REV. FEBRUARY 1, 2015
MANUAL LETTER #06-2015

NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

RESPITE SUBSIDY PROGRAM
464-000-5

To: Program Clients & Individual Service Providers for the following DHHS programs:

- ❖Medically Handicapped Children's Program
- ❖Disabled Children's Program
- ❖Disabled Persons & Family Support
- ❖Lifespan Respite Program

RE: Direct Deposit/Electronic Funds Transfer

The Nebraska Department of Health and Human Services (DHHS) is requesting all service providers and clients receiving payments or reimbursement from a program listed above to sign up for electronic payments by direct deposit. Please complete and sign the enclosed **State of Nebraska Substitute Form W-9 & ACH Enrollment Form** and return. Both sections (Form W-9 and ACH Enrollment) must be filled out.

Under **Substitute Form W-9:** Name, Address, City/State/Zip, Taxpayer ID or SSN, sign and date with printed name and contact phone number.

Under **ACH Enrollment:** all banking information, ****attach voided check, copy of a check OR letter from your bank** indicating routing and account numbers. **The attachment may not be hand-written.** Email address (if available) is used to notify you of a pending payment. **Your** signature at the bottom (not a bank employee) is required for direct deposit of funds. Your "title" is Provider.

If using a reloadable debit card: Funds cannot be deposited onto a debit card without the banking information (routing number and account number). When signing up for the card, you should have received a paper containing this information. If you cannot locate this information, contact the phone number on the back of the debit card to request the required information be mailed to you and submitted with ACH enrollment form. **We cannot accept a copy of your debit card.

Direct deposit requests are submitted during the first week of each month. You will receive a paper check until your direct deposit request has been submitted and approved.

Please submit your completed form and required attachments to:

Department of Health and Human Services
Division of Child and Family Services, Economic Assistance
Attn: Payment Reviewer
PO Box 95026
Lincoln NE 68509-5026

Clear Form

STATE OF NEBRASKA SUBSTITUTE FORM W-9 & ACH ENROLLMENT FORM

Return Form to the Requester. (Rev. October 2013)

Requester Information:

Agency:	NE DHHS - CHILDREN & FAMILY SERVICES	Phone:	
Name:	ATTN PAYMENT REVIEWER	Fax:	
Address:	PO BOX 95026 LINCOLN NE 68509-5026	E-mail:	dhhs.mhc24@nebraska.gov

Substitute Form W-9: (IRS Rev August 2013)

Name (as shown on your income tax return):

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

Check appropriate box for federal tax classification:

☐ Individual ☐ Sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Non-Profit Entity ☐ Government (Local, State or Federal)

☐ Limited Liability Company. Enter the tax classification (C = C Corporation, S = S Corporation, P = Partnership) ____

☐ Other (see instructions) _____

Exemptions (see instructions): Exempt payee code (if any) ____ Exemption from FATCA reporting code (if any) _____

Address:

City, state, and ZIP code

Remit Address (if different):

City, state, and ZIP code

Taxpayer Identification Number (TIN):

Social Security Number (SSN): ____-____-_____ **OR** Employer Identification Number (EIN): ____-_____

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 due to failure to report interest and dividend income, and
3. I am a U.S. citizen or other U.S. person (defined in the instructions), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

For additional instructions please refer to http://www.irs.gov/pub/irs-pdf/fw9.pdf to obtain a copy of the IRS Form W-9 General Instructions.

Signature of US Person: _____ Date: _____

Printed Name: _____ Contact Phone: _____

Comments or Business/Entity Notes:

ACH Enrollment: (Rev. October 2013) ☐ Initial Setup ☐ Change

This information is REQUIRED to process payments. Without this information, your payment may be delayed.

Financial Institution Name:	Nine Digit Routing Number:	☐ Check here if the bank is outside of the United States.
Address:	Depositor Account Number:	☐ Check here if the following must be discussed with your entity: There are new processing requirements for electronic vendor payments that are being sent to a financial institution outside of the United States. If our payments to you are being forwarded from a U.S. financial institution to a financial institution in another country, please advise (identify who within your company).
City, state and ZIP code:	Type of Account: ☐ Checking ☐ Savings	

This account will be used for all payments by the State of Nebraska unless specified here: _____

E-mail: _____
(Used for ACH payment notifications.)

Vendor Signature:	**Attachment Required!** (Select and attach **one** of the following items for verification):
Printed Name:	☐ Blank check (voided) or ☐ Photocopy of a check
Title:	☐ Letter or statement from your financial institution
Date	☐ Vendor Invoice or ☐ Vendor Letter with ACH instructions

Internal Use Only: