iLIFE
iLIFE, LLC Fiscal Agent

Fiscal Agent
Vendor Application

Vendor Demographics

Organization Name: ABC Company

Contact Name: Jane Smith

Telephone Number: (123) 456-7890 Email: jane@abccompany.com

Are you applying as (choose one): ☑ Agency ☐ Individual Provider

Type of application (choose one): ☑ Initial application ☐ Reinstatement

☐ Supplemental (vendor status change or adding Employer/Client)

NOTE: If adding Employer/Client, only the following is needed: Organization Name, Employer/Client Information, licensure information for the services to be provided, dated Employer/Client signature, and dated Vendor signature.

W-9 Name (as shown on tax return): Jane Smith

W-9 Business Name (if different from W-9 name): ABC Company

W-9 Exempt: ☐ Yes ☑ No State of WI Dept. of Financial Institutions ID No.: _____

Billing and Claims Contact Information

Check all that apply: ☑ Primary Office ☑ Mailing Address ☑ Billing Address

Tax Identification Number: 1234657890 Tax Qualifier: ☑ EIN ☐ SSN

Billing Contact Name: Jane Smith

Telephone Number: (123) 456-7890 Email: jane@abccompany.com

Fax: _____

Address: 1234 Main Street

City: Milwaukee State: WI ZIP: 12345

Background Check Verification for Agencies

I certify that the Agency I represent runs background checks on all employees in accordance with the Wisconsin Caregiver Program.

☑ Yes ☐ No ☐ Not applicable (I am an individual provider.)

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Employer/Client Information

Employer/Client Name: John Doe

Services To Be Provided	Rate	Unit
☐ Adult Day Care	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Supportive Home Care	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Pre-Vocational Services	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Daily Living Skills Training	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Day Services	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Supportive Employment	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Consumer Education and Training	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Home Modifications	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Respite	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Outside Chore Services	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Speech, Occupation, Physical or Massage Therapy	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Home Delivered Meals	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Adaptive Aids	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☑ Transportation	$ 10.00	per ☑ Hour ☐ Day ☐ Week ☐ One Time
☐ Personal Emergency Response Services (PERS)	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time
☐ Other: _____	$	per ☐ Hour ☐ Day ☐ Week ☐ One Time

Vendor Driver's License Information (if providing transportation)

Will you provide transportation services? ☑ Yes ☐ No

Name (as appears on license): Jane Smith

License Number: A123-5467-8888-90 Expiration Date: 12/15/2020

Liability Insurance: policy number 12-333-444444

If you are to provide specialized transportation, by submitting this application you certify that the vehicle you will use is and will be mechanically sound; has properly functioning lighting, safety, ventilation and braking systems; and has properly inflated tires without excessive wear.

IMPORTANT: Attach copy of insurance and license.

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Vendor Certifications and ID Numbers

State of Licensure/Certification	ID Number	Type	Expiration Date

Other ID Numbers:

Type of Number	ID Number	Expiration Date
Medicaid Provider Number		

IMPORTANT: List all current licenses and attach copy of current license(s). For list of service occupations that have licensing requirements, see the License Requirements List.

Employer/Client Acknowledgement and Signature

I understand that the services that I will receive are subject to Medicaid regulations and that I may not charge in excess of the amount agreed upon in this application.

Employer/Client Signature: John Doe _____ Date: 7/31/2017

Vendor Acknowledgement and Signature

I understand and agree that this application will not be processed until the application is deemed complete by iLIFE. It is my responsibility to provide a complete application. I understand that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility.

I certify that the information in this document and any attached documents is true, correct and complete. I understand and agree that any misrepresentation, misstatement or omission from this application, if discovered after Vendor participation has been awarded, may lead to suspension or termination of Vendor participation.

I understand that these services are provided under Medicaid regulations and that I may not charge in excess of the amount agreed upon in this application. After services have been performed per this agreement, invoices are due to iLIFE per the iLIFE Fiscal Agent Vendor Schedule.

Vendor Signature: Jane Smith _____ Date: 7/31/2017