



VENDOR INFORMATION FORM

Instructions for Completing the Vendor Information Form

STEP 1: COMPLETE THE FORM

STEP 2: SUBMIT THE FORM

To help ensure the security of your tax identification information submit this form via e-mail to:
MHVendor@methodisthospitals.org

The Methodist Hospitals, Inc. Vendor Information Form

The Vendor Information Form is The Methodist Hospitals, Inc. and must be completed and signed by the individual/entity to receive payment. If you need help, e-mail us at MHVendor@methodisthospitals.org

Vendors please complete the information in steps 1 through 3:

Form definitions and explanations at end of form

Step 1 – Tax Information

Name of Individual or Business Name (if sole proprietor, please list name of owner and name of business.)

If completing form as an Individual, provide birth date:

Gender: Male Female

Taxpayer Identification Number

Enter Social Security Number (SSN), Federal Employer ID Number (FEIN) or Individual Taxpayer Identification Number (ITIN) (if Applicable), associated with the above name

Is this business a disregarded entity for tax purposes? Yes No

Enter Social Security Number (SSN), Federal Employer ID Number (FEIN) or Individual Taxpayer Identification Number (ITIN) (if Applicable), used for federal tax reporting purposes (if different from above)

Parent Company Name (if different than above)

Please mark all that apply:

Individual

S-Corp/Solely Owned Corporation

Tax Exempt Organization

Sole Proprietor

Corporation/Incorporated

Med Health Care Services Provider

Sole Proprietor LLC

Corporation LLC

Real Estate Agent

Partnership

Government Entity

Attorney

LLC Partnership

Not-for-Profit Corporation

Trust or Estate

Individuals: Please check the appropriate classification.

U.S. Citizen U.S. Permanent Resident Resident Alien for Tax Purposes Non-Resident Alien

Businesses: Please check the appropriate classification.

U.S. Company Foreign Vendor with U.S. Presence Foreign Vendor

Permanent Residence/Corporate Office Address (Address, City, State, Zip Code, Phone, Fax, E-mail)

Payment Address (if different from above)

Purchase Order Address (if different from above)

Types of Goods and Services Provided

Goods Services Attorney Royalties Medical Other (please describe)

Describe in detail the Goods or Services to be Provided

Step 2 – Type of Operation (check all that apply)

Diverse Business

Women-Owned Business Enterprise (WBE) Minority-Owned Business Enterprise (MBE)
Veteran-Owned Business Enterprise (VBE)

Diverse Business Certifying Organization

Provide letter(s) of certification from certifying agency when submitting this form

Not Certified
INDOT (Indiana Department of Transportation)
NMSDC (National Minority Supplier Development Council)
OMWBD (City of Indianapolis Office of Minority and Women Business Development)
Great Lakes WBC (Great Lakes Women's Business Development)
Other (Please Specify)

Small Business - check all that apply

Is your business considered a Small Business with the State of Indiana? Yes No

Is your business located within Lake or Porter County, Indiana? Yes No

Is your business considered a Small Business with the
Federal Government Small Business Administration (SBA)? Yes No

Small disadvantage business Women-owned small business Veteran-owned small business
HUBZone small business Service-disabled veteran-owned small business

Step 3 – Certification and Signature

I certify that:

1. 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 Service (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.
2. I or the organization I represent will comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations promulgated there under, to the extent applicable in each transaction.
3. Neither the organization I represent nor any of its employees or subcontractors who may provide services pursuant to any Contract with The Methodist Hospitals, Inc. is currently Subject of an investigation or proceeding to exclude it as a provider under Medicare or Medicaid or under any other federal or state health care program or under any third party insurance program, nor is it currently excluded or debarred from submitting claims to Medicare or Medicaid or to any other federal or state health care program or to any their party insurer. My organization represents and warrants it has checked the U.S. General Service Administration's (GSA) Excluded Party Listing System (EPLS), which lists parties excluded from Federal procurement and non-procurement programs. The EPLS website includes GSA/EPLS, the U.S. Department of Health and Human Services (HHS) Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), and the U.S. Department of Treasury's (Treasury) Specially Designated Nationals (SDN) list. My organization also represents and warrants it has checked the Indiana Office of Inspector General (OIG) Provider Sanctions list of individuals and entities excluded from state procurement with respect to my organization's employees and agents. See the following websites: <https://sam.gov/content/home> and <https://www.in.gov/ig/>. The Methodist Hospitals, Inc. will terminate any contract without penalty to The Methodist Hospitals, Inc. if my organization becomes excluded during the life of any contract.
4. I certify that the information contained herein is correct. I understand that misrepresentation may be cause for removal from the qualified vendor list.
5. If any of the vendor information on this form changes the vendor must complete a new form and check updated vendor information. The form must then be resubmitted to the address indicated on this form.

Vendor Signature

Date

Printed Name / Phone Number / E-mail

Vendor Information Form Definitions

Disregarded Entity

A business entity that is separate from its owner, but which elects to be disregarded from the business owner for federal tax purposes.

Diverse Business

You are considered a diverse business if you meet the following criteria:

- At least 51 percent owned and controlled by persons who are minority, female, or a Veteran.
- Must be a United States Citizen

Small Business

You are considered a small business if you meet the following criteria:

- An Indiana business
- Average annual receipts under \$7.5 million
- Number of employees less than 500

Veteran Business

You are considered a veteran business if you meet the following criteria:

- Home office must be located in Indiana
- Average annual receipts under \$7.5 million
- At least 51 percent owned and controlled by Veteran-owned small business (VOSB) or Service-disabled veteran-owned small business (SDVOSB) living in Indiana