PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Aging Services
P.O. Box 807
Trenton, N.J. 08625-0807

SARAH ADELMAN
Commissioner

LOUISE RUSH
Asst. Commissioner

Prospective Providers
Jersey Assistance for Community Caregiving

Dear Applicant:

Thank you for your interest in providing service to participants of the Jersey Assistance for Community Caregiving (JACC) program. This program is designed to help nursing home eligible seniors stay in their own homes by providing them with the day-to-day services they require. A Fact sheet on JACC is enclosed for your reference. All providers **must** be enrolled in order to be reimbursed for service delivery to program participants. Enrollment does not guarantee work. The seniors, working in conjunction with their case managers, will determine which services and providers will best meet their needs.

If the Department of Human Services, Division of Aging Services has approved you as a service provider, you will be notified. Your name/agency will be included in the vendor database in which counties participating in the JACC program have access. Reimbursement for services provided is achieved through the Billing Agent, the Public Partnerships, LLC (PPL). Instructions for claim submission will be provided upon approval of your application. Participants in the programs are responsible for a portion of the cost of services on a sliding scale basis. Although this cost share is collected by PPL, failure of a client to submit his/her cost share may reduce the amount of services authorized for the individual.

Enclosed you will find the application to become a service provider. The following forms and back up evidence must be submitted with your application:

- Section I – General Information
- Section II – Ownership Disclosure Form
- Section II – Certification Re: Debarment & Suspension
- Section II – State of New Jersey W-9/Vendor Questionnaire
- Section III – Application for Services

Only complete applications will be processed. Please return the completed forms to DoAS.DMU@dhs.nj.gov (preferred method); or fax to 609-588-7153; or mail to:

New Jersey Department of Human Services
Division of Aging Services
Data and Medicaid Management Unit
JACC Provider Enrollment
P.O. Box 807
Trenton, NJ 08625-0807

Should you have any questions about the forms or required documentation, please contact the Data Management Unit at 609-588-7265.

GENERAL INSTRUCTIONS
For the
JACC PROVIDER APPLICATION

General Information

ALL applicants must complete the *General Information* portion of the Application:

- *Legal Name of Applicant:* Use the official name that appears on the Federal Identification Number (FID) certificate. Individuals use your name as it appears on your Social Security Card.

- *Business / Company Name:* Use the name under which business is conducted (i.e., "ABC Co., Inc" [Legal Name] **"We Can Help"** [Company Name]). Sometimes this is shown as: ABC Co., Inc. dba (or "Trading as") We Can Help.

- *Federal Identification Number (FID):* This is the number that would be used to report the company's income to the Internal Revenue Service, also called *Taxpayer Identification Number*. The nine digit number format is xx-xxxxxxx. Individuals please use your Social Security Number (nine digit format xxx-xx-xxxx).

- *Addresses:* There is space on the application for three different addresses; Headquarters, Mailing and Billing. If the same address is used for all three you need only provide it once, and write "SAME" in the other blanks.

- *Contacts:* The application asks for two contacts; Headquarters and Billing. The headquarters contact is the person authorized to speak for your organization and receive information regarding the JACC program. The Billing contact is the person you want contacted if there are questions regarding payment for services. If only one person is to be contacted for all questions you need only provide their name once, and write "SAME" in the other blank.

- *New Jersey Counties to be Served:* Please identify the names of the Counties that you are willing to provide service to. If you would like to serve all twenty-one counties, please write "ALL".

PLEASE NOTE: If you are providing service from more than one location, please list all sites. If additional space is required you may reproduce the form.

Required Forms

ALL applicants must complete the following forms:

- *Certification Regarding Debarment and Suspension* form, certifying that your company is eligible to receive payments from the Federal Government and the State of New Jersey.

- *Ownership Disclosure Form*, providing personal information on officers of the company and persons who hold at least a 10% interest in your firm. This also certifies that the officers and owners are eligible to receive Federal and State funds.
- *W-9 Questionnaire*, Part I must be filled in, this certifies that the *Tax Payer Identification Number* (either your company's Federal ID Number or your Social Security Number) is correct. Please submit original to OMB Vendor Control (listed on form) and a copy with this application.

Services

APPLICANTS MUST COMPLETE

One or more of the "Service" Applications: PLEASE READ CAREFULLY the requirements for each service you intend to supply. If you do not meet the criteria for providing services DO NOT apply for that service (example: many health care providers state in their literature that they provide "Homemaker" services. Only Home Health Agencies and Health Care Service Firms, who have been accredited as "Homemaker" agencies, can apply to become homemaker providers).

Submission

COMPLETED APPLICATION

Send the completed application packet consisting of the above and photocopies of any required documentation to DoAS.DMU@dhs.state.nj.us (preferred method); or fax to 609-588-7153; or mail to:

New Jersey Department of Human Services
Division of Aging Services
Data and Medicaid Management Unit
JACC Provider Enrollment
P.O. Box 807
Trenton, NJ 08625-0807

NOTE: Make sure to keep a photocopy of your application for your records. All incomplete applications and applications that do not have copies of required documentation will be returned.

JACC PROVIDER APPLICATION

Section I. GENERAL INFORMATION

Send Completed Forms to: DoAS.DMU@dhs.nj.gov (preferred method); or fax to 609-588-7153; or mail to:

New Jersey Department of Human Services
Division of Aging Services
Data and Medicaid Management Unit
JACC Provider Enrollment
P.O. Box 807
Trenton, NJ 08625-0807

Applicant Information

Legal Name of Applicant:

Business / Company Name:

Federal Tax ID Number:

Headquarters Address:

Telephone Number:

Fax Number:

Email Address:

Headquarters Contact:

Telephone Number:

Fax Number:

E-Mail Address:

Mailing Address (if different):

Billing Address:

Billing Contact:

Telephone Number:

Fax Number:

E-Mail Address:

New Jersey Counties to be Served:

Section II **New Jersey Department of Human Services**

OWNERSHIP DISCLOSURE FORM

Company Name	**Company Address**

INSTRUCTIONS: Provide below the names, home addresses, dates of birth, and ownership interest of all officers of the firm named above. I additional space is necessary, provide on an attached sheet.

NAME	HOME ADDRESS	DATE OF BIRTH	OFFICE HELD	OWNERSHIP INTEREST (Shares Owned or % of Partnership)

INSTRUCTIONS: Provide below the names, home address, dates of birth, and ownership interest of all individuals not listed above, and any partnerships, corporations and any other owner having a 10% or greater interest in the firm named above. If a listed owner is a corporation or partnership, provide below the same information for the holders of 10% or more interest in that corporation or partnership. If additional space is necessary, provide that information on an attached sheet. If there are no owners with 10% or more interest in your firm, enter "None" below. Complete the certification at the bottom of this form. If this form has previously been submitted to the Purchase Bureau in connection with another bid, indicate changes, if any, where appropriate, and complete the certification below.

NAME	HOME ADDRESS	DATE OF BIRTH	OFFICE HELD	OWNERSHIP INTEREST (Share Owned or % of Partnership)

COMPLETE ALL QUESTIONS BELOW

	YES	NO
1. Within the past five years has another company or corporation had a 10% or greater interest in the firm identified above? (I*f yes, Complete and attach a separate disclosure form reflecting previous ownership interests.)*	☐	☐
2. Has any person or entity listed in this form or its attachments ever been arrested, charged, indicted or convicted in a criminal or disorderly persons matter by the State of New Jersey, any other state or the U.S. Government*? (If yes, attach a detailed explanation for each instance.)*	☐	☐
3. Has any person or entity listed in this form or its attachments ever been suspended, debarred or otherwise declared ineligible by any agency of government from bidding or contracting to provide services, labor, material or supplies*? (If yes, attach a detailed explanation for each instance.)*	☐	☐
4. Are there now any criminal matters or debarment proceedings pending in which the firm and/or its officers and/or managers are involved? *(If yes, attach a detailed explanation for each instance.)*	☐	☐
5. Has any federal, state or local license, permit or other similar authorization, necessary to perform the work applied for herein and held or applied for by any person or entity listed in this form, been suspended or revoked, or been the subject of any pending proceedings specifically seeking or litigating the issue of suspension or revocation*? (If yes, to any part of this question, attach a detailed explanation for each instance.)*	☐	☐

CERTIFICATION: I, being duly sworn upon my oath, hereby represent and state that the foregoing information and any attachments thereto to the best of my knowledge are true and complete. I acknowledge that the State of New Jersey is relying on the information contained herein and thereby acknowledge that I am under a continuing obligation from the date of this certification through the completion of any contracts with the State to notify the State in writing of any changes to the answers or information contained herein. I acknowledge that I am aware that it is a criminal offense to make a false statement or misrepresentation in this certification, and if I do so, I recognize that I am subject to criminal prosecution under the law and that it will also constitute a material Breach of my agreement(s) with the State of New Jersey and that the State at its option, may declare any contract(s) resulting from this certification void and Unenforceable.

I, being duly authorized, certify that the information supplied above, including all attached pages, is complete and correct to the best of my knowledge. I certify that all of the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me is willfully false, I am subject punishment.

DATE: ----------

(Signature) ----------

(Name) ----------

Print or Type > (Title) ----------

Section II New Jersey Department of Human Services

CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

In accordance to Federal Executive Order 12549, "Debarment and Suspension," the undersigned certifies, to the best of his or her knowledge that as an applicant, this agency or its key employees:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency, or by the State of New Jersey;

b. have not within a 3-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense, in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or Local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State, or Local) with commission of any offenses enumerated in paragraph (b) of this certification; and

d. have not within a 3-year period preceding this application had one or more public transactions (Federal, State, or Local) terminated for cause or default.

The applicant agrees that by submitting this application, it will obtain from all its sub grantees a certification that includes without modification paragraphs (a), (b), (c), (d), of this certification in accordance with Federal Executive Order 12549.

_____

NAME OF AGENCY

_____

NAME AND TITLE OF OFFICIAL SIGNING FOR AGENCY

_____

SIGNATURE OF ABOVE OFFICIAL DATE SIGNED

NOTE: The following document related to Debarment and Suspension as required by Federal regulation will be used as the basis for completion of this certification:

> List of parties excluded from Federal Procurement or Non-Procurement Programs. U.S. General Services Administration distributes this document. U.S. Printing Office, Washington, D.C. This document can be acquired from the Superintendent of Documents by calling (202) 783-3238.

INSTRUCTIONS FOR STATE OF NEW JERSEY W-9/QUESTIONNAIRE FOR NON-PROCUREMENT VENDORS

The enclosed form is required by the State of New Jersey's Comprehensive Financial System, and must be completed by non-procurement vendors/payees who intend to do business with the State of New Jersey or by New Jersey State employees who are seeking reimbursement for travel or training expenses. Procurement vendors **SHOULD NOT** complete this form but should register at NJSTART.GOV. Procurement vendors include vendors who sell goods or provide a service (including healthcare and legal services). Please answer ALL questions and print clearly. If you have questions or need assistance completing the form, please contact vendor control at (609) 633-0783 or via email: AAIUNIT@treas.nj.us

Select the appropriate action that you are requesting. For payees that are registering for the first time, select 'Establish New Vendor.' For payees that have been previously established within the accounting system and want to add or change a remittance address, select the appropriate box.

PART I. REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

Part One is a W-9 form as required by the Internal Revenue Service to verify the name, address, and federal identification number for vendor/payees who may receive a 1099.
Questions 1-4:
If there is no preprinted data, populate the form with the vendor/payee's name (as shown on your tax return), address, city, state, zip code, and Taxpayer Identification Number. Sign and date the form under question number six.
If the form contains preprinted data and the preprinted information is correct, sign and date the form under question six.
If the form contains preprinted data and the preprinted information is not correct, cross out the incorrect data and make any changes immediately to the right of the preprinted information. Sign and date the form under question six.
Question 5: If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space any code(s) that may apply to you (See IRS Form W-9 instructions for codes).
Question 6: Sign and date the form.

PART II. VENDOR/PAYEE DATA: STATE OF NEW JERSEY VENDOR/PAYEE INFORMATION QUESTIONNAIRE

1. Enter the code that best describes the primary business function from the choices provided.
2. Print the name, phone number, and e-mail address of the primary contact person for the vendor listed in Part One.
If you are an employee of the State of New Jersey or manage a Confidential Fund or a Petty Cash Fund for a State agency, do not answer the remaining portion of the questionnaire (Questions three and four).
3. Enter the code that best describes your organization from the choices provided.

SUBMISSION OF THE STATE OF NEW JERSEY W-9/QUESTIONNAIRE

Mail or fax completed forms to The Office of Management and Budget (OMB):
OMB-Vendor Control Unit
PO Box 221
Trenton, NJ 08625-0221
Fax: (609) 984-5210

ACCESSING YOUR ACCOUNT INFORMATION

Details regarding specific payments, similar to a check stub, may be obtained over the internet through the Vendor Payment Inquiry (VPI) system. To access VPI, users must first create a 'MyNewJersey' portal account.
Begin by logging onto the State of New Jersey's web page, NJ.GOV and creating a log in and password (click on the 'register' link under the 'home' tab). Once the 'MyNewJersey' portal account has been established, users will have to sign up for the VPI application by clicking the 'enroll here' button on our website, https://www-tyomb.state.nj.us/TYM_VPI/home.
The online tutorial for VPI can be found at https://www-tyomb.state.nj.us/treasury/omb/TYM_VPI/docs/GettingStarted.pdf
VPI provides two years of historical data (such as issuing agency, payee reference, payment amount, payment date, etc) and allows for the review of scheduled payments.

☐ Establish New Vendor ☐ Establish Additional Remittance Address ☐ Change Remittance Address

STATE OF NEW JERSEY

W-9/QUESTIONNAIRE FOR NON-PROCUREMENT VENDORS

THE STATE OF NEW JERSEY REQUIRES THE FOLLOWING INFORMATION TO ESTABLISH YOUR NAME, ADDRESS, AND TAXPAYER ID ON STATE RECORDS. THE INFORMATION IS USED TO POPULATE AND MAINTAIN THE STATE'S VENDOR/PAYEE FILE AND MUST BE COMPLETED BEFORE PAYMENTS ARE MADE. **NOTE: PROCUREMENT VENDORS SHOULD NOT COMPLETE THIS FORM BUT SHOULD REGISTER AT NJSTART.GOV.**

IMPORTANT: YOU WILL NOT BE PAID BY THE STATE OF NEW JERSEY UNTIL THIS FORM IS COMPLETED, SIGNED, AND RETURNED. FOR ADDITIONAL INFORMATION CALL (609) 633-0783 OR EMAIL: AAIUNIT@TREAS.NJ.GOV.

Return completed form to:
OMB VENDOR CONTROL
PO BOX 221
TRENTON, NJ 08625 or
FAX: (609) 984-5210

PART I. REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

1. **Name** (as shown on your tax return): _____

   Doing business as (if different than name): _____

2. **Address**: _____

3. **City:** _____ **State:** _____ **Zip:** _____
   If the above contains preprinted data that is incorrect, cross it out and write the correct information immediately next to it.

4. **Taxpayer Identification Number (TIN)** Enter your TIN below and check the type of number listed.
   ☐ SOCIAL SECURITY NUMBER
   ☐ EMPLOYER IDENTIFICATION NUMBER

5. **Exemptions** (codes apply only to certain entities, not individuals; see IRS Form W-9 instructions page 3):
   Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____

6. **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 US person as defined by the IRS.
   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 of underreported interest or 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 IRA, and generally payments other than interest or dividends, you are not required to sign the certification, but you must provide your correct TIN.

Sign Here	Signature	Date

PART II. VENDOR/PAYEE DATA: STATE OF NEW JERSEY VENDOR/PAYEE INFORMATION QUESTIONNAIRE

NOTE: PROCUREMENT VENDORS SHOULD REGISTER AT NJSTART.GOV.

1. Enter the code from the list below that best describes your primary business function:

☐☐

NON-PROCUREMENT PAYEES:

AC=AUTHORITY/COMMISSION CF=CONFIDENTIAL FUND PC=PETTY CASH SD=SCHOOL DISTRICT FA=FEDERAL AGENCY
FD=FIRE DISTRICT CM=COUNTY/MUNICIPALITY EP=NJ STATE EMPLOYEE SA=STATE AGENCY WB=WELFARE BOARD
CU=STATE COLLEGE/UNIVERSITY

OTHER PAYEES:

OT=OTHER VENDOR (PLEASE SPECIFY): _____

2. Primary Contact Information **(ALL FIELDS ARE REQUIRED):**

Name: _____ Phone: _____
Email: _____

☐ Please check here if you are interested in receiving information about payments by direct deposit.

IF YOU ARE A NJ STATE EMPLOYEE, NJ MANAGER OF A CONFIDENTIAL FUND OR PETTY CASH FUND, DO NOT ANSWER THE BALANCE OF THE QUESTIONAIRE.

3. Enter the code from the list below that best describes your organization

☐ C=CORPORATION I=INDIVIDUAL P=PARTNERSHIP L= LIMITED LIABILITY COMPANY G=GOVERNMENT

IMPORTANT: ANSWER ALL QUESTIONS (PRINT CLEARLY OR TYPE)

NJ W9 rev 10/21