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.

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 Michigan law governs electronic funds transactions authorized by this agreement in all respects except as otherwise superseded by federal law.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: darrowd@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.