Signature | Telephone | Date

Regional Center Approval of Enrollment

To be completed by Regional Center,
please leave blank.

Return Provider Agreement to the Regional Center

Save As