

**ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES DIVISION OF SENIOR &
DISABILITIES SERVICES PROVIDER AGREEMENT
FOR
ASSISTED LIVING HOME PROVIDING
SERVICES FOR THE PROTECTION OF VULNERABLE ADULTS**

Fiscal Year _____

PROVIDER:

FACILITY NAME:

ADDRESS:

CITY, STATE, ZIP:

TELEPHONE & FAX:

PROVIDER PERIOD:

The State of Alaska, Department of Health & Social Services (hereinafter, the "Department"), Division of Senior & Disabilities Services (hereinafter, the "Division"), under the authority provided to it under AS 47.24.011, enters into this agreement for services with the above-named provider (hereinafter, the "Provider") for vulnerable adults who have been determined to be eligible by Adult Protective Services for Financial Assistance for the Protection of Vulnerable Adults in Assisted Living Homes (formerly known as general relief services) under 7 AAC 47.

The Provider agrees to comply with the regulations and statutes of AS 47.24, AS 47.33, and 7 AAC 47, and 7 AAC 75, 7 AAC 81, regarding the Protection of Vulnerable Adults, Assisted Living Home Care, and Financial Assistance for the Protection of Vulnerable Adults in Assisted Living Homes, and Provider Services for Individuals.

1. The Provider agrees to review the application of each eligible individual referred by adult protective services under 7 AAC 47.440 (c) (1)
2. The Provider agrees to comply with the standard established in 7 AAC 47.450 (b) regarding the personal-needs allowance and management of the allowance.
3. The Provider agrees to report to adult protective services any absence or discharge required to be reported by 7 AAC 47.490 (a).
4. The Provider and the Department agree that this agreement may be terminated as indicated in 7 AAC 47.440.
5. The Provider and the Department agree to **the minimum daily reimbursement rates** set out in 7 AAC 47.470. see **Appendix B**

6. The Provider and the Department agree to the augmented daily reimbursement rates set out in 7 AAC 47.471 (b) (1) not to exceed \$22 a day.

7. The Provider agrees to provide the services required under 7 AAC 47.475 (a) (b), including housing and food services, and other services indicated as needed in the resident's residential services contract, the assisted living plan of care, the Medicaid waiver plan of care, and the application for financial assistance under 7 AAC 47.330 (8), including the physician's statement.

8. Monthly payments will be made to the Provider only upon receipt in the Division's Anchorage office of the Invoice Form. The Provider shall bill only for units of service delivered within authorized dates. Payment will be made to the provider for the day of client admission, but not the day of departure. The Provider shall certify the monthly invoice and submit it to:

Senior & Disabilities Services
Department of Health & Social Services
550 West 8th Ave
Anchorage, AK 99501

The invoice shall be signed and submitted within 30 days after the end of the month in which service was provided. Invoices not received by the Division within 60 days after the month of service will require special approval by the Division for circumstances beyond the control of the provider in order to be paid. The State of Alaska conducts business during a fiscal year beginning July 1st and ending the following June 30th which is also the close of the fiscal year and the invoice for service provided in June shall be submitted by July 10th.. June 30 is the close of the fiscal year and the invoice for service provided in June shall be submitted by July 10th. The Division will only authorize payment for clients approved by the Division. This agreement does not, however, guarantee placement of clients by the Division.

9. The Provider shall immediately report the absence of a Division-authorized client to the client's care coordinator or other Division representative, unless the absence is for social or medical reasons, and will not exceed three days. No payment will be made for a social or medical absence exceeding three days unless previously approved by the Division.

10. The Provider shall allow representatives of the Division to visit the Provider's home at any reasonable time.

11. The Provider shall observe and provide information to the Division regarding the client's functioning. The Provider will advise the client's care coordinator of any significant changes in the client's condition.

12. The Provider shall cooperate with the Division in following suggestions and recommendations of Division representatives regarding the health and well-being of any client placed in the Provider's home.

