CEDA

Community and Economic Development
Association of Cook County, Inc.

www.cedaorg.net

Vision Provider Registration Packet

CEDA's Family Support and Community Engagement

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A letter from CEDA's CEO

Dear community businesses,

The Community and Economic Development Association of Cook County, Inc. (CEDA) is one of the largest private, nonprofit Community Action Agencies in the country, serving residents throughout Cook County, Illinois. **We serve more than 300,000 people and more than 150,000 households every year.**

CEDA offers a variety of programs and services in the areas of community and economic development, education, emergency assistance, employment and training, energy conservation and services, health and nutrition, and housing. We learned from our 2021 Community Needs Assessment how important dental care needs are to so many individuals and families that currently do not have the means to obtain or gain access to these services.

We invite you to partner with us in providing these vital services to the community. Your participation in this program will help reduce barriers that hinder families striving for self-sufficiency. In the process, your business will help give people hope and a chance to realize their full potential.

Please visit our website at cedaorg.net to download our Community Needs Assessment and review all the services we provide to families. Enclosed you will find more information on our Dental Care Program, policies, procedures, and a Provider Registration Packet with instructions on how to become a vendor.

Our mission is to empower individuals, families, and communities facing poverty to secure a better quality of life. We hope you will partner with us in this endeavor.

Sincerely,

Harold Rice, Jr.

Harold Rice, Jr.
CEO/President

Program Purpose

The purpose of CEDA Family Support and Community Engagement (FsACE) Vision Care Program is to help Suburban Cook County residents with low incomes to get vision care they need to stay healthy or to pursue their employment or education goals. This is done by giving them access to vision care through a network of licensed and insured providers. The assistance provided by this program is funded by CEDA's Community Services Block Grant (CSBG).

How the Program Works

Individuals interested in CEDA FsACE programs, must complete an intake process with CEDA which determines their eligibility to receive services. Eligible customers must live within suburban Cook County and meet program income guidelines.

Referral Form Issuance

Eligible customers interested in vision care services will receive a Referral Form from CEDA and identify a vendor of their choosing from the provider list. Customer will then schedule an estimate appointment with the provider to determine the services needed.

Estimate Appointment

During the estimate appointment, customer will present their CEDA Referral Form, valid ID, and customer contribution (if applicable) to the provider. The customer contribution is similar to a co-pay and further explained on page 10.

We ask that providers conduct a comprehensive exam of the treatment services needed. Providers can bill CEDA for exam services. The treatment plan should be sent to CEDA to continue voucher processing.

Voucher Issuance

Once the treatment plan is sent to CEDA, a voucher will be issued to the customer for services. The voucher will indicate the services to be provided, the vendor selected, the customer contribution amount, and the approved amount for services to be paid by CEDA. (see voucher example on page 9)

1st Service Appointment

Once a customer obtains a voucher, they are required to schedule the first service appointment with the provider within 14 days.

During the first service appointment, the customer will bring their voucher, a valid photo ID, and if applicable a customer contribution or good faith effort towards the service (if not paid at the estimate appointment).

Providers must copy the photo ID provided by the customer and ensure the correct person is accessing the service. In addition, the provider will collect the customer's contribution if applicable.

At the first service appointment, the provider will perform the services approved on the voucher.

Completing Service / Billing

If necessary, the customer will schedule another appointment to complete the services. However, all voucher services must be completed within 45 days of the first service appointment date. When all services for the customer have been rendered, the provider bills CEDA (further explained on pages 11-13). Once all billing documents are submitted, CEDA pays the provider directly within 45 days.

Provider Eligibility

In order to achieve the purpose of this program, CEDA partners with vision care providers who meet the following criteria:

- Licensed doctors in the State of Illinois
- Provide care to patients in a location within the State of Illinois
- License must be in good standing with the State of Illinois and possess a history free of disciplinary actions
- Providers must also have a minimum of three (3) years' experience

(Information on provider registration available on page 15)

Covered Services

This program issues vision care vouchers to customers as a means to access treatment to:

- correct vision via an eye exam
- secure a new or updated prescription for corrective lenses
- repair or replacement of eyeglasses due to damage or loss
- obtain eyeglasses, including frame and lenses (a minimum one-year warranty is required)

The vision voucher covers the aforementioned services **ONLY**.

