



New Vendor Information Form

Vendor Name (legal name): \_\_\_\_\_  
Vendor dba (if applicable): \_\_\_\_\_

Payment Remittance Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Send Purchase Order to: \_\_\_\_\_  
(Email address preferred)

Business Telephone number: \_\_\_\_\_ Business Fax number: \_\_\_\_\_  
Contact Person Name: \_\_\_\_\_ Contact Person Email: \_\_\_\_\_  
Contact Person Cell Phone: \_\_\_\_\_

Does your company qualify as an MWBE/MWDBE: \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please specify by circling: MBE WBE DBE  
Is your company a state or other certified MWBE/MWDBE: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Please specify certification: \_\_\_\_\_

Elderwood standard payment terms are net 60 days from receipt of invoice. All invoices are to be sent to [APInvoices@Elderwood.com](mailto:APInvoices@Elderwood.com) or mailed to Accounts Payable, Elderwood Administrative Services, 500 Seneca Street, Suite 100, Buffalo, NY 14202.

Email completed information form along with relevant documents to: [VendorCompliance@elderwood.com](mailto:VendorCompliance@elderwood.com)

I verify and affirm that I have received a copy of the Post Acute Partners Code of Conduct, Compliance Program Overview Deficit Reduction Act Notice. I further verify and affirm that I have read the Code of Conduct, Compliance Program Overview Deficit Reduction Act Notice thoroughly, that I understand it, and that I agree that I, my company and my employees, agents and independent contractors (if any) will be bound by and comply with it. I specifically agree not only to discharge my responsibilities to the best of my ability and in a manner consistent with applicable laws, rules, regulations, policies and procedures, but to inform my contact at the Company, or the Compliance Officer, if I learn of inappropriate conduct by others in connection with the Company. I recognize that the Code of Conduct, Compliance Program Overview Deficit Reduction Act Notice constitute an important part of my responsibility to and relationship with the Company, and that it is my obligation to comply with the Plan and Code.

\_\_\_\_\_  
Authorizing Signature Date

**Internal Use ONLY**

Requested by: \_\_\_\_\_ Facility: \_\_\_\_\_ Date: \_\_\_\_\_  
Vendor approved by: \_\_\_\_\_ Date \_\_\_\_\_ Date sent to AP: \_\_\_\_\_

- Documents received:
- Certificate of Liability Insurance
  - Worker's Compensation Certificate
  - W-9
  - Signed acknowledgement pages of the False Claims Policy and Company Code of Conduct.
  - Other documents might include Business license, Business Associates Agreement.
  - EPStaffCheck

Failure to submit all requested documents will result in delays in setting new vendor and/or update existing vendor information.