13. The Provider shall notify the Division when the client does not successfully adapt to the home or requires more care than the Provider can provide. The Provider shall also notify the Division when a client leaves without previous planning.

14. The Provider shall maintain a record of the client, including the client's full name, birth date, and telephone numbers of his/her physician, family members and person(s) to notify in an emergency. The record will also include dates of admission and discharge and the days of social and/or medical leave authorized by the Division. The provider will also ensure that a Residential Services Contract and an Assisted Living Plan of Care is in each client's record and specific to that client.

15. The Provider shall comply with the **Civil Rights of Clients** provisions listed in **Appendix A**.

16. The Provider shall follow the provisions of 7 AAC 36.020 - 7 AAC 36.150 as guidelines to safeguard confidential client information. The Provider shall also comply with the Health Insurance Portability and Accountability Act of 1996 and other federal and state requirements for safeguarding information, preserving confidentiality and for the secure transmission of all records, whether electronic or not, to the Division.

Any information about General Relief clients that is obtained or developed under General Relief Provider Agreements or via the General Relief program is confidential. Client information cannot be released without the written authorization of the Division, except as permitted by other state or federal law.

17. The Provider shall maintain records and reports required by the Division, make financial and other records (e.g. census records and physicians' statements) available to the State upon request, and cooperate with the Department in monitoring the provision of services under this agreement.

18. Any dispute concerning a question of fact arising under this agreement which is not resolved by mutual agreement shall be decided without bias by the Division Director, who shall inform the Provider in writing of the decision. The decision of the Director is final and conclusive unless within fifteen (15) days from the receipt of the Director's decision, the Provider mails or otherwise furnishes the Director a written appeal addressed to the Commissioner of Health & Social Services. The Commissioner will make a final written determination concerning the appeal. The Provider has the right to present evidence in support of his/her appeal. Pending final decision of a dispute, the Provider shall proceed diligently with the performance of this agreement and in accordance with the Division Director's decision.

19. This agreement shall be subject to the availability of funds.

20. The Division may obtain for or assign to a state placed resident a care coordinator (person or agency) to monitor the resident's needs and well being, and to act as the resident's advocate. The provider agrees to coordinate with the designated care coordinator, to plan and implement the resident assisted living plan of care in conjunction with the care coordinator and to give the care coordinator full and direct access to and communication with the resident at all reasonable times.

21. RESIDENT PAYMENT: The resident is required to be responsible for payment to the facility for income available to the resident, minus \$100 a month spending allowance for an individual who is eligible for Medicaid or chronic and acute medical assistance or \$150 a month spending allowance for an individual who is not eligible for Medicaid or chronic and acute medical assistance. The resident must reimburse the state for money paid by the state when retroactive or other sources of payment become available to the resident. Any reimbursement monies will be forwarded to the Division of Senior & Disabilities Services, Accounting Section, 550 W. 8th Avenue, Anchorage, AK 99501. The amount reimbursed will not be more than the amount paid by the state.

By their signatures below, the parties hereto have executed this provider agreement:

FOR THE PROVIDER:

Facility: _____

Name of Administrator _____

Tax I.D. or Social Security Number: _____

Business License Number: _____

Dates of License: _____

Assisted Living Home License Number: _____

Date of License: _____

Physical Address: _____

City, State, Zip Code: _____

Mailing Address: _____

City, State, Zip Code: _____

Telephone: _____

Cell Phone: _____ Fax: _____

Email: _____

Print Name: _____

Signature: _____

FOR THE STATE:

By: _____ DATE: _____

Lynn Thurston
General Relief Program Manager
Senior & Disabilities Services
Department of Health & Social Services

APPENDIX A

CIVIL RIGHTS OF CLIENTS

(a) The Provider shall comply with Titles VI and VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Food Stamp Act of 1977, Alaska Statutes, Sections 18.80.200 - 18.80.280, and pertinent sections of the Code of Federal Regulations.

