Fiscal Assistance, Inc.
4646 S. Biltmore Lane
Madison, WI 53718
Phone: (855) 201-4230
Fax: (844) 650-1968

Managed Care Organization Checklist for Home Care Employees

All new employees must fill out each form, sign, date, and return all forms to FA **before** a start date can be established.

** Please wait for confirmation of your start date **before** you begin working **

Please return only the highlighted forms you complete/sign.

Keep the rest for information

- ❑ Employee Acknowledgment Form
- ❑ Relationship Disclosure Form
- ❑ Background Information Disclosure
- ❑ Form I-9, Employment Eligibility Verification

****Refer to instructions****

- Section 1 - Employee must *fill in and complete* Section 1. Sign and date.
- Section 2 - **Employer (Person you will be working for must complete and SIGN)**
  - o must *examine* one original document from List A **OR** *examine* one original document from List B **AND** *examine* one original document from List C.
  - o must *record* the title, number, and expiration date of the original documents in the spaces under List A **OR** List B **AND** List C in Section 2.
  - o must *sign*, then enter his/her address, and *date* the form in the Certification fields in Section 2.

- ❑ W-4 and WT-4 Forms - Federal and State Tax Withholding
- ❑ Medicaid Provider Agreement
- ❑ MCO Training Verification Form **(Employer and Employee MUST both sign)**
- ❑ Direct Deposit Authorization (Direct Deposit of Wages)
  A copy of a **voided check or an account verification letter** from your bank **must** accompany this form.
- ❑ Electronic Visit Verification **(Employer and Employee MUST both sign)**

RETURN PACKET TO:

Fiscal Assistance, Inc.
4646 S. Biltmore Lane
Madison, WI 53718
Phone: 1-855-201-4230
General Fax: 1-844—650-1968
Email: enrollment@fiscalassistance.org

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For your information

New Employee Information

Welcome to Self-Directed Services!

A participant (employer) has selected you as a potential employee. As an employee, you will provide in-home care services to your employer. The employer or his/her representative will direct the work you do, including hiring, firing, scheduling, training, supervising and managing your employment.

Fiscal Assistance, Inc., (FA), will serve as a Fiscal/Employer Agent on behalf of the participant/employer.

Overview of Self-Directed Services

In this employment model, employers select, hire, train, schedule, supervise and manage their own employees. The employer may elect to have a representative, a trusted friend or family member, who will help them manage their services. The employee is always an employee of either the employer or his/her representative.

The employer appoints a Fiscal/Employer Agent to help with some of the administrative employer responsibilities.

Fiscal Assistance, Inc., (FA), is the Fiscal/Employer Agent.

FA supports the employer or representative by doing the following:

- Assisting with completing initial employer/employee paperwork
- Performing background checks on potential employees
- Receiving timesheets
- Ensuring completed timesheets meet all requirements of the program
- Paying only those hours that are authorized in the participant's budget
- Paying employees, including withholding taxes and processing any other deductions
- Issuing Forms W-2 at year-end

Getting Started

Before you can serve as an employee, you must be approved to provide services. To be approved, you must do the following:

- Correctly complete and return ALL of new employee application forms. See the Checklist for Home Care Providers
- Pass a criminal background check
- Be authorized to work in the United States
- Be issued a start date from Fiscal Assistance, Inc.

You are an employee when ALL paperwork has been processed and a **start date** has been established.

Contact Information

Fiscal Assistance is available for support Monday through Friday from 8:00am to 4:30pm and can be reached at **1-855-201-4230** and at **www.fiscalassistance.org**.

Fiscal Assistance is not open on state or federal holidays.

Employer Agent Team

Payroll, Timesheets and Wage Verifications please contact our payroll specialists:		
MY CHOICE WI	**payroll@fiscalassistance.org**	**608-819-7752**
ICARE	**payroll@fiscalassistance.org**	**608-819-7734**
CLTS/CHILDREN (DANE ONLY)	**payroll@fiscalassistance.org**	**608-819-7739**
CLTS/ CHILDREN (ALL OTHER COUNTIES)	**payroll@fiscalassistance.org**	**608-819-7734**

Payroll Manager	Direct: 608.733.6241 TF 1.855.201.4230 ext. 16 payroll@fiscalassistance.org
Executive Director – Carol Richards	Direct: 608.819.9309 TF 1.855.201.4230 ext. 11 CarolR@fiscalassistance.org

To Submit Timesheets:

1. **Email to:** ***timesheets@fiscalassistance.org*** (**Scanned/Emailed PDF Format, No Photos**)
2. **Fax to:** 1-844-727-7533
3. **Mail or drop off at:** Fiscal Assistance, Inc., **4646 S. Biltmore Lane Madison, WI 53718**

__Wage verifications__ – to request a wage verification, please have the requesting party *fax or email* the employment verification form to the FA payroll department. The payroll specialist will complete the form and email or fax back to the requesting party within 3-5 business days.

Fiscal Assistance, Inc.
4646 S. Biltmore Lane
Madison, WI 53718
Phone: 1-855-201-4230
General Fax: 1-844-650-1968
Timesheet Fax: 1-844-727-7533

Sign up for our CAREGIVER REGISTRY if you are interested in providing care/service/respite for other adults/children. Individuals and parents can search online and contact you directly.
https://fiscalassistance.org/post-caregiver-listing/

For your information

PROGRAM INTEGRITY and FRAUD PREVENTION

Maintaining and improving program integrity is one of the most important aspects of the self-directed program. Program integrity including fraud prevention is critical to sustaining this program model. Participants, guardians, and providers are vital to preventing fraud and maintaining program integrity.

Fraud and abuse in Medicaid costs states billions of dollars each year, diverting funds that could otherwise be used for additional services or to assist more people that need care. As a participant, guardian, representative, care provider or recipient of funds, you must comply with all State and Federal laws and prevent misuse or fraud. Honesty and integrity are expected of all who participate in any Medicaid programs.

Definition

Fraud is to intentionally misrepresent, cheat or deceive in order to benefit or gain something of value. Medicaid fraud is knowingly falsifying or misrepresenting the truth to obtain unauthorized benefits. Abuse includes any practice inconsistent with acceptable practices that will unnecessarily increase costs

Examples of Fraud and Abuse Include

- Recording hours on a timesheet that weren't worked
- Approving/authorizing hours that employees didn't actually work
- Recording more time or stating different times than you actually work
- Changing hours on a timesheet after it has been approved
- Not providing the services the participant needs
- Falsifying a worker's compensation claim
- Falsifying or misrepresentation on applications or documentation
- Billing for services while in the hospital or other care facility
- Duplicate billing (for multiple participants)
- Providing false information on the LTC screens to obtain a higher budget

Results

Fraud and abuse of funds may result in termination of services/funds, penalties, fines and/or criminal prosecution and incarceration. It is your responsibility to be a good steward of the funding you are using/receiving and be responsible for your authorized hours.

REPORTING

If you suspect or know of fraud or abuse occurring, it is your duty and responsibility to report this immediately to the Office of Inspector General at **1-877-865-3432** or www.reportfraud.wisconsin.gov/

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Employee Acknowledgment Form

Employee Information

Legal Name:

Maiden/other

Address_____
Street Apt City State ZIP

Phone Number ( )_ _____ Alt. Number (_____) _____

Email Address_____

Employer Information- *employee will provide care to*:

Employer Name:

Employer phone_____ Email: _____

Employer support agency? _____

Employer case manager/ care manager? _____

Employee Acknowledgment

I have received and read the "New Employee Information" and "Program Integrity and Fraud Prevention" documents provided by Fiscal Assistance, Inc. (FA Inc)

I understand the employer listed above is my employer. My employer is responsible for all employment actions including orientation, training, supervising, and termination. If I have employment concerns, I discuss these with the employer above.

FA Inc. has been selected to provide payroll services and administrative/paperwork tasks for my employer. FA Inc. is **NOT** my employer. I understand that FA Inc. will issue a start date for my employment after all needed paperwork has been processed and approved, including a background check. **I will not begin working for my employer prior to the start date**.

I understand I am responsible for maintaining program integrity by preventing and reporting fraud.

Signature_____ Date_____

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Relationship Disclosure Form
Residence and Overtime Disclosure
2014-7 "Difficulty of Care Act" Exclusion

Employee Name:

Employer Name:

1

Employee/Employer Relationship Disclosure

Are you related to the Employer? ____Yes ____No (**If yes,** how are you related to the employer?)

Please check only one - the employer is my…

❑ Spouse	❑ Grandparent
❑ Parent	❑ Grandchild
❑ Step-Parent	❑ Sibling
❑ Child under 21 Birthdate __/__/____	❑ Stepchild
❑ Child over 21 Birthdate __/__/____	❑ Other _____

***If you are the **parent** of the employer, please answer the following questions.

- Does your employer (child) have a child or stepchild living in the home? ____Yes ____No
- Is your employer (child) a widow/widower, divorced not remarried, or living with a spouse who, because of a mental or physical condition, can't care for the child or stepchild for at least 4 continuous weeks in the calendar quarter in which the service is performed? ____Yes ____No
- Is the child or stepchild either under age 18 or, due to a mental or physical condition, requires the personal care of an adult for at least 4 continuous weeks in the calendar quarter in which the service is performed? ____Yes ____No

If **Yes** to all of the above questions, the parent's wages are subject to Social Security and Medicare taxes.

2

Residence and Overtime Disclosure

"Domestic service workers who reside in the employer's home and are employed by an individual, family, or household are exempt from the overtime pay requirement, although they must be paid at least the federal minimum wage for all hours worked." https://www.dol.gov/agencies/whd/fact-sheets/79b-flsa-live-in-domestic-workers

❑ **I am a Live In Worker:** I permanently live at the same residence as my employer.

3

2014-7 "Difficulty of Care Act" Exclusion

https://www.irs.gov/individuals/certain-medicaid-waiver-payments-may-be-excludable-from-income

Under penalties of perjury, I declare that I am an individual care provider receiving payments under a qualifying state Medicaid program as defined in IRS Notice 2014-7 for care I provide to the employer/member named above whom I live with under a plan of care. I am not required to report income earned under this program. Federal and state income taxes should not be withheld from my paycheck.

I choose to take advantage of federal withholding tax exclusion. ____Yes ____No

I acknowledge and understand the tax implications of my relationship with my employer.

Signature_____ Date_____

Note: It is the employee's responsibility to notify Fiscal Assistance Inc. if this relationship or living arrangement changes.

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BACKGROUND INFORMATION DISCLOSURE (BID)

- **PENALTY: Knowingly providing false information or omitting information may result in a forfeiture of up to $1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).**
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- Refer to DQA form F-82064A, *BID Instructions,* for additional information.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- **PRINT OR TYPE YOUR ANSWERS.**

Check the box that applies to you.

☒ Employee / Contractor (including new applicant)
☐ Household member (lives on premises, but is not a client)
☐ Applicant for a license, certification, or registration (including continuation or renewal)
☐ Other – Specify:

NOTE: If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Full Legal Name – *First*	*Middle*	*Last*

Position Title (Complete only if a prospective or current employee or contractor.)	Birth Date *(MM/dd/yyyy)*	Sex
NOT APPLICABLE		☐ Male ☐ Female

Any Other Names By Which You Have Been Known (Including Maiden Name)

Race / Ethnicity (Check ONLY one.)	Social Security Number
☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown	

Home Address	City	State	Zip Code

Business Name and Address – Employer or Care Provider (Entity)
N/A

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

   Yes ☐ No ☐

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.
   You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.

   Yes ☐ No ☐

3. **IMPORTANT: Read before completing item 3.**

Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. "All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential." Reports and records may be disclosed only to the persons identified in this section.

☐ **If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.**

Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? Yes ☐ No ☐

If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? Yes ☐ No ☐

If **Yes,** explain, including when and where it happened.

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? Yes ☐ No ☐

If **Yes**, explain, including when and where it happened.

6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person**? Yes ☐ No ☐

If **Yes**, explain, including when and where it happened.

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? Yes ☐ No ☐

If **Yes**, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes ☐ No ☐

   If **Yes,** explain, including when and where it happened.

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? Yes ☐ No ☐

   If **Yes,** explain, including when and where it happened and the reason.

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? Yes ☐ No ☐

   If **Yes**, indicate the year of discharge: _____

   Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. Have you resided outside of Wisconsin in the last three (3) years? Yes ☐ No ☐

   If **Yes**, list each state and the dates you resided there.

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? Yes ☐ No ☐

   If **Yes**, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years? Yes ☐ No ☐

   If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? Yes ☐ No ☐

If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

_____ I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

Name – Person Completing This Form	Date Submitted

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

PASSPORT **List A** Identity and Employment Authorization **OR** PHOTO ID **List B** Identity **AND** SS CARD **List C** Employment Authorization OR BIRTH CERT.

List A	List B	List C
Document Title	Document Title	Document Title
Issuing Authority	Issuing Authority	Issuing Authority
Document Number	Document Number	Document Number
Expiration Date *(if any)(mm/dd/yyyy)*	Expiration Date *(if any)(mm/dd/yyyy)*	Expiration Date *(if any)(mm/dd/yyyy)*
Document Title		
Issuing Authority		
Document Number		
Expiration Date *(if any)(mm/dd/yyyy)*		
Document Title		
Issuing Authority		
Document Number		
Expiration Date *(if any)(mm/dd/yyyy)*		

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

(d) IF you WANT to claim EXEMPT, write it here --->>>

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ **Employee's signature** (This form is not valid unless you sign it.) ▶ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

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Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

Employee's legal name *(last, first, middle initial)*			Social security number	**Please check one box
Employee's address *(number and street)*			Date of birth	☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note**: If married, but legally separated, check the Single box.
City	State	Zip code	Date of hire	

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3 only if your Wisconsin exemptions are different than your federal allowances.

1. (a) Exemption for yourself – enter 1 . . . . . _____
   (b) Exemption for your spouse – enter 1 . . . . . _____
   (c) Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent . . . . . _____
   (d) Total – add lines (a) through (c) . . . . . _____
2. Additional amount per pay period you want deducted (if your employer agrees) . . . . . _____
3. I claim complete exemption from withholding (see instructions). Enter "Exempt" . . . . . _____

I CERTIFY that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming complete exemption from withholding, I certify that I incurred no liability for Wisconsin income tax for last year and that I anticipate that I will incur no liability for Wisconsin income tax for this year.

Signature _____ Date Signed _____, _____

EMPLOYEE INSTRUCTIONS:

- **WHO MUST FILE:**
  Every Employee is required to file a completed Form WT-4 with each of his or her employers unless the Employee claims the same number of withholding exemptions for Wisconsin withholding tax purpose as for federal withholding tax purpose. Form WT-4 (or federal Form W-4 if a Form WT-4 is not filed) will be used by your employer to determine the amount of Wisconsin income tax to be withheld from your paychecks. If you have more than one employer, you should claim a smaller number or no exemptions on each Form WT-4 filed with employers other than your principal employer so that the total amount withheld will be closer to your actual income tax liability.

  Your employer may also require you to complete this form to report your hiring to the Department of Workforce Development.

  You may file a new Form WT-4 any time you wish to change the amount of withholding from your paychecks, providing the number of exemptions you claim does not exceed the number you are entitled to claim.
- **UNDER WITHHOLDING:**
  If sufficient tax is not withheld from your wages, you may incur additional interest charges under the tax laws. In general, 90% of the net tax shown on your income tax return should be withheld.
- **OVER WITHHOLDING:**
  If you are using Form WT-4 to claim the maximum number of exemptions to which you are entitled and your withholding exceeds your expected income tax liability, you may use Form WT-4A to minimize the over withholding.
- **WHEN TO FILE IF YOUR EXEMPTIONS CHANGE:**
  You must file a new certificate within 10 days if the number of exemptions previously claimed by you DECREASES.

  You may file a new certificate at any time if the number of your exemptions INCREASES.

WT-4 Instructions – Provide your information in the employee section.

- **LINE 1:**
  (a)-(c) Number of exemptions – Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1(a)-(c) or you may enter into an agreement with your employer to have additional amounts withheld (see instruction for line 2).

  (c) Dependents – Those persons who qualify as your dependents for federal income tax purposes may also be claimed as dependents for Wisconsin purposes. The term "dependents" does not include you or your spouse. Indicate the number of dependents that you are claiming in the space provided.
- **LINE 2:**
  Additional withholding – If you have claimed "zero" exemptions on line 1, but still expect to have a balance due on your tax return for the year, you may wish to request your employer to withhold an additional amount of tax for each pay period. If your employer agrees to this additional withholding, enter the additional amount you want deducted from each of your paychecks on line 2.
- **LINE 3:**
  Exemption from withholding – You may claim exemption from withholding of Wisconsin income tax if you had no liability for income tax for last year, and you expect to incur no liability for income tax for this year. You may not claim exemption if your return shows tax liability before the allowance of any credit for income tax withheld. If you are exempt, your employer will not withhold Wisconsin income tax from your wages.

  You must revoke this exemption (1) within 10 days from the time you expect to incur income tax liability for the year or (2) on or before December 1 if you expect to incur Wisconsin income tax liabilities for the next year. If you want to stop or are required to revoke this exemption, you must file a new Form WT-4 with your employer showing the number of withholding exemptions you are entitled to claim. This certificate for exemption from withholding will expire on April 30 of next year unless a new Form WT-4 is filed before that date.

Employer's Section

Employer's name				Federal Employer ID Number
Employer's payroll address *(number and street)*		City	State	Zip code
Completed by	Title	Phone number ( )	Email	

EMPLOYER INSTRUCTIONS for Department of Revenue:

- If you do not have a Federal Employer Identification Number (FEIN), contact the Internal Revenue Service to obtain a FEIN.
- If the Employee has claimed more than 10 exemptions OR has claimed complete exemption from withholding and earns more than $200.00 a week or is believed to have claimed more exemptions than he or she is entitled to, mail a copy of this certificate to: Wisconsin Department of Revenue, Audit Bureau, PO Box 8906, Madison WI 53708 or fax (608) 267-0834.
- Keep a copy of this certificate with your records. If you have questions about the Department of Revenue requirements, call (608) 266-8646 or (608) 266-2776.

EMPLOYER INSTRUCTIONS for New Hire Reporting:

- This report contains the required information for reporting a New Hire to Wisconsin. If you are reporting new hires electronically, you do not need to forward a copy of this report to the Department of Workforce Development. Visit http://dwd.wisconsin.gov/uinh to report new hires.
- If you do not report new hires electronically, mail the original form to the Department of Workforce Development, New Hire Reporting, PO Box 14431, Madison WI 53708-0431 or fax toll free to 1-800-277-8075.
- If you have questions about New Hire requirements, call toll free (888) 300-HIRE (888-300-4473). Visit dwd.wisconsin.gov/uinh for more information.

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WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

(PROVIDER IS EMPLOYEE)

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Phone Number	
Address – Street	City	State	Zip Code

The above-referenced provider of home and community-based waiver services under Wisconsin's Medicaid program, hereinafter referred to as the provider, hereby agrees and acknowledges as follows:

1. To provide only the items or services authorized by the managed care organization or IRIS program.
2. To accept the payment issued by the managed care organization or IRIS program as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the managed care organization or IRIS program.
5. To keep any records necessary to disclose the extent of services provided consistent with the provider's business type.
6. To provide, upon request by the managed care organization, the IRIS program, or the Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program including the caregiver background check law.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants **for a period of ten (10) years** and to furnish upon request to the DHS, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. This requirement includes retaining all records and documents according to the terms provided by Wis. Admin. Code § DHS 106.02(a)-(d); (f)-(g).
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the managed care organization and upon request, to the Department in writing:

    a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

    b) The names and addresses of all persons who have a controlling interest in the provider;

c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;

d) The names and addresses of any subcontractors who have had business transactions with the provider;

e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.

12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.
13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.
14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

Modifications to this agreement cannot and will not be agreed to. Altering this agreement in any way voids the Department of Health Services' signature. This agreement is not transferable or assignable.

Name – Provider (Typed or Printed)	
SIGNATURE – Provider	Date Signed

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)	
SIGNATURE – Department of Health Services	Date Signed
	8/14/17

For your information

MCO SELF DIRECTED SUPPORTED HOME CARE TRAINING RESOURCES

MCO Self Directed Supportive Home Care

Service Description: Supportive Home Care (SHC) is the provision of a range of services for members who require assistance to meet their daily living needs, ensure adequate functioning in their home and permit safe access to the community. SHC includes personal services such as activities of daily living, assistance in the use of adaptive equipment, mobility and communication aids and accompanying the member to appointments. It may also include assisting the member follow through on treatment plans. Household services may include performing household tasks and home maintenance activities such as meal preparation, shopping, laundry and house cleaning.

Personal Assistance and Household/Chore Services

Required Minimum Training and Qualified Provider Standards

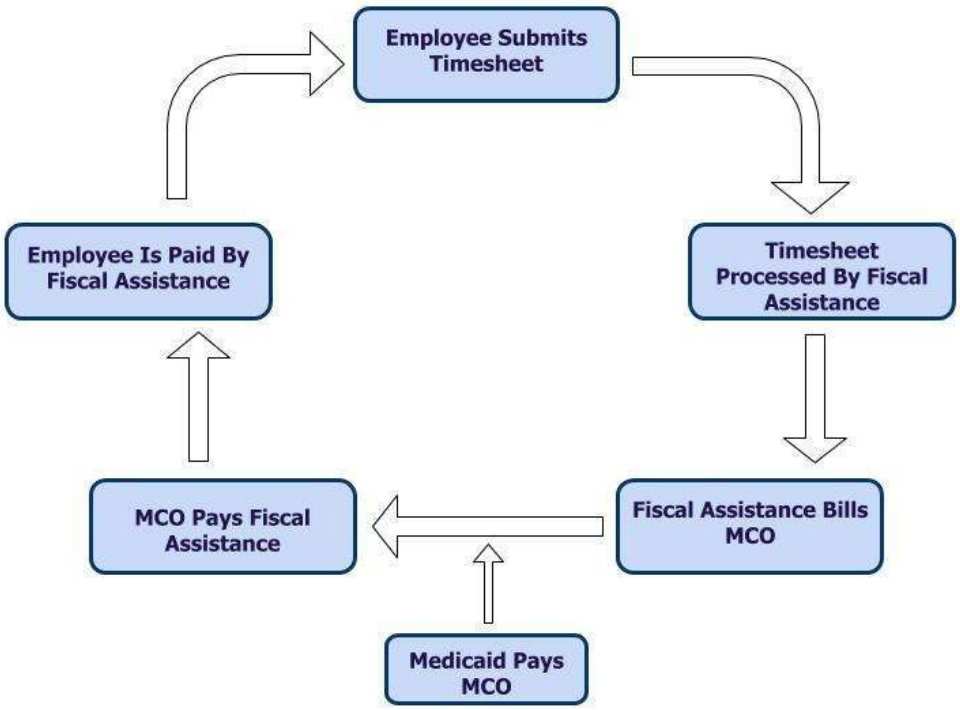
Providers of supportive home care and personal assistance services must meet the following DHS required minimum training and qualified provider standards to deliver services and receive payments using Medicaid funding. *Each member/employer is responsible for providing information and training to each member-hired employee(s) on specific care needs.*

1. Policies, Procedures and expectations

Including HIPAA compliance and other confidentiality requirements, ethical standards, including respecting personal property, safely providing services to members, scheduling and procedure/notice for needed time off and initiating back up services as needed. Share your back-up plan with your employees as identified in the care plan.

2. Billing and payment processes and relevant contact information

The graphic below illustrates the importance of submitting a timesheet correctly and on time. This complex process begins only when the timesheet is submitted.



Record keeping, reporting, and contact information including the name and contact information of the primary contact information of the member and Fiscal/employer agent or co-employment agency. Questions regarding timesheets and reimbursements can be directed towards your care manager or Fiscal Assistance. Forms can be found at the website below.

4646 S Biltmore Lane
Madison, WI 53718
Phone: 855.201.4230
Fax: 844.650.1968
Timesheet Fax: 844.727.7533
www.fiscalassistance.org

3. Recognizing & Responding to Emergencies

Protocols for contacting local emergency response systems. When to notify care manager, Fiscal Assistance, and member's primary contact.
Examples: emergency contact numbers, when to call 911, fire/tornado plan, prompt notification to support team, etc.

4. Member/Employer Specific Information

Member individual needs, medical conditions, strengths, abilities, preferences/rules; expectations for providing care needs safely.
Examples: wearing gloves, washing hands, handling equipment, transfers, transportation, grooming preferences, how to use adaptive/mobility aids, preparation of foods, preferences for assistance with daily living and abilities.

5. General Target Information

Any general information that might apply to the care of the member.
Example: info on working with elderly, people with physical or cognitive disabilities, or mental health challenges.

6. Providing Quality Homemaking/Household Services (if provided)

Understanding good nutrition, special diets, meal planning and preparation. Understanding and maintaining a clean, safe & healthy environment. Respecting member preferences in housekeeping tasks and shopping
Examples: how to run the washer/dryer, washing dishes, preparing meals, etc.

7. Working Effectively with Employee/Participant

Understanding and respecting member self-direction, individuality, independence and rights. Procedures for handling conflict and complaints, cultural differences and family relationships and behavioral supports (if needed).

Training Verification Form (TVF)

A copy of the training verification form is provided in the application packet for all new care providers. **All care providers are required to have this form completed with their signature and the member they work for.** Care provider must have a TVF signed for EACH MEMBER they work for. This form is proof that the care provider and member agree they are trained to perform the job duties. Completed forms are turned into Fiscal Assistance. Additional copies are available on the Fiscal Assistance website listed above

MCO Self Directed Supportive Home Care

TRAINING VERIFICATION FORM

Service Description: Supportive Home Care (SHC) is the provision of a range of services for members who require assistance to meet their daily living needs, ensure adequate functioning in their home and permit safe access to the community. SHC includes personal services such as activities of daily living, assistance in the use of adaptive equipment, mobility and communication aids and accompanying the member to appointments. It may also include assisting the member follow through on treatment plans. Household services may include performing household tasks and home maintenance activities such as meal preparation, shopping, laundry and house cleaning.

Employee/Care provider:

Address:

Phone:

Employer/Member:

Personal Assistance and Household/Chore Services
Required Minimum Training and Qualified Provider Standards

Providers of supportive home care and personal assistance services must meet the following DHS required minimum training and qualified provider standards to deliver services and receive payments using Medicaid funding. **Each member/employer is responsible for providing information and training to their employees on specific care needs.**

1. Policies, Procedures

Including HIPAA compliance and other confidentiality requirements, ethical standards, including respecting personal property, safely providing services to members, scheduling and procedure/ notice for needed time off and initiating back up services as needed.

2. Billing and payment processes and relevant contact information

Record keeping, reporting, and contact information including the name and contact information of the primary contact information of the member and Fiscal/employer agent or co-employment agency.

3. Recognizing & Responding to Emergencies

Protocols for contacting local emergency response systems prompt notification to primary member contact, MCO team and Fiscal Employer Agent.
Examples: emergency contact numbers, when to call 911, fire/tornado plan, prompt notification to support team, etc.

4. Member/Employer Specific Information

Member individual needs, medical conditions, strengths, abilities, preferences/rules; expectations for providing care needs safely.
Examples: wearing gloves, washing hands, handling equipment, transfers, transportation, grooming preferences, how to use adaptive/mobility aids, preparation of foods, preferences for assistance with daily living and abilities.

5. General Target Information

Any general information that might apply to the care of the member
Example: info on working with elderly, people with physical or cognitive disabilities, or mental health challenges

6. Providing Quality Homemaking/Household Services (if provided)

Understanding good nutrition, special diets, meal planning and preparation. Understanding and maintaining a clean, safe & healthy environment. Respecting member preferences in housekeeping tasks and shopping
Examples: how to run the washer/dryer, washing dishes, preparing meals, etc.

7. Working Effectively with Employee/Participant

Understanding and respecting member self-direction, individuality, independence and rights. Procedures for handling conflict and complaints, cultural differences and family relationships and behavioral supports (if needed).

OVER for SIGNATURES

Exemption and Waiver from Training Requirements

Prior to employment, the employer/member may exempt a prospective service provider from the personal service and household chore service training requirements when it is determined that the provider already has sufficient comparable knowledge or experience.

Exemption: Due to a licensure or Credential, the following professions may be exempted from the training requirements: Certified Nursing Assistant (CNA), Licensed Practical Nurse (LPN), Registered Nurse (RN), Physical or Occupational Therapist (PT, OT) or certified Physical or Occupational Assistant (CPTA or COTA). When an exemption is granted, the employee/provider must still document the license or certification. ***The employer/member ensure the worker performing medically oriented tasks such as tube feedings, wound care or tracheotomy care is competent in performing those tasks specific to the employer/member.***

❑ ***This provider is exempt due to licensure or certification as***

- ❑ Licensed Practical Nurse (LPN)
- ❑ Certified Nursing Assistant (CNA)
- ❑ Physical or Occupational Assistant
- ❑ Registered Nurse (RN)
- ❑ Physical or Occupational Therapist

Waiver: Some or all of the required training may be waived based on knowledge and skills attained through prior experience (e.g., personal care worker with a certified personal care agency). When a waiver is granted, ***the employer/member ensure the worker performing medically oriented tasks such as tube feedings, wound care or tracheotomy care is competent in performing those tasks specific to the employer/member.***

❑ ***This provider is waived from specific training due to prior training and/or experience.***

LIST Prior Experience/Training

SIGNATURES

By signing below, I attest I meet the minimum training and qualified provider standards in order to provide Supported Home Care and Personal Care to my employer/member. As the Employer, I attest the above person meets all provider standards and training requirements set by DHS as explained.

Employee/care provider	Date
Employer/ Representative Signature	Date

Return Form to: **Fiscal Assistance, Inc. 4646 S. Biltmore Lane Madison, WI 53718**
Phone: 1-855-201-4230
Fax: 1-844-650-1968
Email: Enrollment@fiscalassistance.org

Direct Deposit Authorization

Legal Name: _____

Bank Name: _____

Fiscal Assistance, Inc. <u>requires</u> all employees to select a direct deposit option, either an account/s you specify **or** a Bank Corp Rapid pay debit card. If account verification information (voided check or bank letter) isn't provided at the time of employment, a Rapid pay card will be issued to you and will be used until other account information/verification is provided.

Please select **at least one** direct deposit option, and indicate the <u>percentage</u> of earnings you would like deposited to each account. *You need to provide verification information for each account you choose.*

❑ **Checking**: _____**%** Attach either a **<u>voided check</u>** or **<u>a letter from the bank</u>**
- Letter must be printed on bank letterhead
- Must have the routing and account numbers for the account
- Must be typed with name/s of the account holder/s
- Starter checks <u>may not</u> be used

❑ **Savings:** _____**%** Attach a **letter from the bank**.
- Must be printed on bank letterhead
- Must have the routing and account numbers for the account
- Must be typed with name/s of the account holder/s

❑ **WEX Rapid Pay Card**: I authorize Fiscal Assistance, Inc. to issue me a Bank Corp Rapid pay debit card using my identifying information and initiate payroll deposits to this card account. (You will receive your card in approximately 2 weeks)

I hereby authorize Fiscal Assistance, Inc. to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries in error to my bank account at the financial institution noted above. This authorization is to remain in full force and affect until Fiscal Assistance, Inc. receives <u>written notice</u> from me of its termination, in such time and manner as to allow Fiscal Assistance, Inc. and the financial institution a reasonable opportunity to act on it.

Signature: _____ ***Date:*** _____

❑ ****Check box if this is a <u>CHANGE</u> from your current Direct Deposit****

Please attach a copy of a voided check and/or a verification letter from your bank – If this information isn't attached you will be issued a Rapid Pay Card until account verification information is received

WISCONSIN DEPARTMENT of HEALTH SERVICES

Electronic Visit Verification

What is Electronic Visit Verification?

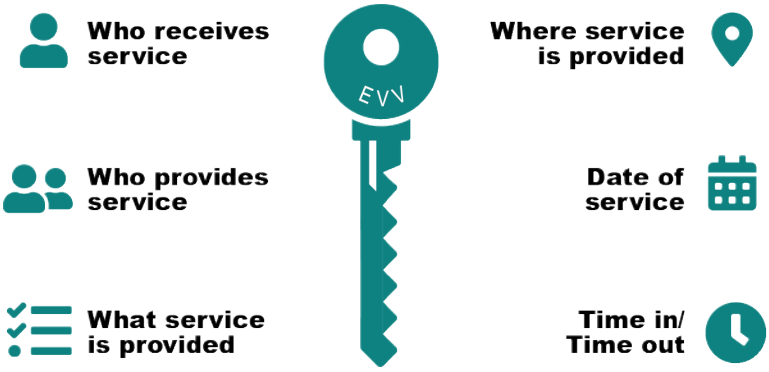
The federal 21st Century Cures Act requires all states to put Electronic Visit Verification (EVV) into effect. This applies to all Medicaid-covered personal care and some supportive home care services.

EVV uses technology to make sure members and participants get their personal care or supportive home care services. EVV will not change your care. You will continue to receive the care you need.

Starting in November 2020, workers must use EVV for each visit. During each visit, six pieces of information will be recorded.

6 KEY DATA POINTS

- Your worker will check in and out at the start and end of each visit.
- Your worker may use a mobile phone app, a landline, or a small digital device you keep in your home to check in and check out.
- This information is sent securely when Wi-Fi or cell service is available.



To Learn More

Visit our website
https://www.dhs.wisconsin.gov/evv

Email us
VDXC.ContactEVV@wisconsin.gov

Sign up for email
https://public.govdelivery.com/accounts/WIDHS/subscriber/new?topic_id=WIDHS_190

Contact us
Wisconsin EVV Customer Care
833-931-2035

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Frequently Asked Questions

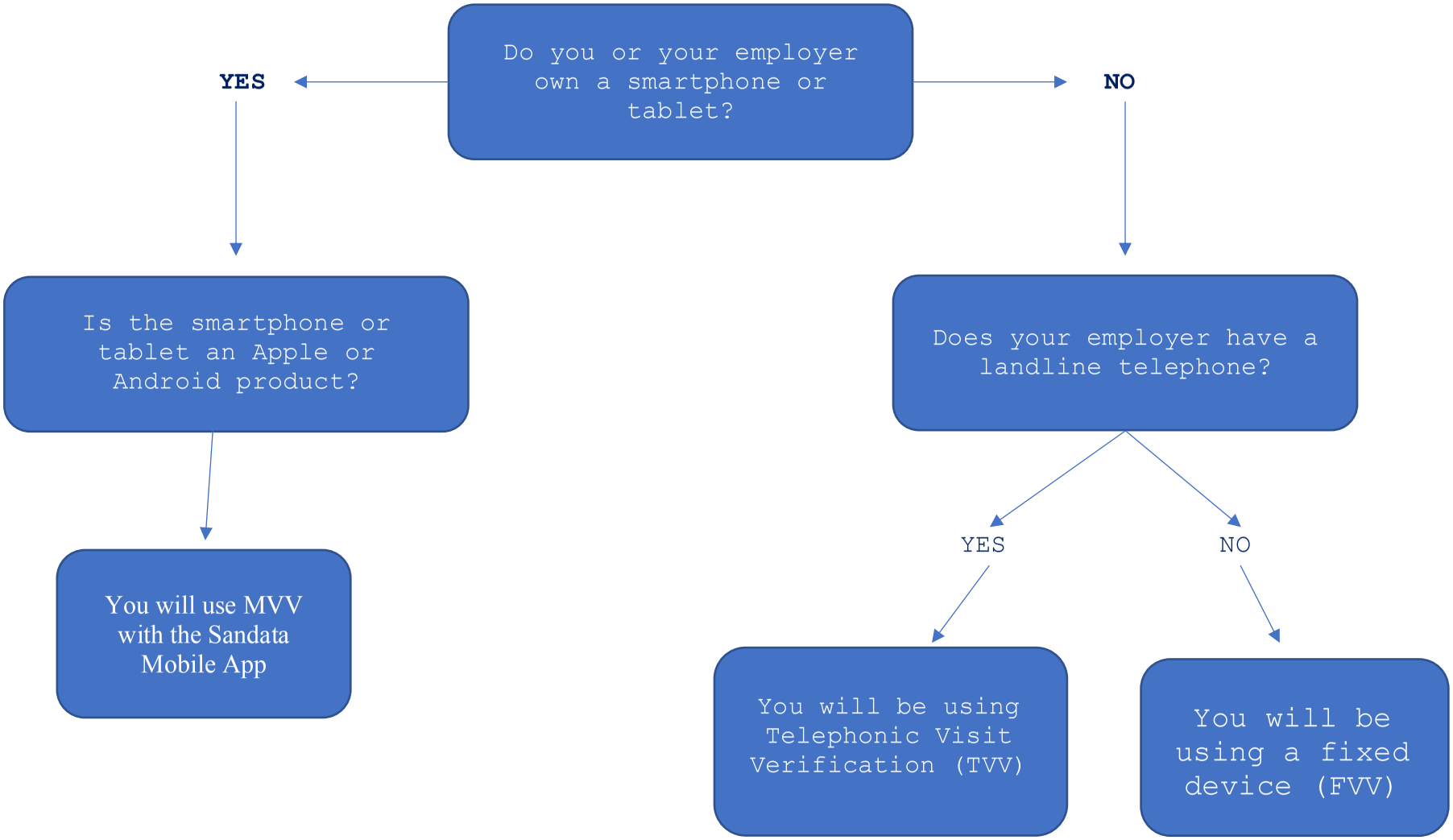
- What is EVV?
  - Electronic Visit Verification (EVV) is a system that uses technology to verify that authorized services were provided. Workers will be required to send information to an EVV system at the beginning and end of each visit, including:
    - Who receives the service.
    - Who provides the service.
    - What service is provided.
    - Where service is provided.
    - Date of service.
    - Time in/time out.
- Are live-in caregivers required to use EVV?
  - Live-in caregivers are exempt from participation in EVV. A person is considered a live-in caregiver if they have proof that their legal address is the same address as the person they are providing care for. Contact FA if you are uncertain of your live-in caregiver status.
- Do I still need to turn in timesheets?
  - Yes, timesheets are still required. EVV is an additional step. Failure to turn in timesheets will result in a delay of pay.
- Why implement EVV?
  - Wisconsin State Department of Health Services (DHS) is implementing EVV to be in compliance with the Federal 21st Century Cures Act. This is mandatory for Medicaid programs in all states. The Centers for Medicare & Medicaid Services (CMS) will fine state programs if they do not implement EVV
- How does EVV fit into a self-direction model?
  - Fiscal Assistance is committed to maintaining the integrity of members self-directing their services as an employer of their workers in accordance with Federal and State mandates.
- I have concerns about the implications about EVV. For instance, my worker does not get paid enough to do both timesheets and EVV. Who can I contact about these concerns?
  - These concerns can be directed to the Omsbudsman program with Disability Rights Wisconsin.
    800-928-8878
    https://www.disabilityrightswi.org/about/contact-us/
- I have security concerns about the implementation of EVV. Who can I contact about these concerns?
  - These concerns can be directed to the Omsbudsman program with Disability Rights Wisconsin.
    800-928-8878
    https://www.disabilityrightswi.org/about/contact-us/

- Why haven't I received any information about EVV from FA yet?
  - Covid-19 has resulted in a significant delay in the ability to train employers and employees. You will be contacted regarding when you should begin using EVV. We appreciate your patience as we implement EVV.
- When does EVV start?
  - FA began rolling out EVV at the beginning of November 2020. Covid-19 has resulted in a significant delay in the ability to train employers and employees. You will be contacted in regard to when you should begin using EVV. We appreciate your patience as we implement EVV.
- Where can I find more information on EVV training materials?
  - For MVV training materials: fiscalassistance.org/mvv
  - For TVV training materials: fiscalassistance.org/tvv
  - For FVV training materials: fiscalassistance.org/fvv
- What is MVV, TVV, & FVV?
  - MVV is a form of electronic visit verification that uses the Sandata Mobile App.
  - TVV is a form of electronic visit verification that uses the employer's landline telephone.
  - FVV is a form of electronic visit verification that uses a fixed device. This is used when MVV and TVV is unavailable.
- Will EVV require internet access?
  - An onsite internet connection is not needed to check in and out on the mobile app. The encrypted visit information can be uploaded at a later time when an internet connection is available. No internet connection is required through TVV or FVV
- Does the EVV GPS monitor a worker at all times, including before and after work?
  - The technology used to verify the worker's location only records locations at the start and end of the service. It does not record their location at any other time.
- What happens if I forget to clock in or clock out?
  - When you remember, call 608-733-6258 or email evv@fiscalassistance.org
  - Leave the following information:

    Your name
    The name of the person(s) you provide care for
    Clock in time
    Clock out time

fa,inc.

Which EVV method is right for you?



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Electronic Visit Verification Agreement

Please fill the highlighted fields below

☐ *Check this box if you are a live-in caregiver. Live-in caregivers are exempt from the EVV requirement. By checking this box and signing below, you understand that you are responsible for notifying Fiscal Assistance, Inc. should you no longer live with your employer. Skip to sign and date.*

In order to be exempt from EVV, live-in caregivers are required to submit proof of live-in status. See next page for list of valid documents to submit.

Initial the following statements if you agree:

_____ I understand I am required to provide an email address to Fiscal Assistance.

Email (print clearly): _____

_____ I understand I am required to check this email regularly.

_____ I understand I am required to record visits through Electronic Visit Verification.

_____ I understand Electronic Visit Verification training materials will be provided after my start date is established.

_____ I understand that both timesheets and Electronic visit verification are required.

_____ I understand the dates and times recorded through Electronic Visit Verification must match with your timesheets.

_____ I understand failure to comply with Electronic Visit Verification requirements may result in interruption of pay.

Employee/Caregiver Name (Print) _____

Employee/Caregiver Signature _____ Date _____

Employer/Member Name (Print) _____

Employer/Member Signature _____ Date _____

ELECTRONIC VISIT VERIFICATION LIVE-IN WORKER IDENTIFICATION

This page is for live-in caregivers only. Disregard if you are not a live-in caregiver.

Instructions:. Proof of address is required for caregiver only. Check one of the following and attach documentation if applicable. The document can be a copy.

- Current and valid State of Wisconsin driver's license or state ID card
- Other official ID card or license issued by a Wisconsin governmental body or unit
- Real estate tax bill or receipt for the current year
- Residential lease for current year
- Check or other document issued by a unit of government within the last three months
- Current or past month's gas, electric, or phone service statement
- Current or past month's bank statement

**Note: documentation only needs to have caregiver's name and address listed*

fa,inc.

DON'T HAVE AN EMAIL ADDRESS?

The Wisconsin State Department of Health Services requires that caregivers have a valid email address.

1. Find a device with internet access.
   - -Local library
   - -Neighborhood center
   - -A smartphone or tablet
2. Choose an email provider.
   - -Free email providers:
     - Gmail
     - Yahoo
     - Outlook
3. Follow directions to set up email address.