(See voucher example on page 9)

Under most circumstances, it does not cover routine annual eye exams, non-emergency renewal of lenses or frames, contacts, special options (tint, non-glare coating, etc.) and other surgical/laser treatment or any cosmetic procedures.

Only the conditions previously mentioned will be covered by the CEDA FsACE Vision Care Voucher. If you as the vision provider believe that another procedure is necessary to complete treatment, please contact the CEDA FsACE **Regional Manager** listed on the voucher to get prior approval.

Please note: The vision care program cannot be used to pay for vision services that were performed before the date the voucher was issued.

Vision Care Voucher

1. Payment for covered services can be up to $300 per household.
   ****Vouchers are issued based on eligibility for a one-time event per person***

2. Customers must bring a valid photo identification card *and* their voucher to receive services. Please Note: A copy of the photo ID and voucher must be submitted with your invoice upon completion of vision services.

3. Dates of service must correspond with the dates of service indicated on the voucher. In other words, the customer must have an appointment scheduled with a vision provider within fourteen (14) business days of the date listed on the FsACE Vision Care Voucher. Keep in mind that all related vision care associated with the voucher must be completed within 45 business days from the 1st appointment date.

4. The voucher issued will show the vision practice to which it is made. All billing and invoicing will have the exact same provider (and treating doctor) information listed.

5. Only approved doctors can provide services to customers through this program. Services provided by a non-approved doctor will **not be paid** by the customer nor CEDA.

6. If a voucher was issued incorrectly and needs to have the provider information corrected, please contact CEDA FsACE regional office to request a corrected voucher. Furthermore, approved vouchers and patient service plans cannot be revised without direct approval from CEDA FsACE management staff.

7. Patients must receive any eyewear, corrective eyeglass lenses and/or frames from the provider before CEDA FsACE vision assistance can make payment to the provider.

8. In cases where the patient has other vision coverage such as insurance, Medicaid, etc., all other vision plans must be billed PRIOR to applying the value of the voucher.

9. Vouchers are valid for individual treatment only and are not transferable to others.

10. If the same patient (or another household member) needs services for a different vision problem, that person will need to contact the CEDA FsACE Vision Care Program to determine eligibility. If approved, a new voucher for the care will be issued.

Vision Care Voucher (EXAMPLE)

CEDA

FsACE VISION CARE PROGRAM VOUCHER 2023

September 14, 2023 (DATE)	SV-23 032 (VOUCHER NO.)
Bill Jones (AUTHORIZED RECIPIENT)	Dr. Jorge Mathis (NAME OF PHYSICIAN/OPTICIAN)
123 Maine Street (ADDRESS)	Mathis Optical (PRACTICE NAME)
Park Forest , IL 60466 (CITY, STATE, ZIP)	6534 Old Red Road (ADDRESS)
3/10/1975 (PATIENT D.O.B.)	Richton Park (CITY) / IL (STATE) / 60471 (ZIP CODE)
773-465-6824 (TELEPHONE NO.)	708-795-6565 (PHONE NO.) / 708-795-6565 (FAX NO.)

SERVICE DISCLAIMER

This voucher is non-transferrable and has no cash value. The authorized recipient must provide valid photo identification with this voucher. This voucher is valid when an appointment for service is within 14 business days of the date on this voucher. All services and products must be completed within 45 business days from the first appointment date, or by December 31, 2023, whichever comes first. [Note: CEDA reserves the right to request an earlier completion date if required by the funding source]. This voucher can only be used for the authorized provider listed above. The FsACE Vision Program will authorize up to $300.00 per household for allowable vision services, however each eligible household member will have a separate voucher. If a service exceeds the voucher amount by $300 or more, there must be a signed payment arrangement between the provider and patient to satisfy the balance. The payment arrangement must be submitted to the FsACE Regional Manager for approval before service can begin. CEDA FsACE has referred this service recipient, but does not assume responsibility or liability for the vision service that may be provided. Utilization of this voucher is deemed acceptance of this release of liability by the service recipient and/or provider.

For program service questions or allowable service/costs please contact Region team at or email your questions to csbgVendorinfo@cedaorg.net. Upon completion of the service, please submit the billing invoice along with a digital image of the original voucher and the patient's photo ID to CSBGINVOICE@CEDAORG.NET

SERVICE REQUESTED by Family Support Specialist, Eleanor Smith *Remote*	Voucher Not to Exceed
Bill Jones is in need a corrective eyeglasses	300.00

BEFORE treatment is performed, the Patient must pay the provider the Customer Contribution of $ 25.00

I certify that the above service request meets the authorized criteria for services as outlined by the CEDA FsACE Vision Care Program and that the service event is new and has not been previously completed by another vision care provider.

Isreala Miller — 9/14/2023

CEDA FsACE Regional Manager- **DATE**

Telephone Number: 312-588-1538 **Email:** sample@cedaorg.net

An appointment has been made. **Initial appointment date is** _____

PROVIDER ATTESTATION (to be signed and submitted with billing)

I understand that this voucher cannot be used for vision care services that would be covered by the patients' Medicaid or other vision or medical insurance. I attest that any applicable insurance was been billed prior to applying the value of this voucher.

Signature of Provider or Medical Biller _____ Title _____ Date _____

Service Expiration / Void or Closed Vouchers

(TIME SENSITIVE)

1. All 1st appointments must be made within 14 business days of the date on the voucher

2. All services must be completed within 45 business days from the 1st appointment date, or the end of the calendar year, whichever comes first.

3. If the customer fails to make an appointment within 14 business days from the voucher issuance date, the voucher is void and cannot be used (please refer customer back to CEDA FsACE).

4. If the customer fails to make a scheduled appointment and does not re-schedule within (2) weeks, the voucher will be closed (not available for future use) and you can submit for payment at that time by submitting the voucher and invoice for processing with an explanation to CEDA FsACE.

Customer Contribution

All customers are required to provide a modest financial contribution towards their services before the financial assistance from a program can be applied. This customer contribution is similar to a co-pay and must be collected by the vision provider at the time of service. The customer contribution amount will be listed on the vision voucher. In some instances, this amount may be zero.

The customer's payment must be reflected on the provider's invoice for services.

Fees for Services

CEDA FsACE Vision Care Program encourages the use of sliding scale fees for services, when possible, for those that are income eligible according to the vision provider's own fee policy. We track and appreciate these contributions as they allow the program to assist more qualified recipients in suburban Cook County.

A vision provider will be expected to utilize their usual and customary fee structure if a sliding scale does not exist. CEDA FsACE Vision Care Program requests that vision providers honor any coupons, discounts or advertised specials they offered at the time of service for covered services prior to applying the value of the voucher.

Billing for Services

Please read the voucher carefully. The voucher indicates that the customer is responsible for the portion of the treatment that exceeds the amount listed on the voucher. Please be mindful that we serve low-income families. It is not in the best interest of the customer or the vision practice to exceed the voucher amount. Keep in mind that excessive payment arrangements can create a financial hardship for our customers.

Any agreed upon payment plan between the provider and patient for more than $300.00 over the voucher amount **must get prior approval** from FsACE. The payment arrangement and approval must be submitted with the original invoice and voucher for processing.

When submitting billing for payment, please indicate the patient's customer contribution or other payment on the invoice billing the same way you report a payment by another insurance carrier.

- **Please submit only one (1) invoice per patient.**
- **Invoices must be submitted within (30) business days from the completion of the work.**

If you are discounting services or providing a service at no cost, please indicate this on the invoice as well, so we can capture the actual cost and all discounted or donated services.

Billing invoices submitted for non-covered services will be denied and the individual may not be billed for these services.