The Provider shall make no distinction or discriminate against a client, recipient, applicant or beneficiary of the Department's federally assisted programs on the basis of race, color, age, national origin, sex, political belief, religious creed, or handicap. No client, recipient, applicant or beneficiary of these federally assisted programs shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Department has responsibility.

(b) Distinction on the grounds, or race, color, age, national origin, sex, political belief, religious creed, or handicap includes:

1. Any type of segregation, separate, or different treatment, or other discrimination on that ground.
2. The imposition of any admission, enrollment, quota eligibility, or other requirement or condition which individuals must meet in order to be provided any service or other benefit under the program or to be afforded an opportunity to participate in the program if the race, color, age, national origin, sex, political belief, religious creed, or handicap of individuals is considered in determining whether they met any such requirement or condition.
3. The use of membership in a group as a basis for the selection of individuals for any purpose if in electing members of the group there is discrimination on the grounds or race, color, age, national origin, sex, political belief, religious creed, or handicap.
4. The assignment of personnel to provide services, or the assignment of times or places for the provision of services, on the basis on the race, color, age, national origin, sex, political belief, religious creed, or handicap of the individual to be served.

(c) The Provider shall set up and operate internal information collection systems to provide necessary racial statistics for staff, clients, beneficiaries and/or participants. Records and reports shall be available for review by the Department of U.S. Department of Health and Human Services, and the U.S. Department of Agriculture, upon request.

(d) The Provider shall make available to beneficiaries, participants, and other interested persons, information regarding the provisions of Titles VI and VII of the Civil Rights Acts of 1964, the Age Discrimination in Employment Act of 1977, The Americans with Disabilities Act, Alaska Statutes Sections 18.80.100 - 18.80.280, and pertinent section of the Code of Federal Regulations.

(e) The Provider shall inform and instruct staff members concerning obligations under Titles VI and VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1977, The Americans with Disabilities Act, Alaska Statutes Sections 18.80.100 - 18.80.280, and pertinent

section of the Code of Federal Regulations.

(f) The Provider shall comply with procedures furnished by the Department for processing of complaints alleging discrimination on the basis of race, color, age, national origin, sex, political belief, religious creed, or handicap.

(g) In determinations of whether a Provider is legally discriminating in the provision of benefits or services, consideration shall be given to the purpose of the services as expressly stated in any federal statutes, state statute, or local statute or ordinance adopted by an elected general purpose legislative body. In making such determinations, it shall be acknowledged that certain federal, state, or local funding is legally designated for specific groups, by age, sex, handicap, income, or other specific and legal eligibility criteria. For example, programs for the aged, blind, disabled, and youth provide services legally only for those groups. Also, institutions may legally serve a special age, sex, or handicap group depending upon their protective, treatment, rehabilitative needs and funding sources to provide the services.

Appendix B

Minimum Daily Reimbursement Rates

Anchorage	70.00
South Central region (not Anchorage area)	72.80
Southeast region	70.00
Interior region	80.50
Southwest region	93.10
Northwest region	96.60



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

Department of
Health and Social Services

DIVISION OF SENIOR AND DISABILITIES SERVICES

550 W 8th Ave.
Anchorage, Alaska 99501
Main: 907.269.3666
Fax: 907.269.3648

TO: All Assisted Living Homes Receiving Financial Assistance
(General Relief) Through Adult Protective Services

RE: General Relief Reimbursements to the Department Follow-up
Letter to Assisted Living Homes January 2007

Dear Assisted Living Home Administrator:

On June 28, 2002, new Assisted Living regulations were adopted. Assisted Living Homes are now required to reimburse General Relief payments that have also been covered by Medicaid Waiver or any other source. (2 AAC 42.235. CONCURRENT APPLICATION; REIMBURSEMENT TO DEPARTMENT BY RESIDENT OR BY ASSISTED LIVING HOME).

Specifically, the services portion (60% of the minimum daily rate plus any augmentation) paid through the General Relief program must be reimbursed to the State of Alaska when a Medicaid waiver has been approved for retroactive payment for the same services. If you do not voluntarily reimburse the State/Department, recovery will be made by the most appropriate means. These actions may include referral to the Medicaid Provider Fraud Unit for repeated non-payment.

The Division of Senior and Disabilities Services calculates your home portion of General Relief payment that should be refunded. When a statement is sent to your attention, please review the calculations, and if you have any questions or disagree with the amounts indicated, contact our office at 269-3666.

Payment in the amount indicated on the statement, should be made to the State of Alaska and sent within 30 days of the statement date to:

Senior and Disabilities Services
550 West 8th Ave
Anchorage, Alaska 99501

If payment is not received within 30 days the amount due will be deducted from your next General Relief invoice.

Please sign and date the bottom of this form and return it with your provider agreement.

Your signature acknowledges that you understand you are required to reimburse the General Relief program upon receipt of Medicaid monies for a client that has met the criteria for waiver eligibility.

If you have any questions please feel free to contact this office.

Sincerely,

Lynn Thurston
General Relief Program Manager
Phone: (907) 269-3441 Fax: (907) 269-3648

Assisted Living Home Owner Signature _____ Date _____



THE STATE
of **ALASKA**

GOVERNOR SEAN PARNELL

Department of
Health and Social Services

SENIOR AND DISABILITIES SERVICES
Director's Office

550 W. 8th Avenue
Anchorage, AK 99501
Main: 907.269.3666
Toll free: 800.478.9996
Fax: 907.269.4973

CONFIDENTIAL

Lynn Thurston
General Relief Program Manager
Division of Senior & Disabilities Services
550 W. 8th Ave., Anchorage, AK 99501
Phone: (907) 269-3441 Fax: (907) 269-4973

RE: Notice of 24/7 care

Dear ALH Administrator,

7 AAC 47.310. Assisted living care

Assisted living care is a range of care described in AS 47.33 and 7 AAC 75 that includes more than housing and food service, but does not include continuous nursing or medical care. Assisted living care encompasses 24-hour supportive and protective services in the activities of daily living and in the instrumental activities of daily living for an individual who is 18 years of age or older, as those services are described in that individual's residential services contract executed under AS 47.33.210 and assisted living plan prepared under AS 47.33.220 and 47.33.230. Assisted living care is provided in a residential environment and encourages independent living to the greatest extent possible for each resident.

Authority: AS 47.05.010, AS 47.24.011, AS 47.24.017, AS 47.25.120, AS 47.33.210, AS 47.33.220, AS 47.33.230, AS 47.33.920

The State of Alaska, Division of Senior and Disabilities Services ("SDS"), manages the General Relief Assisted Living Home Care Assistance Program under state statutes AS 47.25.120--300 and state regulations 7 AAC 47.300--47.525. Under this authority, the Division is responsible for ensuring statutory and regulatory compliance.

Compliance with General Relief regulations is required. A copy of all General Relief Regulations can be found on the SDS website [www. http://dhss.alaska.gov/dsds](http://dhss.alaska.gov/dsds).

Please feel free to call with any questions.

Sincerely,

Lynn Thurston

The information contained in this transmission is confidential. State and Federal law prohibits disclosure of this information without specific written consent of the person to whom it pertains or otherwise permitted by law. If you are not the intended recipient, you are hereby notified that any disclosure of the contents of this transmission is strictly prohibited. If you have received this fax in error, please call the above telephone number and return the original message to us via mail or destroy in a confidential manner!



General Relief Guidelines and Procedures

- Care Coordinators, Discharge Planners, Hospital Social Workers, or a responsible person acting on an applicant's behalf can complete a General Relief/Temporary Assistance Application; per 7AAC.47.390
- All Notifications must be received in our office via fax (907) 269-3648, mailed to Senior and Disabilities Services @ 550 W. 8th Ave Anchorage, AK 99501, or delivered in person within 10 working days of any placement changes for the consumer, such as hospitalization, incarceration, or any other absences that may arise with the consumer. In the event of the death of a consumer, notification must be received within 24 hours.
- **A Notification should be initiated:**
 1. When a consumer is admitted or discharged from the assisted living home; per 7AAC.47.420, and 7AAC47.490.
 2. When a consumer is admitted or discharged from the Hospital or API.
 3. Consumer is approved for a waiver program.
 4. Consumer has Income Changes.
 5. If the consumer is deceased.
 6. When a consumer has been demonstrating behaviors which do not support Assisted Living Care or otherwise violates house rules.
 7. Notify APS/General Relief immediately if you move or have any licensing changes that affect the General Relief Consumers.
 8. The General Relief Program does not pay for any absences past 3 days.
 9. Consumers have 30 days to apply for other programs. Non-compliance will result in the General Relief Funds to become suspended, 7AAC 47.300, 7AAC47.525.
- Please Allow up to 3 business days for processing of notifications.
- You will not receive written verification of the notification(s) unless you have delivered it in person to the office of Senior and Disabilities Services @ 550 W. 8th Ave Anchorage, AK 99501

- **Processing Invoices**

1. **The State of Alaska has 30 days for processing the invoices for payment. If after 30 days you have not received payment, please contact the General Relief Program. We will no longer verify payment prior to 30 days.**
2. **If you have set up direct deposit with the Finance Department, please allow up to 3 business days for the funds to show up in your account.**
3. **If you are receiving funds via check, please allow up to 10 business days for mail delivery times.**
4. **Any notification received regarding a client for the invoice month, will be processed within 3 business days. The Calculation sheet and invoice will be mailed/faxed on the following Friday.**

Utilize additional resources of information such as the Websites for:

Senior and Disabilities Services: <http://hss.state.ak.us/dsds>

Adult Protective Services: www.hss.state.ak.us/dsds/aps.htm

Thank you

The General Relief Staff



State of Alaska
 Department of Administration
Substitute Form W-9

Questions? Email DOA.DOF.Vendor.HelpDesk@alaska.gov

RETURN COMPLETED FORM TO:

Department of Administration
 Division of Finance
 P.O. Box 110204
 Juneau, AK 99811-0204
 Or FAX to: (907) 465-2169

DO NOT send to IRS

Taxpayer Identification Number (TIN) Verification

The Internal Revenue Service requires the State of Alaska to issue 1099 forms when payments to individuals, partnerships or limited liability companies for rents, services, prizes, and awards meet or exceed \$600.00 for the year. An IRS Form 1099 is not required when payments are specifically for merchandise or made to some types of corporations.

Print or Type

Please see attachment or reverse for complete instructions

Legal Name (as shown on your income tax return)	State of Alaska Vendor Number (if known)
Business Name , if different from above (use if doing business as (DBA) or enter business name of Sole Proprietorship)	Entity Designation (check only one type) Individual / Sole Proprietor Partnership General Corporation Medical Corporation Legal Corporation Limited Liability Company – Individual Limited Liability Company – Partnership Limited Liability Company – Corporation Government Entity Estate / Trust Organization Exempt from Tax - Nonprofit (under Section 501 (a)(b)(c)(d))
Primary Address (for 1099 form) PO Box or Number and Street, City, State, Zip + 4	
Remit Address (where payment should be mailed, if different from Primary Address) PO Box or Number and Street, City, State, Zip + 4	
	Exemption (See Instructions) Exempt payee code (if any) Exemption from FATCA Reporting Code (if any)

Taxpayer Identification Number (TIN) Provide Only One (If sole proprietorship provide EIN, if applicable)

Social Security Number (SSN)	Employer Identification Number (EIN)
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If Change of Ownership or Entity Designation	Date of Change:
Previous Owner / Business Name	Previous Taxpayer Identification Number (TIN)

Certification

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number, **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. person (including a U.S. resident alien), **AND**
4. The FATCA code(s) entered on this form (if any) indicating I am exempt from FATCA reporting is correct.

Printed Name	Printed Title	Telephone Number
Signature	Date	Email Address

Instructions for Completing Taxpayer Identification Number (TIN) Verification (Substitute W-9) -- Page 1

Legal Name

As registered with the Internal Revenue Service (IRS)

- Individuals: Enter First Name MI Last Name
- Sole Proprietorships: Enter First Name MI Last Name
- LLC Single Owner: Enter owner's First Name MI Last Name
- All Others: Enter Legal Name of Business

Business Name

- Individuals: Leave blank
- Sole Proprietorships: Enter Business Name
- LLC Single Owner: Enter LLC Business Name
- All Others: Complete only if doing business as a DBA

Primary Address

Address where 1099 tax form should be mailed.

Remit Address

Address where payment should be mailed. Complete only if different from primary address.

State of Alaska Vendor Number

Your vendor number is an eight character alphanumeric code assigned to your company in the State of Alaska's accounting system. You may contact us at the email address listed on the form if you do not know your vendor number.

Entity Designation

Check *ONE* box which describes the type of business entity.

Taxpayer Identification Number

LIST ONLY ONE: Social Security Number OR Employer Identification Number. **See "What Name and Number to Give the Requester" at right.**

If you do not have a TIN, apply for one immediately. Individuals use federal form SS-05 which can be obtained from the Social Security Administration. Businesses and all other entities use federal form SS-04 which can be obtained from the Internal Revenue Service.

Change of Ownership or Entity Designation

This information is requested to allow taxable income to be reported correctly for both the new and old entities.

Certification

You must cross out item 2 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.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to furnish your correct TIN to persons who must file information

returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to an IRA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not furnish a TIN to a payer. Certain penalties may also apply.

What Name and Number to Give the Requester

For this type of account:	Give name and SSN of:
Individual	The individual
Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
Sole proprietorship or Single-Owner LLC	The owner ¹
For this type of account:	Give name and EIN of:
Sole Proprietorship or Single-Owner LLC	The owner ³
A valid trust, estate, or pension trust	Legal entity ⁴
Corporation or LLC electing corporate status on Form 8832	The corporation
Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
Partnership or multi-member LLC	The partnership
A broker or registered nominee	The broker or nominee
Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ **You must show your individual name**, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Instructions for Completing Taxpayer Identification Number (TIN) Verification (Substitute W-9) -- Page 2

Exemptions

If you are exempt from backup withholding and/or Foreign Account Tax Compliance Act (FATCA) reporting, enter in the Exemptions box any code(s) that may apply to you. See **Exempt payee code** and **Exemption from FATCA reporting code** below.

Exempt payee code

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following codes identify payees that are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
2. The United States or any of its agencies or instrumentalities
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities
5. A corporation
6. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States
7. A futures commission merchant registered with the Commodity Futures Trading Commission
8. A real estate investment trust
9. An entity registered at all times during the tax year under the Investment Company Act of 1940
10. A common trust fund operated by a bank under section 584(a)
11. A financial institution
12. A middleman known in the investment community as a nominee or custodian
13. A trust exempt from tax under section 664 or described in section 4947

Exemption from FATCA reporting code

The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements.

- A. An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)
- B. The United States or any of its agencies or instrumentalities
- C. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities
- D. A corporation the stock of which is regularly traded on one or more established securities markets, as described in Reg. section 1.1472-1(c)(1)(i)
- E. A corporation that is a member of the same expanded affiliated group as a corporation described in Reg. section 1.1472-1(c)(1)(i)
- F. A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state
- G. A real estate investment trust
- H. A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940
- I. A common trust fund as defined in section 584(a)
- J. A bank as defined in section 581
- K. A broker
- L. A trust exempt from tax under section 664 or described in section 4947(a)(1)
- M. A tax exempt trust under a section 403(b) plan or section 457(g) plan

STATE OF ALASKA

ELECTRONIC PAYMENT AGREEMENT

Mail completed form to:
 DIV OF FINANCE / DEPT OF ADMINISTRATION
 PO BOX 110204 / JUNEAU AK 99811-0204
 or FAX to: (907) 465-3798

FOR VENDORS DOING BUSINESS WITH THE STATE OF ALASKA

PAYEE INFORMATION

AKSAS VENDOR NUMBER (PVN)		TAXPAYER ID - SSN / EIN		<i>ID number assigned to the legal name below and used for tax reporting</i>	
LEGAL NAME <i>(Name that Tax ID above is assigned to and is used for tax reporting)</i>					
BUSINESS NAME <i>(DBA - Doing Business As Name. If different from legal name shown above)</i>				ACCEPT CREDIT CARD PAYMENTS <input type="radio"/> YES <input type="radio"/> NO	
MAILING ADDRESS			CITY	STATE	ZIP CODE + 4
CONTACT NAME		DAYTIME PHONE NUMBER		FAX NUMBER	
EMAIL ADDRESS					

BANKING INFORMATION

Per National Automated Clearing House Association (NACHA) Operating Rules, the State of Alaska must send a pre-note zero dollar test transaction to verify the accuracy of the banking information below. Payments will not be sent electronically until the pre-note process is complete, generally ten business days. The State of Alaska will contact you if the pre-note fails.

ARE YOU <input type="radio"/> ADDING, <input type="radio"/> CHANGING, <input type="radio"/> OR CANCELLING THIS AGREEMENT?					
FINANCIAL INSTITUTION NAME			ACCOUNT NAME <i>(Business / Legal Name on Account)</i>		
ABA/ROUTING TRANSIT NUMBER (9-DIGIT RTN)			FULL ACCOUNT NUMBER <i>Please attach a voided check or other bank verification of account number as applicable</i>		
ACCOUNT TYPE <input type="radio"/> CHECKING <input type="radio"/> SAVINGS					
IS THIS ACCOUNT PRIMARILY A PERSONAL OR BUSINESS ACCOUNT? <input type="radio"/> PERSONAL. Payments are deposited separately with one addendum (remittance) record for each payment. - OR - <input type="radio"/> BUSINESS. Choose ONE of the business account addenda information format options below. <input checked="" type="radio"/> Payments deposited separately with one addendum (remittance) record for each payment. <input checked="" type="radio"/> Payments combined into one deposit with multiple addenda (remittance) records for each payment in the deposit (used by large businesses expecting multiple daily payments).					
<p>NACHA Operating Rules requires your banking institution to provide you with addenda (remittance) information that the State includes on each payment. Any banking charge to receive this information is the responsibility of the account holder.</p> <p>For EDI Payment Inquiry and other electronic payment information, visit our website at: http://fin.admin.state.ak.us/dof/electronic_payments/index.jsp</p>					

AGREEMENT AND AUTHORIZATION

I hereby authorize the State of Alaska to satisfy payment obligations due me by making deposits to the account indicated above. I understand that receipt of the electronic fund transfer(s) will fulfill the State's payment obligation and the State will be credited for the full amount on the date the fund transfer is completed. I understand the State will make a reasonable effort to notify me within 24 hours if a reversing entry is made against this account. This authority is to remain in full force through the duration of this agreement. I understand that thirty (30) days written notice is required if I change financial institutions, account numbers or type of account.

In addition, as required by the Federal Office of Foreign Asset Control in support of U.S.C. Title 50, War and National Defense, I attest that the full amount of my direct deposit is not being forwarded to a bank in another country and that if at any point I establish a standing order with my receiving bank to forward the full direct deposit to a bank in another country, I will inform the State of Alaska immediately.

I certify all information regarding this authorization is true and correct. Any intent to falsify information is punishable under AS 11.56.210 as a class A misdemeanor.

If the State discovers that the full amount of a direct deposit has been forwarded to another country or if information on the form has been falsified, this agreement shall be terminated. All correspondence with the State concerning this agreement or any changes to account information should be sent to the address at the top of this form. All terms remain in effect until this agreement is terminated by either party.

PRINTED NAME	TITLE
SIGNATURE	DATE

Print **Reset**