The Arc Central Chesapeake Region
Self-Directed Services
Phone: 1.866.252.6871 | Fax: 1.888.272.2236
Vendor Payment Request Submittal: FMSVendor@thearcccr.org
Open a Customer Service Ticket: thearcselfdirected.zendesk.co

Vendor Payment Request Form

Please complete ALL information below and provide the required documentation to request a vendor payment for goods & services as indicated in the approved person-centered plan and budget.

EMPLOYER NAME:	DEPT #:
VENDOR/BUSINESS NAME: ☐ Please check if this is a NEW vendor. Please review requirements below.	
VENDOR MAILING ADDRESS INCLUDING STREET/CITY/STATE/ZIP:	
VENDOR EMAIL ADDRESS:	

SERVICE CODE/DESCRIPTION	DATES OF SERVICE	AMOUNT DUE
	TOTAL AMOUNT DUE FOR INVOICE	

EMPLOYER/AUTHORIZED REP SIGNATURE:

BY SIGNING ABOVE, I CERTIFY THAT THE GOODS & SERVICES REFLECTED BY THIS VENDOR PAYMENT REQUEST WERE DELIVERED/RECEIVED AND ARE IN ACCORDANCE WITH MARYLAND DDA STANDARDS. I CERTIFY THAT THE INVOICE IS TRUE AND ACCURATE. FALSE INFORMATION CONSTITUTES MEDICAID FRAUD.

PAYMENT TYPE	INVOICE REQUIREMENTS/INFORMATION NEEDED
Vendor Invoice Requirements	**An invoice or quote should be submitted with the following:** a) The vendor's name, address, and email b) The employer's name as the recipient c) The goods or services to be purchased Service invoices should reflect the *exact* dates of services with the following: d) Participant name e) Vendor name f) The service(s) rendered as authorized in the Person-Centered Plan g) Date(s) the services were rendered h) Start and end times of the services each day i) Number of hours/units for each day (broken down by the quarter hour) j) Name of each employee who provided the service(s) k) A description of tasks completed by the vendor for each time entry l) Total amount charged

Reimbursement Requirements	**When submitting a request for reimbursement, provide the following:** a) A detailed receipt with date of purchase, item(s) purchased, total cost, and method of payment b) For cash purchases, provide a cash receipt/and or withdrawal statement to support cash payment c) For purchases made by check, please provide a copy of the canceled check or bank statement showing the purchase. All other transaction info may be redacted d) For purchases made by debit/credit card, please provide a copy of the credit card receipt showing the purchase. All other transaction info may be redacted e) Upon initial request for health insurance reimbursements, submit the Participant's Employee written policy to FMSVendorCompliance@thearcccr.org listing the maximum dollar amount allowed for each staff benefit f) CPR certificates must be provided as supporting documentation to show proof of certification g) IFGDS goods and services for each plan year must be approved by DDA prior to purchase and submission for reimbursement
General Requirements	**Participants should review the following requirements when submitting an invoice for processing:** a) Prior to payment, vendors must submit required documents and credentials as outlined on the **Vendor Requirements** form and submit to fmsvendorcompliance@thearcccr.org b) Vendors must adhere to the waiver service, billing units, and hour limitations as written in DDA's Self-Directed Services Manual c) Reimbursements cannot be issued directly to the employer or their support broker d) Vendor addresses on the VPR and in Bill.com must match for reimbursement to be processed e) Invoices and vendor payment requests with discrepancies such as amounts, budget depletion, and unreadable attachments will be returned for corrections and must be resubmitted to fmsvendor@thearcccr.org f) Submissions that are not revised to match the exact amounts available in the budget once depletion is identified will be returned for corrections g) Invoices submitted with service dates over 11 months old cannot be processed h) VPRs submitted without the participant's or designated representative's signature will be returned for correction i) Participants or their designated representative must be copied when submitting reimbursement request

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<td>List of Service Descriptions by Name (Please select the waiver code that applies)</td>
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The correct Service Code should be selected:

a) Assistive Technology
b) BSS - Behavioral Assessment
c) BBS - Behavioral Plan
d) BSS - Behavioral Consultation
e) BSS - Brief Support Implementation
f) Community Development Services 1:1
g) Community Development Services 2:1
h) Day Habitation
i) Employment Services Milestone 1; Employment Service Milestone 2;Employment Service Milestone 3
j) Employment Service - Self Employment Development Support
k) Employment Services - Job Development
l) Employment Service – On Going Job Supports
m) Employment Services - Follow Along Support
n) Employment Services - Co-Worker Support
o) Environmental Assessment
p) Environmental Modification
q) Family and Peer Mentoring Support
r) Family Caregiver Training and Empowerment
s) Housing Support Services
t) Live- In Caregiver
u) Nursing Support Services
v) Personal Support
w) Personal Support Enhanced
x) Personal Support 2:1
y) Remote Support Services
z) Respite Care Services - Camp
aa) Respite Care Services - Licensed Site
bb) Respite Care Services - Hour
cc) Support Broker
dd) Supported Living
ee) Transition Services
ff) Transportation Orientation, Travel Training, and Taxi, Uber, Lyft
gg) Vehicle Modification

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