Fiscal Agent Program -- Vendor

Referral Processing Contacts

Please complete all forms and return as soon as possible to be sure you are paid/reimbursed timely.

Beth F. Phone Extension: 279 Email: beth.flansburg@lkichoice.com	**Jenny J.** Phone Extension: 219 Email: jennifer.jeidy@lkichoice.com
Jessica B. Phone Extension: 281 Email: jessica.brewer@lkichoice.com	**Tricia H.** Phone Extension: 250 Email: tricia.hummel@lkichoice.com

- **Please call with any questions regarding these forms or the process on how you will be paid/reimbursed.**

Note(s):

Main # **1-608-326-0434**
Toll Free Phone # **1-844-534-7225**
Toll Free Fax # **1-844-634-7225**
Email payroll@lkichoice.com

106 S Beaumont Road
Prairie du Chien, WI 53821
Website Portal: www.lkichoice.com

Form **W-9**
(Rev. October 2018)
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.

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 ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ 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) ________

(Applies to accounts maintained outside the U.S.)

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.*

COMPLETE AND RETURN

Payroll Information Form

Name: _______________________________________ Phone Number: _________________

Address: ____

Email Address (Required for EVV): ____

Please check all that apply:

- ☐ **Receive paystub via email**
- ☐ **Secure Email** - Allows you to send timesheets or other information securely.
- ☐ **Web Entry** Allows you to submit payroll hours using our Web Entry Portal, both you and the Member/Employer will need to have an email and agree to utilize Web Entry.
- ☐ **Direct Deposit* -** Complete below sections. You may also include a Voided Check.
- ☐ **Paper Check –** no direct deposit, mail check

**With direct deposit, Employees have their pay directly deposited in their account on payday rather than waiting for a check to arrive in the mail.*

Name of Bank: ____

Action to be taken: ☐New Deposit Authorization ☐Change from previous authorization

Type of Account: ☐Checking ☐Savings Amount: ____________%

Account #: ____

9-Digit Routing #: ____

***For Multiple Accounts:**

Name of Bank: ____

Action to be taken: ☐New Deposit Authorization ☐Change from previous authorization

Type of Account: ☐Checking ☐Savings Amount: ____________%

Account #: ____

9-Digit Routing #: ____

LKiChoice, a division of Lori Knapp Richland, Inc., is authorized to directly deposit my pay to the account(s) identified in this document, which include my signature and date. Authorization will remain in effect until I modify, cancel in writing, or employment terminates.

✓ Employee Signature: ________________________________ Date: _____________________

LKiChoice
106 S. Beaumont Rd.
Prairie du Chien WI 53821
Fax: 844-634-7225
Phone: 608-326-0434

Lori Knapp Richland, Inc.
www.lkichoice.com

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Phone Number	
Address – Street	City	State	Zip Code

The above-referenced provider of home and community-based waiver services under Wisconsin's Medicaid program, hereinafter referred to as the provider, hereby agrees and acknowledges as follows:

1. To provide only the items or services authorized by the managed care organization or IRIS program.
2. To accept the payment issued by the managed care organization or IRIS program as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the managed care organization or IRIS program.
5. To keep any records necessary to disclose the extent of services provided consistent with the provider's business type.
6. To provide, upon request by the managed care organization, the IRIS program, or the Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program including the caregiver background check law.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants **for a period of ten (10) years** and to furnish upon request to the DHS, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. This requirement includes retaining all records and documents according to the terms provided by Wis. Admin. Code § DHS 106.02(a)-(d); (f)-(g).
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the managed care organization and upon request, to the Department in writing:

    a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

    b) The names and addresses of all persons who have a controlling interest in the provider;

c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;

d) The names and addresses of any subcontractors who have had business transactions with the provider;

e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.

12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.
13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.
14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

Modifications to this agreement cannot and will not be agreed to. Altering this agreement in any way voids the Department of Health Services' signature. This agreement is not transferable or assignable.

Name – Provider (Typed or Printed)	
SIGNATURE – Provider	Date Signed

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)	
SIGNATURE – Department of Health Services	Date Signed 8/14/17

LKiChoice

Fiscal Agent Program

Payroll Processing Contacts

Your Payroll Specialist is marked below

Deb M. Phone Extension: 230	**Jayne M.** Phone Extension: 205
Julie M. Phone Extension: 265	**Justina K.** Phone Extension: 264
Michelle C. Phone Extension: 203	**Sarah T.** Phone Extension: 282
Tammy H. Phone Extension: 206	***Electronic Visit Verification (EVV)*** **Beth AP** Phone Extension: 284

Items to remember when completing timesheet:

- Work weeks run from Sunday to Saturday and so does your authorized hours, miles, or services
- Must have in and out times for each shift listed. Hours are paid in quarter hours.
- Stay within your authorized hours, miles, or services. If unsure of what your authorized hours are or what your service code is, please call your Payroll Specialist.
- Write clearly and in dark blue or black ink only and enter only one shift per line
- When working past midnight, start a new line for the new workday
- Don't write over numbers already written on timesheet. If you make an error place a line through it, initial, and write clearly next to it or on a new line.
- Have the Member/Legal Rep and Employee sign off on the timesheet after all days of service have been worked for that pay period. Date the signatures for the same date as the signatures were written.
- Put total number of hours worked on each individual timesheet
- Check your correct Funding Source at the bottom of all timesheets. If unsure of Funding Source contact your Payroll Specialist.

Main # **1-608-326-0434**
Toll Free Phone # **1-844-534-7225**
Toll Free Fax # **1-844-634-7225**
Email payroll@lkichoice.com

106 S Beaumont Road
Prairie du Chien, WI 53821
Website Portal: www.lkichoice.com

FOR YOUR INFORMATION

2022 Time Reports & Pay Schedule Information

A Time Report is a *payroll time sheet* submitted to LKiChoice on a scheduled basis by providers/employees of the Self-Directed Supports/Fiscal Agent Programs.

After you complete work on the following day … **(Pay Period)**	Ensure that your Time Report(s) are at the Prairie du Chien Office by … **(Time Report Due Date)**	So that you are PAID on the following date via Direct Deposit: **(Pay Date)**
12/16/2021 to 12/31/2021	*01/05/2022*	**01/14/2022**
01/01/2022 to 01/15/2022	*01/20/2022*	**01/28/2022**
01/16/2022 to 01/31/2022	*02/04/2022*	**02/15/2022**
02/01/2022 to 02/15/2022	*02/18/2022*	**02/28/2022**
02/16/2022 to 02/28/2022	*03/04/2022*	**03/15/2022**
03/01/2022 to 03/15/2022	*03/18/2022*	**03/30/2022**
03/16/2022 to 03/31/2022	*04/05/2022*	**04/15/2022**
04/01/2022 to 04/15/2022	*04/20/2022*	**04/29/2022**
04/16/2022 to 04/30/2022	*05/05/2022*	**05/13/2022**
05/01/2022 to 05/15/2022	*05/19/2022*	**05/27/2022**
05/16/2022 to 05/31/2022	*06/03/2022*	**06/15/2022**
06/01/2022 to 06/15/2022	*06/20/2022*	**06/30/2022**
06/16/2022 to 06/30/2022	*07/05/2022*	**07/15/2022**
07/01/2022 to 07/15/2022	*07/20/2022*	**07/29/2022**
07/16/2022 to 07/31/2022	*08/05/2022*	**08/15/2022**
08/01/2022 to 08/15/2022	*08/19/2022*	**08/30/2022**
08/16/2022 to 08/31/2022	*09/06/2022*	**09/15/2022**
09/01/2022 to 09/15/2022	*09/20/2022*	**09/30/2022**
09/16/2022 to 09/30/2022	*10/05/2022*	**10/14/2022**
10/01/2022 to 10/15/2022	*10/20/2022*	**10/28/2022**
10/16/2022 to 10/31/2022	*11/04/2022*	**11/15/2022**
11/01/2022 to 11/15/2022	*11/18/2022*	**11/30/2022**
11/16/2022 to 11/30/2022	*12/05/2022*	**12/15/2022**
12/01/2022 to 12/15/2022	*12/20/2022*	**12/30/2022**

Payment dates for hours worked and if timely submission of your time report:

- **between the 1st and the 15th of a month**, payment will be the 30th day of the same month
- **between the 16th and the 31st of a month**, payment will be the 15th day of the following (next) month

LATE TIME REPORTS: Time Reports received *after* the date indicated in the column titled **"Time Report Due Date"** will be processed in the next pay period. **No Exceptions.**

FORMS & SUBMISSION – Questions call 608-326-0434

- Forms are available on our Fiscal Agent Services website: **www.lkichoice.com**
- Faxing your Time Report: **(844) 634-7225** – Must call 608-326-0434 to assure fax is received.
- Mailing your Time Report: **106 S Beaumont Road, Prairie du Chien, WI 53821**
- Emailing your Time Report: **payroll@lkichoice.com**

LKiChoice

106 S. Beaumont Rd.
Prairie du Chien WI 53821
Fax: 844-634-7225
Phone: 608-326-0434

Division of Lori Knapp Richland, Inc.
www.lkichoice.com

Participant Check Request

Member Name: ________________________ Member Phone Number: ______________

Pay to:
Vendor Name: _________________________Vendor Phone: ______________________

Vendor Address: ____

____

Services and supplies may only be paid up to the authorized amount.

Description of Purchases or Services:____	
Dates of Service or Purchases (If applicable please send receipts for purchases):	
_____/_____/_____ $_______________	_____/_____/_____ $_______________
_____/_____/_____ $_______________	_____/_____/_____ $_______________
_____/_____/_____ $_______________	_____/_____/_____ $_______________
_____/_____/_____ $_______________	_____/_____/_____ $_______________
_____/_____/_____ $_______________	_____/_____/_____ $_______________
_____/_____/_____ $_______________	_____/_____/_____ $_______________
# of units: __________ Unit Rate: $__________ Total: $__________	

Approved: _____________________________ Date: ________________
Member Signature

Approved: _____________________________ Date: ________________
Vendor Signature

Please check your Funding Source:

❑MyChoice/Care (MCW) **❑ Independent Care - iCare** **❑Inclusa** **❑ Lakeland Care Inc**

❑ Menominee ITOW **❑CLTS County:** ____________________ **❑Other:** ____________________

*It is your responsibility to verify that your completed and accurate check request has been received by LKiChoice once you submit via mail, fax, or email. Please call us at **1-844-534-7225** to verify your timesheet(s) has been received.*

Submit Mileage Log to: LKiChoice @ 106 S Beaumont Rd Prairie du Chien, WI 53821 Fax: 844-634-7225
Payroll email: payroll@lkichoice.com For questions please call 844-534-7225 Website: www.lkichoice.com

Participant Check Request

Member Name: ______________________ Member Phone Number: _____________

Pay to:
Vendor Name: ________________________ Vendor Phone: _____________________

Vendor Address: ____

____

Services and supplies may only be paid up to the authorized amount.

Description of Purchases or Services: ____

Dates of Service or Purchases (If applicable please send receipts for purchases):

____/____/____ $______________	____/____/____ $______________
____/____/____ $______________	____/____/____ $______________
____/____/____ $______________	____/____/____ $______________
____/____/____ $______________	____/____/____ $______________
____/____/____ $______________	____/____/____ $______________
____/____/____ $______________	____/____/____ $______________

# of units: __________ Unit Rate: $__________ Total: $__________

Approved: ___________________________ Date: _______________
Member Signature

Approved: ___________________________ Date: _______________
Vendor Signature

Please check your Funding Source:

❑MyChoice/Care (MCW) **❑ Independent Care - iCare** **❑Inclusa** **❑ Lakeland Care Inc**

❑ Menominee ITOW **❑CLTS County:** _________________ **❑Other:** _________________

*It is your responsibility to verify that your completed and accurate check request has been received by LKiChoice once you submit via mail, fax, or email. Please call us at **1-844-534-7225** to verify your timesheet(s) has been received.*

Submit Mileage Log to: LKiChoice @ 106 S Beaumont Rd Prairie du Chien, WI 53821 Fax: 844-634-7225
Payroll email: payroll@lkichoice.com For questions please call 844-534-7225 Website: www.lkichoice.com

Revision: 12/29/2021