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	$ 0.00
Employer/Authorized Rep Signature:		**Date:**

By signing **and dating** 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:** • The vendor's name, address, and email • The employer's name as the recipient • The goods or services to be purchased Service invoices should reflect the *exact* dates of services with the following: • 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

Reimbursement Requirements	**When submitting a request for reimbursement, provide the following:** • 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
Health Insurance Reimbursement Requirements	**Participant employers may reimburse their employees' Health Insurance Premiums.** • 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. **In order to process any health insurance reimbursements, Fello must have a copy of the following:** • 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. **For each reimbursements request, please send the following to sdsvendor@fello.org:** • 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.

	Please note that only basic medical plans can be reimbursed. The following do not qualify for reimbursement: • 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.
General Requirements	**Participants should review the following requirements when submitting an invoice for processing:** • Prior to payment, vendors must submit a W-9 and all required documentation for a serve as outlined in the DDA Self-Directed Services manual 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 • The FMCS cannot process payment for services performed over 11 months ago. Participants should ensure invoices are submitted in a timely manner so that payments are processed before this deadline. If a payment is not processed according to the AP calendar, please place a customer service ticket. • 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
List of Service Descriptions by Name (Please select the waiver code that applies)	The correct Service Code should be selected: • 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