



Fello Self-Directed Services

Phone: 1.866.252.6871 | Fax: 1.888.272.2236

Vendor Payment Request Submittal: SDSVendor@fello.org

Open a Customer Service Ticket: <https://felloselfdirection.zendesk.com>

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:		
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	<p>An invoice or quote should be submitted with the following:</p> <ul style="list-style-type: none"> • The vendor's name, address, and email • The employer's name as the recipient • The goods or services to be purchased <p>Service invoices should reflect the <i>exact</i> dates of services with the following:</p> <ul style="list-style-type: none"> • Participant name • Vendor name • The service(s) rendered as authorized in the Person-Centered Plan • Date(s) the services were rendered • Start and end times of the services each day • Number of hours/units for each day (broken down by the quarter hour) • Name of each employee who provided the service(s) • A description of tasks completed by the vendor for each time entry • Total amount charged 	

<p>Reimbursement Requirements</p>	<p>When submitting a request for reimbursement, provide the following:</p> <ul style="list-style-type: none"> • A detailed receipt with date of purchase, item(s) purchased, total cost, and method of payment • For cash purchases, provide a cash receipt/and or withdrawal statement to support cash payment • 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 • 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 • Upon initial request for health insurance reimbursements, submit the Participant's Employee written policy to SDSVendorCompliance@fello.org listing the maximum dollar amount allowed for each staff benefit • CPR certificates must be provided as supporting documentation to show proof of certification • IFGDS goods and services for each plan year must be approved by DDA prior to purchase and submission for reimbursement
<p>Health Insurance Reimbursement Requirements</p>	<p>Participant employers may reimburse their employees' Health Insurance Premiums.</p> <ul style="list-style-type: none"> • Health insurance reimbursements may only be made for health insurance coverage for the employee. Coverage for spouses, children, and other family members cannot be reimbursed. • Only policies purchased directly by the employee qualify for this reimbursement. • Reimbursement payments cannot be processed until after the date of service. <p>In order to process any health insurance reimbursements, Fello must have a copy of the following:</p> <ul style="list-style-type: none"> • The participant's written Employee Policy that outlines the maximum dollar amount that may be used toward an employee's health insurance premium. This can be sent to sdsvendor@fello.org, and you only need to send it in once each plan year. <p>For each reimbursements request, please send the following to sdsvendor@fello.org:</p> <ul style="list-style-type: none"> • A monthly invoice/itemized billing statement for the period that was paid for. • Proof of payment, including a redacted billing statement that includes the name of the employee. • Policy enrollment documentation showing who is covered by the plan and a breakdown of the coverage type. The full policy is not required; only the page showing who is covered by the plan, including any dependents. Please note Fello cannot provide reimbursements for plans that include dependents. • Written permission to make payment signed by the participant or designated representative. The Vendor Payment Request form serves this purpose.

	<p>Please note that only basic medical plans can be reimbursed. The following do not qualify for reimbursement:</p> <ul style="list-style-type: none"> • Supplemental plans (e.g., fixed-indemnity plans). • Retirement plan health policies. • Medicaid policies. • Medicare policies. • Policies provided by another employer, including those purchased by unions. • Policies provided by a former employer, including Consolidated Omnibus Budget Reconciliation Act (COBRA) policies. • Dental and vision coverage.
<p>General Requirements</p>	<p>Participants should review the following requirements when submitting an invoice for processing:</p> <ul style="list-style-type: none"> • Prior to payment, vendors must submit required documents and credentials as outlined on the Vendor Requirements form and submit to SDSVendorCompliance@fello.org • Vendors must adhere to the waiver service, billing units, and hour limitations as written in DDA's Self-Directed Services Manual • Reimbursements cannot be issued directly to the employer or their support broker • Vendor addresses on the VPR and in Bill.com must match for reimbursement to be processed • 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 SDSvendor@fello.org • Submissions that are not revised to match the exact amounts available in the budget once depletion is identified will be returned for corrections • Invoices submitted with service dates over 11 months old cannot be processed • VPRs submitted without the participant's or designated representative's signature will be returned for correction • Participants or their designated representative must be copied when submitting reimbursement request
<p>List of Service Descriptions by Name (Please select the waiver code that applies)</p>	<p>The correct Service Code should be selected:</p> <ul style="list-style-type: none"> • Assistive Technology • BSS - Behavioral Assessment • BBS - Behavioral Plan • BSS - Behavioral Consultation • BSS - Brief Support Implementation • Community Development Services 1:1 • Community Development Services 2:1 • Community Development Services Group 1-4 • Day Habitation • Employment Services Milestone 1; Employment Service Milestone 2; Employment Service Milestone 3 • Employment Service - Self-Employment Development Support • Employment Services - Job Development • Employment Service – On Going Job Supports • Employment Services - Follow Along Support • Employment Services - Co-Worker Support • Environmental Assessment

**List of Service Descriptions
by Name (*continued*)
(Please select the waiver code
that applies)**

- Environmental Modification
- Family and Peer Mentoring Support
- Family Caregiver Training and Empowerment
- Housing Support Services
- Live- In Caregiver
- Nursing Support Services
- Personal Support
- Personal Support Enhanced
- Personal Support 2:1
- Remote Support Services
- Respite Care Services - Camp
- Respite Care Services - Licensed Site
- Respite Care Services - Hour
- Support Broker
- Supported Living
- Transition Services
- Transportation Orientation, Travel Training, and Taxi, Uber, Lyft
- Vehicle Modification