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Membership Enrollment Form

General Member Information

ORGANIZATION NAME: ____________________
(Legal Name)

BILLING ADDRESS:

Address: ____________________

City: ____________________ State: __________ Zip: __________

SHIPPING ADDRESS: (CHECK IF SAME AS BILLING)

Address: ____________________

City: ____________________ State: __________ Zip: __________

County: ____________________ Phone: ____________________ Fax: ____________________

Average Census: ____________________

PLEASE CHECK ALL APPLICABLE BOXES

Facility Type:

- ☐ Adult/Senior Daycare
- ☐ Assisted Living
- ☐ Child Daycare
- ☐ Continuum Care Retirement Centers
- ☐ Daycare for Specialized Needs
- ☐ Education
- ☐ Group Homes
- ☐ Healthcare Meal Delivery
- ☐ Hospice
- ☐ Hospitals
- ☐ Independent Senior Living
- ☐ Long Term Acute Care *(LTAC)*
- ☐ Memory Care
- ☐ Mental Retardation and Developmental Disabilities *(MRDD)*
- ☐ Nursing Home
- ☐ Psychiatric Care
- ☐ Rehab Centers (Addiction & Physical)
- ☐ Senior Centers
- ☐ Other: ____________________

Rebates:

Check *(Add $10 Processing Fee)*
ACH Electronic Deposit *(Attachment C)*

Facility Relationship:

Independent
Multi-Unit Operator *(Attachment A)*

Profit Status:

For Profit
Not-for-Profit

Contact Information

Name: ____________________ Title: ____________________

Phone: ____________________ Email: ____________________

Acknowledgment and Authorization

This Group Purchasing Participation Agreement (the "Agreement") is made and entered into this ________ day of ________________ in the year of __________ ('Effective Date") by and between Health Services, Tampa Florida, herein called "Health Services" and ________________ herein called the "Participant" for the purpose of permitting Participant and its Facilities to obtain certain products and services under Vendor Contracts between Health Services and Vendors. A true and accurate copy of the entire Terms and Conditions of this Agreement can be found on the website of Health Services GPO: hsgpo.com/membershipagreement. By checking the box below, Participant confirms that it has read and understands the Terms and Conditions; and agrees to be bound by them by signing below. Further, subject to the terms under Section 6 hereof, the term of this Agreement shall be for a period of one year commencing on the Effective Date, with automatic renewals thereafter for the terms of one (1) year each. Either Party may terminate this Agreement without cause upon not less than thirty (30) days' prior written notice to the other Party.

☐ **Participant acknowledges that they have read, understand, and agree to the terms of the Agreement.**
IN WITNESS WHEREOF, authorized agents of parties have executed this Agreement as of this date first written above.

PARTICIPANT

Signature: ____________________

Full Name & Title: ____________________

Date: ____________________

HEALTH SERVICES

Signature: ____________________

Full Name & Title: ____________________

Date: ____________________

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Attachment A: Additional Account Listing(s)

Please fill in any additional facilities. Please photocopy this form for additional facilities.

ADDITIONAL FACILITY		
Facility Name		
Address (Please include street address)		
City	State	Zip Code
Phone		Resident Census (Average)
Food Service Distributor Name		Food Service Account Number
Facility Type: ☐ Nursing Home ☐ Assisted Living ☐ Independent Living ☐ Hospital ☐ Other: ______________		
CONTACT INFORMATION		
Contact		Title
Phone	Email	

ADDITIONAL FACILITY		
Facility Name		
Address (Please include street address)		
City	State	Zip Code
Phone		Resident Census (Average)
Food Service Distributor Name		Food Service Account Number
Facility Type: ☐ Nursing Home ☐ Assisted Living ☐ Independent Living ☐ Hospital ☐ Other: ______________		
CONTACT INFORMATION		
Contact		Title
Phone	Email	

ADDITIONAL FACILITY		
Facility Name		
Address (Please include street address)		
City	State	Zip Code
Phone		Resident Census (Average)
Food Service Distributor Name		Food Service Account Number
Facility Type: ☐ Nursing Home ☐ Assisted Living ☐ Independent Living ☐ Hospital ☐ Other: ______________		
CONTACT INFORMATION		
Contact		Title
Phone	Email	

Attachment B: Foodservice Alliance Participation Agreement

Acknowledgment and Authorization

The food and nutrition program encompasses manufacturer programs and broadline foodservice distribution. Participation in this program will allow access to pricing and rebate programs for your food and nutrition purchases through our broadline distribution partner.

I would like to participate in the Health Services Food & Nutrition program offered by: ____
(Food Service Distributor Name)

Food Service Distributor Account Number: ______________________________

GPO Affiliation

Participation in more than one Group Purchasing Organization, through a single vendor is prohibited. Customer is required to submit at time of application a copy of its termination letter to existing GPO programs with the same vendor(s) in order to qualify for participation in Health Services program.

Do you currently have an affiliation with another GPO with the above indicated Food Service Distributor?

No: I am not aware of any other GPO relationships that are currently in effect with the above indicated vendor. Any affiliation that is unknown or undocumented is hereby terminated.

Yes: I am currently participating with a group purchasing organization with the above indicated vendor. I have indicated the name and termination date below.

Current GPO Name: ____

Current GPO Termination Date: ____

Additional Food/Nutrition Information

I do not have any rebates or deviations currently in place.

My distributor has a listing of our existing rebates and deviations. Please contact them to review.

I have direct manufacturer programs outside of my distributor. (Please list on next page)

Acknowledgment and Authorization

I am an authorized agent, owner or employee of the above Business and Acknowledge that I have the authority to enter into a participation agreement with Health Services and, to the best of my knowledge, all information provided is correct. If Health Services should discover that the information provided is not correct, Health Services has the right to cancel or amend our participation in any and all programs.

I acknowledge that any current programs we desire to continue through a direct relationship have been disclosed and I understand that we will not be allowed to participate in the Health Services Programs. Further, if it is discovered that a program exists that was not disclosed above we authorize Health Services to allow us to remain on the Health Services program and I will cancel said direct agreement within 10 business days and agree to deductions in future rebates to repay these duplicate program monies.

By signing this form, I authorize the above distributor(s) to provide regular timely reporting of purchase transaction data for our locations to Health Services' processor. Full cooperation should be extended to Health Services and its processor. I agree to release, indemnify and hold harmless, distributors from any and all claims and liability that may arise with respect to the communication of such information to the processor or Health Services. I acknowledge that Health Services retains a portion earned for program administration.

Additionally, by signing this application, I am authorizing Health Services to enroll the Business listed above in all programs with the exception on Direct Manufacturer agreements. I authorize Health Services to contact all distribution companies listed within this participation agreement in order to obtain product level data reporting for the purpose of price deviations, volume allowances tracking and opportunity analysis. I agree to and acknowledge that Health Services may receive financial consideration from certain program providers backed on my participation.

PARTICIPANT

Signature: ____________________________________

Full Name & Title: ______________________________

Date: ____

HEALTH SERVICES

Signature: ____________________________________

Full Name & Title: ______________________________

Date: ____

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Attachment B (continued): Existing Manufacturer Programs

Please list any manufacturers with whom you have direct programs.
This disclosure helps prevent any potential duplicate billings going forward.
We will contact you if there are any questions or additional information needed.

MANUFACTURER NAME	EXPIRATION DATE

Attachment C: Direct Deposit Enrollment Form

Company Name: ____

I (we) hereby authorize Health Services GPO hereinafter called COMPANY, to deposit any amounts owed to me, by initiating credit entries, and, if necessary, debit entries and adjustments for any credit entries in error to my (our) Financial Institution indicated on this form.

(select one) ☐ **Checking Account** or ☐ **Savings Account**

** If selecting ***Checking Account,*** please attach a voided check (not a deposit slip) from your account. *(copies or photos are acceptable as long as they are legible)*

** If selecting ***Savings Account,*** ask your bank to provide you the Routing/Transit Number as it may differ from a savings deposit slip.

Financial Institution: ____

City: ____ **State:** ______________

Routing/Transit Number: ____ **Account Number:** ______________________________

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time, and in such manner as to afford COMPANY and Financial Institution a reasonable opportunity to act on it.

Name(s): ____
(Please Print)

Authorized Signature: ____ **Date:** __________________

Office Use Only

HSGPO Account Number: ____

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Attachment D: ROi Enrollment

Acknowledgment and Agreement

Health Services has a relationship with Resource Optimization & Innovation, LLC ("ROi") that allows Participant to access and participate in ROi's medical-surgical offerings, as well as those offerings not covered under Health Services' contracts. Participant desires to participate in ROi's offerings which are more fully described at www.hsgpo.com/membershipagreement. By checking the box below, The ROi Participant confirms that it has read and understands the Terms and Conditions; and agrees to be bound by them by signing below, and Participant agrees to the ROi Participant Terms and Conditions. ROi may rely upon the Health Services General Membership Enrollment information, Additional Account Listings, and Direct Deposit Enrollment Form that Participant provides to Health Services, and such information is incorporated herein by this reference. Participant, on behalf of itself and its affiliates hereby designates Resource Optimization & Innovation, LLC ("ROI") as Participant's non- exclusive group purchasing organization for ROi's Primary GPO Portfolio of medical products.

Participant acknowledges that they have read, understand, and agree to the terms of the Agreement.
IN WITNESS WHEREOF, authorized agents of parties have executed this Agreement as of this date first written above.

This Acknowledgement and Agreement is effective on this _______ day of __________________, 20______ ("Effective Date")
IN WITNESS WHEREOF, the parties hereto have executed this Acknowledgement and Agreement as of the Effective Date.

PARTICIPANT ON BEHALF OF ITSELF AND ITS AFFILIATES

Signature: ____

Full Name & Title: ____

Date: ____

RESOURCE OPTIMIZATION & INNOVATION, LLC

Signature: ____

Full Name & Title: ____

Date: ____

(Please copy to letter head or attach business card)

Letter of Termination

To whom it may concern:

________________________________(Facility/Group) has chosen to terminate our relationship with ________________________________ (Current GPO) effective ____________________ (Date). Our purchases through ______________________(Vendor Name) may not be linked to any programs with __________________________________ (Current GPO) as of the effective date above. Thank you for your understanding.

Sincerely,

________________________________ ________________________________

Signature Date

____

Position/Title

Form **W-9**
(Rev. November 2017)
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.*

Health Services

A GROUP PURCHASING ORGANIZATION

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Business Name: ____________________

Customer Name: ____________________

Phone: ____________________

Email: ____________________

Best Day/Time to Call: ____________________

Please indicate interest in the programs you'd like more information.

CAPITAL IMPROVEMENTS

- [ ] Commercial Bulbs.com
- [ ] DRS
- [ ] Lighting Upgrade Solutions
- [ ] LTC interiors
- [ ] STARFLOORS

EDUCATION

- [ ] aspire
- [ ] CEU360.com HomeCEU
- [ ] the Compliance store – Because Getting It Right Matters

EQUIPMENT & SUPPLIES

- [ ] DYKES
- [ ] GRAINGER
- [ ] INVACARE
- [ ] HBD CONSTRUCTION

MEDICAL & THERAPY SOLUTIONS

- [ ] RehabCare – Because Outcomes Matter
- [ ] ROi

MENU TECHNOLOGY & DIETARY CONSULTING

- [ ] Health Technologies
- [ ] OptimaSolutions3 – Dietary Management System

OFFICE ADMINISTRATION

- [ ] Access – Information Protected.
- [ ] American HealthTech
- [ ] CENTIVISE
- [ ] Clayman Promotional Group
- [ ] National enterprise
- [ ] FedEx Office
- [ ] Office DEPOT
- [ ] RICOH
- [ ] ups
- [ ] VENTA

SERVICE SOLUTIONS

- [ ] ALSCO
- [ ] AmeriPride – Providing Uniform and Linen Solutions Since 1889
- [ ] Chef Works
- [ ] HILLYARD – The Cleaning Resource
- [ ] ORKIN – PEST CONTROL DOWN TO A SCIENCE
- [ ] SHOES FOR CREWS
- [ ] US CONSULTING GROUP

TECHNOLOGY

- [ ] ALMO – Distribution on a Personal Level
- [ ] at&t
- [ ] BEST BUY For Business
- [ ] Sprint
- [ ] verizon