AGREEMENT
BETWEEN PALADIN, INC.
4315 East Michigan Blvd. Michigan City, Indiana 46360
219.874.4288 Fax: 219.874.2689

Transportation Provider Name:	Address:	City:	State/Zip:

FOR THE PROVISION OF TRANSPORTATION FOR DAY SERVICES CONSUMERS makes the following agreement with Paladin, Inc., Day service Provider

Agreement Date: From: _____ To: _____

I. Responsibilities

A. Transportation Provider above agrees to:

1. Provide transportation for _____ ❒ to and/or ❒from Paladin Inc. for day services. Hours of day service: 8:00 am – 3:00 pm.
2. Driver will maintain adequate coverage
3. Driver will maintain a monthly record of trips provided.

B. Paladin, Inc. agrees to:

1. Provide notice of scheduled closing dates.
2. Provide notice of emergency closings on specified radio stations.
3. In the event of emergency closing Paladin will notify provider by phone.

C. Both Parties agree to

1. Loss of ability to contract: Both parties agree to notify the other within five (5) days of any change in licensure insurance, or other status which results in a loss of ability to enter this agreement, or the initiation of any procedure which might reasonably result in such a change.
2. Confidentiality: This contract is entered into under confidentiality and both Parties agree not to release information regarding contract without said Approval to outside entities.
3. The agreement may be terminated if state funding is no longer available.

II. Financial Agreement

1. _____ will provide Paladin on approximately the 5th day of each month, the Paladin roster, which indicates that transportation was provided per specified dates and times.
2. Provider will be reimbursed at the rate of $14 per trip.
3. Provider will be paid after Paladin has been reimbursed by the state.
4. The total number of trips paid will not exceed the total trips allowed on the individual's Service Authorization.
5. Provider will be required to complete information requested on Page 2 for receipt of a 1099 form.
6. Form W-9 must be completed by Caregiver and returned to Paladin.

_____

Guardian/Family Member Printed Name Signature Date Signed

_____

Program Manager Printed Name Signature Date Signed

_____

Director Day Services Printed Name Signature Date Signed

CAREGIVER MUST COMPLETE PAGE THIS PAGE AND GIVE TO ACCOUNTING

INFORMATION NEEDED FOR COMPLETION OF A 1099 FORM AT THE END OF THE CALENDAR YEAR BY PALADIN.

LAST NAME MIDDLE NAME (Initial) FIRST NAME

Street Address

City State Zip Code

Social Security Number Birth Date Gender

(These items are needed to enter you on the system that produces the 1099. They are required.)

PLEASE RETURN A COPY OF THE SIGNED AGREEMENT INCLUDING THIS PAGE TO ACCOUNTING DEPARTMENT.

For Accounting Use Only

Payroll ID Number: _____

Entered on (date) **By:**

Accounting: Keep a copy on file with 1099 recap sheet