**CMHPSM New Vendor Form**

The Community Mental Health Partnership of Southeast Michigan requires that all vendors complete this form, as well as form W-9: Request For Taxpayer Identification Number and Certification.

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| Vendor Name: |       |
| Vendor Type: | [ ] Individual/Sole Proprietor [ ] Corporation/State of Incorporation[ ] Limited Liability Corporation [ ] Partnership [ ] Other:       |
| Federal Tax ID or Social Security Number: |       |
| **Vendor Business Address** |
| Street Address: |       |
| City: |       | State: |       | ZIP+4: |       -       |
| Phone #: |       | Fax: |        |
| Main Email: |       |
| **Vendor Contact Information** |
| Primary Contact Name: |       | Email: |       |
| Phone #: |       | Fax #: |       |
| **Financial Institution Information***All CMHPSM vendors will be paid through an electronic direct payment via ACH, instead of paper checks, unless the CMHPSM approves a paper check for an emergency or as an exception.* |
| Financial Institution Name: |       |
| Routing/ABA Number: |       |
| Account Number: |       |
| Vendor Remittance E-Mail Address:(For notification of all transactions) |       |
| [ ]  Checking Account | [ ]  Savings Account |
| *I understand this authorization remains in effect until cancelled by the Vendor or the CMHPSM. I authorize the CMHPSM to recover money electronically deposited in error by either debiting my account or by adjusting future payments. I understand I will be notified if an error does occur. Michigan law governs electronic funds transactions authorized by this agreement in all respects except as otherwise superseded by federal law.**Vendor agrees to these stipulations by checking the agree box or signing or typing in the signature box:*  |
| Agree: [ ]  | Signature of Authorizer: |       |
| Name of Authorizer: |       | Date: |       |

Return this form by email to: finance@cmhpsm.org or by fax to: 734-222-3844; or by mail to: CMHPSM Finance Department 3005 Boardwalk Ave. Ste. 200 Ann Arbor, MI 48108.