**Supply Chain Business Operations**

**Supplier Data Management**

4301 W Markham St, Slot 591

Little Rock, AR 72205

501-686-7273 (P)

501-526-6569 (P)

Payee Information Form

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| **Payee Information:** (*Please Print or Type All Information)* |
| Name (As Shown On Most Recent Tax Return):  |
| Doing Business As / Alternate Name (If Applicable): |
| Federal Taxpayer ID (TIN) or SSN: |
| Street Address or PO Box: |
| City: | State: | Zip Code: |
| Country *(If Outside U.S.)*:  | Region: |
| Phone Number: | Email Address: |

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| **Type Of Request** |
|  Award Non-Employee Reimbursement Research Participant |  Patient Refund Standardized Patient Stipend |

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| **Justification For Payment** |
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| **HIPAA Security Information** |
| In your work for UAMS, will you be accessing, receiving, maintaining, or creating health information of UAMS patients?  Yes (*If yes****,*** *please* ***complete*** *BA HIPAA Security Checklist On Page 3*) No |

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| **Conflict of Interest Verification** |
| 1. Are you or are you aware of anyone at your company who is a current UAMS employee?

 Yes  No | If *Yes* response, please provide the following:Name:Department: |
| 1. Are you or are you aware of anyone at your company who has been an employee of UAMS within the last 12 months?

 Yes  No | If *Yes* response, please provide the following:Name:Department: |
| 1. Are you or are you aware of anyone at your company who is related to a UAMS employee?

 Yes  No | If *Yes* response, please provide the following:Name:Department: |

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| UAMS is a sale and use tax exempt facility. Site permit ID: 070136-84-001. For more details please see: [Sales-and-Use-Tax-Exemption-Permit.pdf (uams.edu)](https://finance.uams.edu/wp-content/uploads/sites/12/2017/09/Sales-and-Use-Tax-Exemption-Permit.pdf) |
| I certify that I have reviewed the UAMS terms & conditions: [Standard Terms & Conditions](https://supplychain.uams.edu/wp-content/uploads/sites/11/2023/02/U-of-A-Standard-Terms-Conditions-Procurement.pdf) Yes  No |

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| I certify that: (i) I am not currently engaged in a boycott of Israel, and (ii) I will not engage in such a boycott for the duration of the contract with UAMS. Yes  No |
| I certify that: (i) I am not currently engaged in a boycott of the energy, fossil fuel, firearms, and ammunition industries, and (ii) I will not engage in such a boycott for the duration of the contract with UAMS. Yes  No |
| UAMS validates all persons or entities that are considered a “foreign source” as defined in the Ark. Code Ann. §6-60-1201 et seq (Transparency in Foreign Investment Act). I, on behalf of Supplier, certify that Supplier:IS \_\_\_\_ or IS NOT \_\_\_\_: (A) a foreign government or agency of a foreign government, (B) a foreign legal entity, (C) a non-US citizen or national, or (D) an agent acting on behalf of a foreign source as described in (A), (B) or (C). |
| UAMS validates all persons or entities that are engaged in business against the federal debarred list. |
| ***Signature:***  | ***Date:***  |

Business Associate (BA) HIPAA Security Check

1. Describe the services to be provided to UAMS and access to or manipulation of UAMS patient data:
2. Do you store UAMS patient data on a computer or laptop? If you do, have you encrypted the data location? Encryption is required and several free options are available.
3. Is UAMS patient data transmitted by the BA? If so, please attest that no internet provided email service is used to transmit UAMS patient data, unless the document is encrypted. Internet services do not qualify for HIPAA regulated data.
4. Are mobile devices used by the BA and if so, describe security controls:
5. Does the BA workforce receive privacy training? Describe:
6. Describe the BA’s facility access controls (locked cabinets, cameras, alarms, etc.) in place to protect UAMS patient data:
7. List the contact information for the BA’s HIPAA Security officer:
	1. Name:
	2. Phones(s):
	3. Email address:
8. List the contact information for the BA’s HIPAA Privacy officer:
9. Name:
10. Phones(s):
11. Email address:
12. List the contact information for the person with signature authority:
13. Name:
14. Phones(s):
15. Email address:

Supplier/Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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