

Hello,

We are happy to welcome you as a potential new vendor to Easterseals New Jersey. Easterseals New Jersey is a fiscal intermediary for individuals with intellectual/developmental disabilities who are self-directing their services. We will be responsible for ensuring the services provided are in alignment with their Plan of Care as well as issuing payment to you in a timely manner.

You are receiving this email because you have been identified as a vendor for fitness, to an individual with a self-directing plan of care. Before we can issue payment to you there are requirements that will need to be met.

Our communication to you is based solely on your business being identified in an individual's Plan of Care for services. If you are interested in becoming a vendor for our entire organization, please note that the payment process and terms will be different (30 days).

Vendor Set-up Requirements

To be set up as a new vendor, we need the following information:

- Federal Income Tax Law requires that we have your **Taxpayer Identification Number (TIN)** on file. Under Federal Regulation I, 604-1, you are required to provide us with this information on the W-9 form included in this email. If you fail to furnish us with this information, the IRS may impose a \$500.00 penalty under Section 6723 and all payments we make to your company could be subject to a 30% backup withholding. For this reason, any vendor who does not supply us with the completed form will not be added as a vendor to our database. If you do business as an individual or sole proprietor, your TIN is your social security number; otherwise, your Federal Employer Identification Number serves as your TIN.
- Easterseals New Jersey requires that specific criteria be met with respect to **General Liability and Worker's Compensation insurance coverage**. If you are providing any contracted service to one of our locations you must maintain at least \$1,000,000 in general liability coverage. The type of service you will be providing will determine if you will also need that amount for coverage of Worker's Compensation or Automobile Insurance. Invoices will not be paid without proper proof of insurance.

Service Criteria

In addition, there are specific licensing qualifications and certification standards set forth in DDD program manuals with which the service provider must comply. Attached is a detailed description of the type of service you have been authorized to provide in the individual's Plan of Care. The following link(s) will give you more service criteria information.

<https://nj.gov/humanservices/ddd/documents/supports-program-policy-manual.pdf>

Supports Program Policy Manual

<https://www.state.nj.us/humanservices/ddd/documents/community-care-program-policy-manual.pdf>

Community Care Program Policy Manual

The following must appear in the Certificate Holder area:

Easterseals New Jersey
25 Kennedy Blvd., Suite 600
East Brunswick, NJ 08816

Electronic Funds Transfer (EFT)

Our terms of payment for self-directing individuals (10 business days of receipt) are through electronic funds transfer, with the exception of your first payment. This enables an efficient and timely payment process. Attached you will find our EFT Transmittal Form to be completed and sent along with other completed paperwork. If your organization does not provide the necessary banking information, our terms of payment will be extended to 15 days. There is all potential you may not be accepted as an organizational vendor.

If you have any questions, please do not hesitate to contact our Customer Service Representatives at 800-471-3086

Kind Regards



Easterseals New Jersey
25 Kennedy Boulevard, Suite 600
East Brunswick, NJ 08816
732.257.6662 phone
732.257.7373 fax
eastersealsnj.org

To: Easter Seals New Jersey Suppliers

Subject: Electronic Funds Transfer (EFT)

After reviewing our internal A/P process and in an effort to improve the efficiencies and reliability of processing payments to our Suppliers we propose the following change:

Easter Seals New Jersey will be moving to Electronic Funds Transfer (EFT), in lieu of paper checks, for the payment of invoices. This change to EFT will ensure prompt, timely payment to our valued suppliers while at the same time eliminating the need for our suppliers to wait for payments via the US Mail and having to manually process paper checks through their banks.

We thank you in advance for complying with this request and appreciate your choice to partner with our company.

Sincerely,

Toni Nuzzo
Purchasing Dept.
732.812.6142

Vendor Request Form

Vendor Addition Request Form

Requestor Name *	<u>Easterseals NJ</u>	Request Date	<u>9/15/2021</u>
Requestor Phone	<u>732-812-6093</u>	Email*	<u>awcpurchasing@nj.easterseals.com</u>
Vendor Offers	<input type="checkbox"/> Software License (HSD, CBN, CATV, VoIP) <input type="checkbox"/> Services <input type="checkbox"/> Software License – Internal Use		

Vendor Name * _____

Contact Person * _____

<u>Banking Information*</u>	<u>Remittance Address</u>	
ABA (Routing #)* _____	Address 1 * _____	
Account #* _____	Address 2 _____	
Type of Account* _____	City * _____	
Bank Name* _____	State * _____	
Phone _____	Country * _____	
Contact Name _____	Zip Code * _____	
Phone * _____	Business Type	
Fax * _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Limited Liability Company (LLC)
E-mail * _____	<input type="checkbox"/> Partnership	
Payment Terms* _____	<input type="checkbox"/> Government	
Federal Tax ID* _____	<input type="checkbox"/> Sole Proprietor (individual)	

*DENOTES
REQUIRED FIELD

Internal use:
Call Back Date:
Call Back Contact:

Vendor Authorized representative _____	Date _____
Procurement Coordinator _____	Date _____
AVP _____	Date _____

Email Completed form along with W-9 and Certificate of Liability Insurance to
awcpurchasing@nj.easterseals.com or fax 732.257.0759

Certificate of Liability Insurance (COI)

Attached is a copy of the Certificate of Liability Insurance (COI) which must be completed by you Insurance Agency. Please contact your Insurance Agent and request a COI form be filled out on your behalf. Once the form has been completed, please attach the document here.

Thank you.

Example Certificate of Liability Insurance (COI)

DATE (MM/DD/YYYY)

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	CONTACT NAME: PHONE (A/C. No. Ext): FAX (A/C. No): E-MAIL ADDRESS: INSURER(S) AFFORDING COVERAGE NAIC #
INSURED	INSURER A : INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR Broad Form Property Damage Blanket Contractual GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y / N If yes, describe under DESCRIPTION OF OPERATIONS below			N / A			WC STATUTORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

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

CERTIFICATE HOLDER

CANCELLATION

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