San Diego Regional Center
4355 Ruffin Road, San Diego, CA 92123
858-576-2996 / www.sdrc.org
Serving individuals with developmental disabilities in San Diego and Imperial Counties

E-Billing, E-Attendance & EFT Payment Processing Agreement

Enrollment Process:
An administrator must be established in every service provider organization. The role of the administrator is:

1) To determine which employees within the organization will have access and submission rights in the eBilling/eAttendance application.

2) To be responsible for deactivating user access for employees who terminate employment with the service provider organization. Each organization's authorized representative must notify the regional center of changes or deactivations of administrator assignments within 24 hours.

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.

If the service provider organization is currently enrolled in Electronic Funds Transfer (EFT), you may ignore Page 3, unless there are changes to report.

Service providers may return completed and signed enrollment packets by email to your assigned Community Services Resource Coordinator.

Please indicate below whether you have received prior training or are currently using the E-billing system with another regional center.

☐ We have NOT received prior E-billing training nor are we using the E-Billing system with another regional center.

☐ We are CURRENTLY USING the E-billing system with another regional center.

ENROLLMENT PROCESS

San Diego Regional Center Billing Agreement Form

A separate agreement form must be completed for each Tax Identification Number (TIN)

Service Provider Name _____ TIN # _____

Name of Governing Body or Management Organization _____

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

Service Address (if different from Mailing Address) (Street) (City) (State) (Zip) _____

Email Address _____

Telephone No. and Contact Person _____

Please list all Service Provider numbers associated with the Tax ID#:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENROLLMENT PROCESS

Provider EFT Information

Service Provider Name	Service Provider Number
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 (Primary Account)	Account Type (Checking: P & I Account
Service Provider SSN or TIN	Email Address
Authorized Representative Name (Please print)	Authorized Signature Date
Approved at Regional Center By	Date

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

Please attach a voided check and W-9 form and allow 30 days for EFT set up to be completed.

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:

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

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

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 the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

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).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

ENROLLMENT PROCESS

Service Provider Administrator User Security Information

Provider Name

User Name (First, Last, M.I.)

User E-Mail Address Business Phone No. Cell Phone No.

User ID ***PASSWORD** *Use this password for your first login

*Note – password must be reset upon initial logon to Ebilling (at least 6 characters in length, numbers and character are ok)

Provider Signature

For Regional Center Use Only

Updated by RC Administrator Date

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. Failures 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 OFCALIFORNIA 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.

Administrator Signature Information

Administrator Name (Please print) Title

Administrator Signature Email Address Date

Regional Center Confirmation of Enrollment (Regional Center Use Only)

Profile Created by Title Date

Approved by Title Date

Return Provider Agreement to your Assigned Resource Coordinator