



CEDA

Community and Economic Development
Association of Cook County, Inc.

www.cedaorg.net



Dental Provider Registration Packet

CEDA's Family Support and Community Engagement

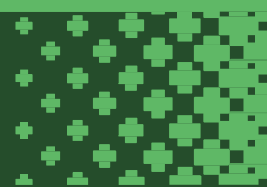


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Dear community businesses,

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.
CEO/President

Program Purpose

The purpose of CEDA Family Support and Community Engagement (FsACE) Dental Care Program is to help Suburban Cook County residents with low incomes to get dental care they need to stay healthy or to pursue their employment or education goals. This is done by giving them access to dental 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 dental 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 9.

We ask that providers conduct a comprehensive exam of the treatment services needed. Providers can bill CEDA for exam services. A 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 8)

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 10-12). 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 dental care providers who meet the following criteria:

- Licensed dentists 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 14)

Covered Services

This program issues dental care vouchers to customers as a means to access treatment to relieve pain, bleeding and/or infection, chewing and eating difficulties. (See voucher example on page 8)

Under most circumstances, it does not cover prophylactic or routine dental procedures, nor does it cover any cosmetic procedures unless the procedure will be for the replacement or repair of missing, broken or decayed front teeth.

Only the conditions previously mentioned will be covered by the CEDA FsACE Dental Care Voucher. If you as the dental 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 dental care program cannot be used to pay for dental services that were performed before the date the voucher was issued.

Dental Care Voucher

1. Payment for covered services can be:
 - a. Up to \$2,000 per household (HH) for basic dental care (i.e. deep cleaning, cavities, root canals or fillings)
 - b. Up to \$3,000 per HH for restoration or crowns **OR**
 - c. Up to \$4,000 per HH with a suitable treatment plan for dentures or partials****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 dental 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 dental provider within fourteen (14) business days of the date listed on the FsACE Dental Care Voucher. Keep in mind that all related dental care associated with the voucher must be completed within 45 business days from the 1st appointment date.
4. The voucher issued will show the dental practice to which it is made. All billing and invoicing will have the exact same provider (and treating dentist) information listed.
5. Only approved dentists can provide services to customers through this program. Services provided by a non-approved dentist 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 removable devices before CEDA FsACE dental assistance can make payment to the provider.
8. In cases where the patient has is other dental coverage, all other dental 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 dental problem, that person will need to contact the CEDA FsACE Dental Care Program to determine eligibility. If approved, a new voucher for the care will be issued.

Dental Care Voucher (EXAMPLE)

CEDA Family Support and Community Engagement (FsACE)
FsACE DENTAL CARE PROGRAM VOUCHER

Customer Name Jacqueline Jones	Date of Birth 01/00/00	FsACE Service 4/1/20XX
Address 123 Main Street Park Forest IL 60466	Phone 708-555-5555	Customer Contribution Required \$ 25.00
Email jones123@gmail.com	Case Manager Virginia Thompson	FPG% from STARS Intake 0.00%
Intake Site South		

CONTACT INFORMATION

Date <u>4/1/20XX</u>	Voucher No. <u>SA-XX-05</u>	Dr. Roberto Lee
Jacqueline Jones		<i>Dentist</i>
<i>Authorized Recipient</i>		ABC Dental Practice
123 Main Street		<i>Dental Practice</i>
<i>Address</i>		53 South Village Road
Park Forest, IL 60466		<i>Address</i>
<i>City, ST Zip</i>		Richton Park, IL 60471
708-555-5555	DOB <u>03/15/73</u>	<i>City, ST Zip</i>
<i>Phone</i>		(708) 973-5444
		<i>Phone</i>
		(708) 073-5445
		<i>Fax</i>

SERVICE DISCLAIMER

This voucher is non-transferrable and has no cash value. The authorized recipient must provide valid photo identification with this voucher. The voucher is valid when an appointment for service is within 14 business days of the date on this voucher, and will cover expenses including x-rays & exams if applicable, performed in association with the treatment outlined in the Dental treatment plan, minus the client contribution and cost exceeding voucher amount.

All associated dental procedures must be completed within 45 business days from the first appointment date, or by December 31, 20XX, whichever comes first. [Note: CEDA reserves the right to request an earlier completion date if required by the funding source]. The voucher can only be used for authorized provider listed above. The FsACE Dental Program will authorize up to \$4,000 per household for allowable dental 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 service 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 the service recipient, but does not assume responsibility or liability for the dental service that may be provided. Utilization of this voucher is deemed acceptance of this release of liability by the service Recipient and/or Provider.

SERVICE REQUESTED

Requesting Case Manager <u>Virginia Thompson</u>	Region <u>South</u>	Approved Voucher Amount Not to Exceed
Jacqueline is in need of dental care assistance. Per the treatment plan, she is in need of a filling and a root canal.		\$2,000.00
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 Dental Care Program and that the service event is new and has not been previously completed by another dental provider.

<u>Jane Doe</u>	<u>Jane Doe</u>	<u>4/1/20XX</u>
<i>Signature</i>	<i>Printed Name</i>	<i>Date</i>
Jane Doe	South	(708) 639-6669
<i>FsACE Regional Manager</i>	<i>Region</i>	<i>Phone</i>
		<u>jdoe@cedaorg.net</u>
		<i>Email</i>

An appointment has been made Initial appointment date is 4/15/XX

PROVIDER ATTESTATION

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

<u>Dr. Roberto Lee</u>	<u>Doctor and Founder</u>	<u>4/1/20XX</u>
<i>Signature of Provider or Medical Biller</i>	<i>Title</i>	<i>Date</i>

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 dental provider at the time of service. The customer contribution amount will be listed on the dental 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 Dental Care Program encourages the use of sliding scale fees for services, when possible, for those that are income eligible according to the dental 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 dental provider will be expected to utilize their usual and customary fee structure if a sliding scale does not exist. CEDA FsACE Dental Care Program requests that dental 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 dental 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 note: CEDA is a tax exempt organization and documentation including estimates and billing should reflect this status.**

- **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 Dental).

If the client 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 Dental 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. Dental 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 ensure CEDA's tax exempt status is reflected*)
(*please note customer's contribution 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 Dental Specialists

If the customer requires a referral to a dental specialist, the dental 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 Dental Program to secure an additional voucher to be used with the specialist.

Referring Customers to Dental 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 Dental Care Program, please provide the customer with CEDA's Information and Referral phone number, which is (312) 795-8948.

Contact Information

For questions regarding **voucher or payment processing**, please contact the FsACE Regional Manager listed on the service voucher.

For questions regarding **dental care program policies and procedures**, please email 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 15)
- 2. Statement of Understanding** (see page 16)
- 3. W9 Form** (see page 17)
- 4. Vendor Add Form** (see page 18)
- 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.



2024 DENTAL PROVIDER REGISTRATION FORM

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

PRACTICE NAME: _____

DENTIST(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: _____

DENTAL 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

ACCESS:

- Free Parking Accessible by Public Transit Wheelchair Accessible

COSTS: (According to costs submitted in RFQ)

Exam Cost: \$ _____ Panoramic X-Ray: \$ _____ Full Mouth X-Ray: \$ _____

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: _____



2024 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.
- CEDA is a tax exempt organization and documentation including estimates and billing should reflect this status.
- A client’s contribution or Good Faith Effort, 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.

_____ *(Date)*

_____ *(Printed Name)*

_____ *(Signature)*

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

Request for Taxpayer Identification Number and Certification

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

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

Print or type.	See Specific Instructions on page 3.	<p>1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.</p> <hr/> <p>2 Business name/disregarded entity name, if different from above</p> <hr/> <p>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.</p> <p><input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate</p> <p><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____</p> <p>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.</p> <p><input type="checkbox"/> Other (see instructions) ▶ _____</p>	<p>4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):</p> <p>Exempt payee code (if any) _____</p> <p>Exemption from FATCA reporting code (if any) _____</p> <p style="font-size: small;">(Applies to accounts maintained outside the U.S.)</p>
		<p>5 Address (number, street, and apt. or suite no.) See instructions.</p> <hr/> <p>6 City, state, and ZIP code</p> <hr/> <p>7 List account number(s) here (optional)</p>	<p>Requester's name and address (optional)</p> <hr/>

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								
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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 ▶
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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.



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:	
TITLE:	
DATE:	

*** For CEDA Use Only ***

UPDATED BY:	DATE:
VALIDATED BY:	DATE: