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Executive Office of Elder Affairs
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Memorandum

To: Assisted Living Residences Executive Directors

From: Secretary Elizabeth C. Chen

SUBJECT: Reimbursement to Assisted Living Residences for Certain Types of COVID-19 Testing

Date: October 5, 2020

The Executive Office of Elder Affairs (EOEA) is issuing this Guidance to Assisted Living Residences (ALRs) regarding reimbursement for the costs associated with polymerase chain reaction (PCR) testing for COVID-19 for the period October 1, 2020 through December 31, 2020.

EOEA is recommending that ALRs follow the Long Term Care Surveillance Testing guidance issued by the Department of Public Health on October 5, 2020. If a new staff case is detected in the ALR community, EOEA will reimburse the testing of all staff at the ALR for a maximum of 2 tests per staff member per 30-day period.

In order to receive the COVID-19 testing reimbursement described in this Guidance, an ALR must: (1) have arranged for and paid directly for testing of its staff; (2) maintain documentation of such testing and payment; (3) submit documentation consistent with the requirements outlined in this guidance, and report such testing in accordance with the procedures outlined below.

For the purposes of this Guidance, the term "staff" includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the ALR. For the purpose of testing "staff," ALRs should prioritize those individuals who are in the ALRs at least weekly and have direct contact with residents or staff.

Calculating the Amount of the COVID-19 Testing Reimbursement

EOHHS will calculate the amount of the COVID-19 testing reimbursement for each eligible ALR as follows:

1. An eligible ALR's COVID-19 testing reimbursement payment will be based on the number of completed qualifying COVID-19 staff tests, as described in Item 2 below.
2. The number of completed qualifying COVID-19 staff tests means the total number of staff tests that meet all of the following criteria:
    a. Staff tests that were arranged and paid by the ALR as a result of a reported new COVID-19 diagnosis, and not for routine surveillance testing;
    b. Not more than two (2) tests per individual staff member per every 30 days;
    c. Staff tests that included the collection of specimens sufficient for diagnostic testing, the processing of a COVID-19 diagnostic test by an FDA-approved method, and the furnishing of results to all appropriate parties in accordance with DPH and CDC guidance;
    d. Staff tests that are able to detect SARS-CoV-2 virus, with a polymerase chain reaction (PCR) of greater than 95 percent sensitivity and greater than 90 percent specificity; and
    e. An attestation that the tests were performed in accordance with this guidance.

3. The reimbursement for each eligible ALR will be equal to the number of completed qualifying COVID-19 tests administered in accordance with this guidance or any subsequent guidance or direction issued by EOEA and DPH. Reimbursement for eligible tests is determined by multiplying the number of eligible tests by $80.00.
4. The COVID-19 testing reimbursement payments will be paid on an as-needed basis not to exceed two reimbursements per ALR location in a 30day period, with each payment calculated based on a new submission of the Request for Reimbursement documentation described below.

Process to Request Reimbursement

In order to request and receive reimbursement under this policy, ALRs must take the following steps.

ALRs should submit one (1) survey response per ALR per 30 days for which reimbursement is being requested (including the two (2) rounds of completed staff testing in the single submission). Submissions must be received within 30 days of the ALR's payment for the staff testing that is eligible to be reimbursed under this guidance. All attachments are included on subsequent pages within this document; ALRs should complete these forms and save them separately as unique files for submission:

1. Complete and sign *Attachment A: ALR COVID-19 Testing Reimbursement Attestation*.
2. Review, complete, and sign *Attachment B: Standard Contract Form*.
3. Complete *Attachment C: Massachusetts W-9 Form: Request for Taxpayer Identification Number and Certification*.
4. Complete *Attachment D: EFT Sign Up Form*.

Scanned copies of all documentation noted above must be submitted electronically through the **ALR COVID-19 Testing Online Survey**, which can be accessed from any internet browser here: https://app.keysurvey.com/f/41518872/4e0e/. ALRs are required to retain all original documents and produce them at the Commonwealth's request.

ALRs are responsible for downloading and retaining a copy of their online survey submission by clicking the "Download Survey" link at the end of the survey.

ALRs are required to read the instructions carefully and fully complete all document requirements (including wet signatures). Incomplete document submissions will result in processing delays. ALRs are responsible for responding to follow up correspondence about completed submissions and remediating all submission errors. If submission errors or omissions cannot be remediated, reimbursement requests may be denied.

The process for submitting testing results for reimbursement does not replace the COVID-19 positive data reporting requirements for ALRs. ALRs must continue to report COVID-19 positive test results to their Local Board of Health/DPH and to EOEA

Attachment A: ALR COVID-19 Testing Reimbursement Attestation

I,_____, hereby certify under the pains and penalties of perjury that I am the administrator or other duly authorized officer or representative of _____ (legal business name), which does business as _____ (doing business as name), locally located in the Commonwealth of Massachusetts at _____, (hereinafter "organization") and that the information provided in this attestation is a true and accurate representation of the COVID-19 testing procedure implemented at such organization.

Specifically, I represent and warrant that:

The organization completed and paid for the reimbursable testing for COVID-19 for ALR staff in compliance with the *Reimbursement to Assisted Living Residences (ALR) for Certain Types of COVID-19 Testing* guidance.

Under the pains and penalties of perjury, I hereby certify that the above information is true and correct.

Printed Name: _____

Title: _____

Signature: _____

Date: _____

The organization must maintain the original executed copy of each submitted attestation, along with the accompanying documentation, receipts, invoices, and reports, in its files and produce them at the Commonwealth's request.

COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

This form is jointly issued and published by the Office of the Comptroller (CTR), the Executive Office for Administration and Finance (ANF), and the Operational Services Division (OSD) as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. The Commonwealth deems void any changes made on or by attachment (in the form of addendum, engagement letters, contract forms or invoice terms) to the terms in this published form or to the **Standard Contract Form Instructions**, **Contractor Certifications** and **Commonwealth Terms and Conditions** which are incorporated by reference herein. Additional non-conflicting terms may be added by Attachment. Contractors are required to access published forms at CTR Forms: https://www.macomptroller.org/forms. Forms are also posted at OSD Forms: https://www.mass.gov/lists/osd-forms.

CONTRACTOR LEGAL NAME: **(and d/b/a):**		**COMMONWEALTH DEPARTMENT NAME: Executive Office of Health and Human Services** **MMARS Department Code: EHS**	
Legal Address: (W-9, W-4):		**Business Mailing Address: 600 Washington Street, 7th Floor, Boston, MA 02111**	
Contract Manager:	**Phone:**	**Billing Address (if different):**	
E-Mail:	**Fax:**	**Contract Manager:**	**Phone:**
Contractor Vendor Code: VC		**E-Mail:**	**Fax:**
Vendor Code Address ID (e.g. "AD001"): AD_____. **(Note: The Address ID must be set up for EFT payments.)**		**MMARS Doc ID(s):** **RFR/Procurement or Other ID Number: Emergency Contract**	

☒ **NEW CONTRACT**

PROCUREMENT OR EXCEPTION TYPE: (Check one option only)

- ☐ **Statewide Contract** (OSD or an OSD-designated Department)
- ☐ **Collective Purchase** (Attach OSD approval, scope, budget)
- ☐ **Department Procurement** (includes all Grants - 815 CMR 2.00) (Solicitation Notice or RFR, and Response or other procurement supporting documentation)
- ☒ **Emergency Contract** (Attach justification for emergency, scope, budget)
- ☐ **Contract Employee** (Attach Employment Status Form, scope, budget)
- ☐ **Other Procurement Exception** (Attach authorizing language, legislation with specific exemption or earmark, and exception justification, scope and budget)

☐ **CONTRACT AMENDMENT**

Enter **Current Contract End Date *Prior*** to Amendment: _____, 20____.

Enter **Amendment Amount**: $_____. (or "no change")

AMENDMENT TYPE: (Check one option only. Attach details of amendment changes.)

- ☐ **Amendment to Date, Scope or Budget** (Attach updated scope and budget)
- ☐ **Interim Contract** (Attach justification for Interim Contract and updated scope/budget)
- ☐ **Contract Employee** (Attach any updates to scope or budget)
- ☐ **Other Procurement Exception** (Attach authorizing language/justification and updated scope and budget)

The Standard Contract Form Instructions, Contractor Certifications and the following Commonwealth Terms and Conditions document is incorporated by reference into this Contract and are legally binding: (Check ONE option): ☒ Commonwealth Terms and Conditions ☐ Commonwealth Terms and Conditions For Human and Social Services

COMPENSATION: (Check ONE option): The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.

☐ **Rate Contract.** (No Maximum Obligation) Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)

☒ **Maximum Obligation Contract.** Enter total maximum obligation for total duration of this contract (or ***new*** total if Contract is being amended). $_____

PROMPT PAYMENT DISCOUNTS (PPD): Commonwealth payments are issued through EFT 45 days from invoice receipt. Contractors requesting **accelerated** payments must identify a PPD as follows: Payment issued within 10 days _____% PPD; Payment issued within 15 days _____ % PPD; Payment issued within 20 days _____ % PPD; Payment issued within 30 days _____% PPD. If PPD percentages are left blank, identify reason: ☒ agree to standard 45-day cycle ☐ statutory/legal or Ready Payments (M.G.L. c. 29, § 23A); ☐ only initial payment (subsequent payments scheduled to support standard EFT 45 day payment cycle. See Prompt Pay Discounts Policy.)

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.)

Pursuant to this Contract, the Executive Office of Health and Human Services (EOHHS) will reimburse the Contractor for certain costs associated with COVID-19 testing of the Contractor's staff and residents of its assisted living residence(s), as described in Attachment A.

ANTICIPATED START DATE: (Complete ONE option only) The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:

☒ 1. may be incurred as of the Effective Date (latest signature date below) and **no** obligations have been incurred **prior** to the Effective Date.

☐ 2. may be incurred as of _____, 20_____, a date **LATER** than the Effective Date below and **no** obligations have been incurred **prior** to the Effective Date.

☐ 3. were incurred as of _____, 20_____, a date **PRIOR** to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE: Contract performance shall terminate as of **December 31 , 2020,** with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS: Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor certifies that they have accessed and reviewed all documents incorporated by reference as electronically published and the Contractor makes all certifications required under the Standard Contract Form Instructions and Contractor Certifications under the pains and penalties of perjury, and further agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, this Standard Contract Form, the Standard Contract Form Instructions, Contractor Certifications, the applicable Commonwealth Terms and Conditions, the Request for Response (RFR) or other solicitation, the Contractor's Response, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:	**AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:**
X: _____. **Date:** _____. **(Signature and Date Must Be Handwritten At Time of Signature)**	**X:** _____. **Date:** _____. **(Signature and Date Must Be Handwritten At Time of Signature)**
Print Name: _____.	**Print Name:** Katherine Harvell Haney.
Print Title: _____.	**Print Title:** Chief Financial Officer.

ATTACHMENT A – PURPOSE AND JUSTIFICATION AND ADDITIONAL TERMS

A. PURPOSE

This Contract is by and between EOHHS and ("Contractor").

Pursuant to this Contract, EOHHS will reimburse the Contractor for the costs of certain COVID 19 testing as described in the *Reimbursement to Assisted Living Residences (ALR) for Certain Types of COVID-19 Testing* guidance issued by the Executive Office of Elder Affairs and as described herein.

B. EMERGENCY JUSTIFICATION

This contract is being entered into on an emergency basis during the COVID-19 public health crisis in order to promote the identification and reduced transmission of the COVID-19 virus in ALRs, and as set forth in this contract.

C. DEFINITIONS

For the purposes of this Contract, the term "staff" includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the ALR. For the purpose of testing "staff," ALRs should prioritize those individuals who are regularly in the ALR (e.g., weekly) and have direct contact with residents or staff.

D. REIMBURSEMENT

EOHHS will reimburse the Contractor for certain COVID-19 testing conducted on eligible staff tests at the Contractor's ALR location(s) and as described herein. In order to be reimbursed for eligible staff tests, the Contractor must have arranged for and paid directly for the testing of its staff, must maintain documentation of such payment, must produce such documentation upon EOHHS's request, and must report the costs of such staff testing in the form and format as designated by EOHHS, and as specified in the *Reimbursement to Assisted Living Residences (ALR) for Certain Types of COVID-19 Testing* guidance issued by EOEA.

EOHHS will calculate the amount of the Contractor's COVID-19 testing reimbursement as follows:

1. The amount of the Contractor's COVID-19 testing reimbursement will be based on the number of completed qualifying COVID-19 staff tests, as described in Item 2 below.
2. The number of completed qualifying COVID-19 staff tests means the total number of staff tests that meet all of the following criteria:
    a. Staff tests that were arranged for and paid directly by the Contractor as a result of a reported new COVID-19 diagnosis, and not for routine surveillance testing;
    b. Not more than two tests per staff member per 30 day period;
    c. Staff tests that included the collection of specimens sufficient for diagnostic testing, the processing of a COVID-19 diagnostic test by an FDA-approved

method, and the furnishing of results to all appropriate parties in accordance with DPH and CDC guidance;

d. Staff tests that are able to detect SARS-CoV-2 virus, with a polymerase chain reaction (PCR) of greater than 95 percent sensitivity and greater than 90 percent specificity;

e. An attestation that the tests were performed in accordance with the EOEA ALR guidance, and that positive, negative, and inconclusive results were reported to EOEA and DPH; and,

f. If EOHHS, through EOEA, determines that the rate of inconclusive test results is unreasonably high, EOHHS may exclude those inconclusive results from the number of completed qualifying COVID-19 tests.

3. The Contractor's total reimbursement amount for eligible tests is determined by multiplying the total number of eligible tests by $80.00.

E. OPTION OF EOHHS TO MODIFY, INCREASE, REDUCE OR TERMINATE SCOPE OF WORK

EOHHS reserves the right, at its sole discretion and at any time during the Contract term, to modify, increase, reduce or terminate any requirements of the Contract, whenever EOHHS deems necessary or reasonable to implement any state or federal statutory or regulatory requirements, judicial orders, settlement agreements, or any state or federal initiatives or changes that may affect in whole or in part any component of the Contract. In the event that the scope of work for any task or portions thereof must be changed, EOHHS will notify the Contractor in writing. EOHHS reserves the right to amend the Contract accordingly, including payments under, or maximum obligation of the Contract.

F. ORDER OF PRECEDENCE

In the event of any ambiguity or inconsistency among the documents that are a part of this Contract, the order of priority to interpret this Contract shall be as follows: (1) the printed language of the Commonwealth Terms and Conditions, (2) the Standard Contract Form, and (3) Attachment A: Purpose and Justification and Additional Terms.

G. CONTRACT TERM

This Contract shall be in effect from the date of execution through December 31, 2020. EOHHS may extend this contract, at its sole discretion and in any increment, it determines necessary for up to two years from the date of execution.

H. TERMINATION OF CONTRACT

Either party may terminate this Agreement without cause by giving written notice to the other party of its intent to do so at least thirty (30) days prior to the effective date of such termination. This thirty (30) day period shall not commence until the other party has received such notice.

Form **W-9**
(Massachusetts Substitute W-9 Form) Rev. March 2020

Request for Taxpayer Identification Number and Certification

Completed form should be given to the requesting department or the department you are currently doing business with.

Name (as shown on your income tax return). Name is required on this line, do not leave this line blank.

Business name/disregarded entity name, if different from above.

Check the appropriate box: ☐ Individual/Sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/ Estate ☐ Other ►----------

Legal Address: number, street, and apt. or suite no.	**Remittance Address**: if different from legal address number, street, apt. or suite no
City, state and ZIP code	**City, state and ZIP code**

Phone: Fax: Email address:

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instruction on page 2**. For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.
Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Vendors:
Dunn and Bradstreet Universal Numbering System (DUNS)

Social security number

☐☐☐-☐☐-☐☐☐☐

OR Employer identification number

☐☐-☐☐☐☐☐☐☐

DUNS ☐☐☐☐☐☐☐☐☐

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 Services (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 an U.S. person (including an U.S. resident alien).
4. I am currently a Commonwealth of Massachusetts's state employee: (check one): No____ Yes ____ If yes**, in compliance with** the State Ethics Commission **requirements.**

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.

Sign Here	**Authorized Signature ►**	**Date ►**

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and , when applicable, to:
1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued).
2. Certify you are not subject to backup withholding

If you are a foreign person, use the appropriate Form W-8. See **Pub 515**, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

What is backup withholding? Persons making certain payments to you must withhold a designated percentage, currently 28% and pay to the IRS of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**
1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions on page 2.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.
Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.
Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line**. Enter the LLC's name on the "Business name" line.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Part I - Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an **LLC** that is **disregarded as an entity** separate from its owner (see ***Limited liability company (LLC)*** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7**, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site **www.irs.gov**.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments.

The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN **or** that you intend to apply for one soon.*

Part II - Certification

To establish to the paying agent that your TIN is correct or you are a U.S. person, or resident alien, sign Form W-9.

For a joint account, only the person whole TIN is shown in Part I should sign (when required).

Real estate transactions**.** You must sign the certification. You may cross out item 2 of the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give 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, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold a designated percentage, currently 28% of taxable interest, dividend, and certain other payments to a payee who does not give 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:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]

For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. 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.

If you have questions on completing this form, please contact the Office of the State Comptroller. (617) 973-2468.

Upon completion of this form, please send it to the Commonwealth of Massachusetts Department you are doing business with.

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Electronic Funds Transfer (EFT) Enrollment/Modification Form

Complete this form to enroll in electronic funds transfer (EFT) with MassHealth or to terminate or modify an existing electronic funds agreement. Additional terms of agreement on page 2 of this form must be completed.

PROVIDER INFORMATION

Provider Legal Name	DBA Name		
Street	City	State	Zip Code

PROVIDER IDENTIFIERS INFORMATION

Provider TIN or EIN	NPI

PROVIDER CONTACT INFORMATION

Provider Contact Name	
Telephone Number	Telephone Number Extension
E-mail Address	

FEDERAL AGENCY INFORMATION

Federal Program Agency Identifier

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name			
Street	City	State	Zip Code
Financial Institution Routing Number	Type of Account at Financial Institution		
Provider's Account Number with Financial Institution			
Provider TIN	NPI		

SUBMISSION INFORMATION

Reason for Submission ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment	Included ☐ Voided Check ☐ Bank Letter
Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment	Submission Date

If you are modifying or changing your bank account information, you must include your old bank account information on page 2 of this form or your request will be incomplete.

Please print double-sided whenever possible.

Please complete page 2 in its entirety.

If you are modifying your bank account information please provide the old bank account information directly below.

Provider Old Bank Account Number _____ Account Type ☐ Checking ☐ Savings

CERTIFICATION

I, _____ , hereby certify that the account(s) indicated on this form is under my direct control and access; therefore, I authorize the State Treasurer as fiscal agent for the Commonwealth of Massachusetts to initiate, change, or cancel credit entries to that account/s as indicated on this form. For ACH debits consistent with the International ACH Transaction (IAT) rules check one:

☐ I affirm that payments authorized hereunder are not to an account that is subject to being transferred to a foreign bank account.

☐ I affirm that payments authorized hereunder are to an account that is subject to being transferred to a foreign bank account.

This authority is to remain in full force and effect until the Office of Comptroller (CTR) has received written notification from either me or an authorized officer of the organization of the account's termination in such time and in such a manner as to afford CTR a reasonable opportunity to act upon it.

This authorization will remain in effect until it is canceled in writing or until an updated form changing information is sent to the department you currently do business with.

Signature of authorized representative _____

- Please contact your financial institution to arrange for the delivery of the CORE (Committee on Operating Rules for Information Exchange)-required Minimum CCD+(Corporate Credit or Debit entry) data elements needed for reassociation of the payment and the Electronic Remittance Advice (ERA).
- Instructions to complete the EFT Enrollment/Modification form can be found at www.mass.gov/eohhs/docs/masshealth/aca/eft-instructions.pdf. You may also confirm the status of your EFT enrollment by contacting the MassHealth Customer Services Center at 1-800-841-2900.
- The EFT user job aid that explains how providers may match the EFT payment to the remittance advice can be found at https://massfinance.state.ma.us/VendorWeb/MassHealthProviderJA.asp.
- The EFT Enrollment/Modification form can be completed manually or electronically. Electronic submissions must be printed, signed, and mailed to the address below. The Commonwealth of Massachusetts requires a "wet" signature on all EFT enrollments, modifications, and terminations. All paper forms must be mailed to the following address.

MassHealth Customer Services Center
Attn: Provider Enrollment and Credentialing
P.O. Box 9162
Canton, MA 02021-5213