If the customer fails to make an appointment within 14 business days from the voucher issuance date, the voucher is void and shouldn't be used (please refer client back to CEDA FsACE Vision Care Program).

If the customer fails to make a scheduled appointment and does not re-schedule within (2) weeks, the voucher will be closed (not available for future use) and you can submit for payment at that time by submitting the voucher and invoice for processing with an explanation to the CEDA FsACE Vision Care Program.

Customers must present their **voucher** and a **valid photo ID** to get services. Providers must **copy the customer's ID** and **retain the original voucher** to submit with the invoice for payment. CEDA cannot pay for services rendered without a voucher.

The date of service and itemized eligible services rendered must exactly the corresponding information on the voucher.

Any additional services provided for the patient that are not covered by the voucher should be billed directly to the customer, separate from the procedures being billed to the CEDA.

How to Bill for Services

To submit billing, the provider will email the following documents to **csbginvoice@cedaorg.net**

1. Vision Care Voucher *(with "Provider Attestation" section signed by provider)*
2. Copy of customer's valid ID *(provided at the time of service)*
3. Any payment arrangement agreement *(if applicable)*
4. Billing Invoice *(please note customer GFE if applicable)*

Billing that is mailed or faxed will not be processed.

Sending invoice documentation to an email other than **csbginvoice@cedaorg.net** will significantly delay payment processing.

Billing is processed quickly by CEDA. As long as your billing is prepared as described above and emailed to **csbginvoice@cedaorg.net** payment can be expected within 30 to 45 days.

All invoices must be submitted no later than 30 business days from the date of completed service.

Referrals

Referring Customers to Vision Specialists

If the customer requires a referral to a vision specialist, the vision provider will need to provide that referral in writing to the customer with all the specialist contact information. The patient will need to notify the FsACE Vision Program to secure an additional voucher to be used with the specialist.

Referring Customers to Vision Providers

CEDA does not make direct referrals to any business, but rather offers customers an option to choose from a directory of providers willing to participate in our program or a provider of their choosing, who has submitted the necessary documents to become an approved provider.

Referring Customers to CEDA

We welcome customer referrals from service providers. If you would like to refer an individual or household to the CEDA FsACE Vision Care Program, please see the service locations and contact information listed below.

Contact Information

In addition, if there are any questions regarding **voucher or payment processing**, please contact the appropriate FsACE regional office, see the contact information listed below.

North Suburbs
CEDA One-Stop
2300 Main Street
Evanston, IL 60202
Office: (847) 328-5166 ext. 5416

West Suburbs
CEDA One-Stop
6141 West Roosevelt Road
Cicero, IL 60804
Office: (708) 222-3824 ext. 4831

South Suburbs
CEDA One-Stop
53 East 154th Street
Harvey, Illinois 60426
Office: (708) 371-1220 ext. 3057

If there are any questions regarding **program policies and procedures**, please contact the manager below.

Angel Smiley, Senior Program and Contracts Manager
(708) 630-9830
csbgvendorinfo@cedaorg.net

Provider Registration

Providers interested in participating in the program would submit the following documents via email to **sfreeman@cedaorg.net.**

1. **Provider Registration Form** (see page 16)
2. **Statement of Understanding** (see page 17)
3. **W9 Form** (see page 18)
4. **Vendor Add Form** (see page 19)
5. **Current Business License**
6. **General Liability Insurance**
7. **Professional Liability Insurance (for each doctor participating)**

**W9 and Vendor Add Forms are needed to process payments*

Upon receipt and review of the documents, providers will receive notification of their status within one to two weeks. Approved providers will be added to our provider list, which is given to each customer to select a provider.

CEDA

2023 VISION PROVIDER REGISTRATION FORM

Please print legibly. This information will be entered on the provider list.

PRACTICE NAME: _____

DOCTOR(S) NAME(S): _____

_____

STREET ADDRESS:_____

CITY _____ ZIP CODE: _____

COUNTY:_____ □ MULTIPLE LOCATIONS (please submit a separate form for each location that will participate.)

TELEPHONE NUMBER:_____ FAX NUMBER:_____

WEBSITE:_____

EMAIL:_____

VISION SPECIALITY:_____

LANGUAGES SPOKEN:_____

HOURS OF OPERATION: **(Please indicate the specific times your office opens and closes)**

Monday_____Tuesday_____Wednesday_____Thursday_____ Friday_____

Saturday_____ Sunday_____

TREATMENT:

□Treats Adults □Treats Disabled Adults □Treats Persons with HIV-AIDs Sedation □ YES □ NO

□Treats Children □Treats Disabled Children □Treats Persons with Diabetes

SERVICES:

□Vision services, including eye exams □Medical eye care for conditions such as glaucoma

□Prescribe and fit eyeglasses □Surgical eye care for trauma, cataracts, glaucoma, etc.

□Provide, adjust, and repair glasses and frames

ACCESS:

□Free Parking □Accessible by Public Transit □Wheelchair Accessible

EXAM COST: $_____

Would you like to limit the amount of referrals made to your office? □ YES* □ NO

** If yes, please indicate the limit: ____ per month ____ per year*

TYPES OF INSURANCE ACCEPTED: □Medicaid □Medicare

Other: _____

Contact information for the Administrator of Accounts Receivable

Name:_____Phone:(_____Email:_____

2023 PROVIDER STATEMENT OF UNDERSTANDING

I, _____ certify that I have read the attached
(Provider Name) and (Name of Practice or Business)

Provider Registration Packet and understand and will comply with all program policies and procedures including the following;

_____ **(Please initial here as your acceptance to all of the following)**

1. **Billing Procedures and Timelines**
   - Billing packets must contain all supporting documentation, including a copy of the customer's ID, customer voucher (retain a copy for your records), invoice, and if applicable, an approved payment arrangement.
   - A Customer Contribution, which is similar to a co-pay, must be collected by the provider before the financial assistance of this program can be applied. Additionally, the customer's payment must be reflected on the provider's invoice for services.
   - Invoice must be submitted within 30 days of service completion. Only one (1) invoice per voucher is accepted.

2. **Vouchering Policies and Procedures**
   - An appointment must be made within 14 days of the voucher date.
   - The service must be completed within 45 days of the first appointment date.
   - The service must comply with the estimate or service plan.
   - For void and closed vouchers, see program guidelines.

3. **Approval Guidelines**
   - If service is anticipated to exceed beyond the (45) day time-frame, you must have an approved CSBG Extension of Service Authorization from CSBG on file.
   - If service costs exceed voucher amount, follow program specific guidelines.

I understand that failure to comply with all program policies and procedures included in the Provider Registration Packet, may result in non-payment for services and/or termination of program partnership.

_____ _____
(Printed Name) *(Date)*

SIGN HERE

_____
(Signature)

Please note: This form must be completed for each doctor or business owner registering for the program.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

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

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II 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 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; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

CEDA

Community and Economic Development Association
Of Cook County, Inc.

Vendor Add/Change Form

This information will be used by CEDA to process vendor payments. Failure to provide the requested information may delay or prevent the receipt of payments. If you are a new vendor, a signed W-9 form should accompany this form. If Action Requested is "Change", please note the reason for the change.

Action Requested (check one)		
NEW ☐	CHANGE ☐	CANCEL ☐

If "Change" is selected, note reason for change:

Vendor Information
VENDOR NAME:
VENDOR ADDRESS:

Contact Information
PRIMARY CONTACT NAME:
E-MAIL ADDRESS:
PHONE NUMBER:
FAX NUMBER:

Vendor Mailing Address
COMPANY NAME:
STREET:
CITY, STATE, AND ZIP:

Remittance Address (if same as Mailing leave blank)
COMPANY NAME:
STREET:
CITY, STATE, AND ZIP:

Vendor Authorization
SIGNATURE: SIGN HERE
TITLE:
DATE:

***** For CEDA Use Only *****

UPDATED BY:	DATE:
VALIDATED BY:	DATE: