

CLTS/Children's Checklist for Home Care Employees

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

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

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

Please return only the highlighted forms you complete/sign.

Keep the rest for information

****Refer to instructions and Sample I-9****

- Section 1 - Employee must *fill in & complete* Section 1. Sign & date.
- Section 2 - **Employer (Person you will be working for must complete and SIGN)**
 - must *examine* one original document from List A **OR** *examine* one original document from List B **AND** *examine* one original document from List C.
 - 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.
 - 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
- Training Verification Form (**Employer and Employee 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.



Family Support and Resource Center



AVENUES TO COMMUNITY
SUPPORT BROKER SERVICES

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

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](https://fiscalassistance.org/post-caregiver-listing/) 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/>

fa,inc. 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/



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 _____



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

Employee Name:

Employer/Client Name:

1 Employee/Employer-Client Relationship Disclosure

Are you related to the Employer/Client? ___Yes ___No (**If yes**, how are you related to the employer?)

The employer/client is my...

(Please check only one)

<input type="checkbox"/> Spouse	<input type="checkbox"/> Grandparent
<input type="checkbox"/> Parent	<input type="checkbox"/> Grandchild
<input type="checkbox"/> Step-Parent	<input type="checkbox"/> Sibling
<input type="checkbox"/> Son/Daughter	<input type="checkbox"/> Other _____
<input type="checkbox"/> Stepchild	

***If you are the **parent** of the employer/client, 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>

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

***If yes, go to part 3.

***If no, **STOP**

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 your responsibility to notify Fiscal Assistance Inc. if this relationship or living arrangement changes.

****Fill in info below. Answer ALL questions. Initial, sign and date****

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 – <i>First</i>	<i>Middle</i>	<i>Last</i>
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Position Title (Complete only if a prospective or current employee or contractor.) NOT APPLICABLE	Birth Date (MM/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Any Other Names By Which You Have Been Known (Including Maiden Name)

Race / Ethnicity (Check ONLY one.) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Unknown	Social Security Number
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Home Address	City	State	Zip Code
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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

Turn over and complete-->>

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.


Turn over and complete-->>

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):

<input type="checkbox"/> 1. A citizen of the United States	QR Code - Section 1 Do Not Write In This Space
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i> <i>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.</i> 1. Alien Registration Number/USCIS Number: _____ 2. Form I-94 Admission Number: _____ 3. Foreign Passport Number: _____	

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

Turn over and complete-->>



Employer Completes Next Page





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

Document Title	Driver License/State ID	Social Security Card
Issuing Authority	WI	SSA
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	Additional Information Fill in your name above.	QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority		
Document Number	List B: Print your Drivers license info or State ID List C: Print your Social Security number	
Expiration Date (if any)(mm/dd/yyyy)	If you have another adult in your household, have them sign below, verifying your documents. If you don't have another adult available, please provide a clear copy of your documents and I will sign below.	
Document Title		
Issuing Authority		
Document Number		
Expiration Date (if any)(mm/dd/yyyy)		

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)
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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
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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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

OMB No. 1545-0074

▶ **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.**

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> 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)

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	<input type="checkbox"/> Single **Please check one box <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, check the Single box.
Employee's address (number and street)			Date of birth	
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.

- (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) _____
- Additional amount per pay period you want deducted (if your employer agrees) _____
- 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/uiuh> 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/uiuh for more information.

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-00180B (02/2014)

STATE OF WISCONSIN
42 CFR 431.107

**WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND
ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION
FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS – SELF-DIRECTED SUPPORTS¹**

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.

*****EMPLOYEE IS PROVIDER*****

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

The above-referenced agency or individual 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 services or items authorized by the local waiver administrative agency as directed by the waiver participant in amounts not to exceed the authorization.
2. To accept the payment issued by the local waiver administrative agency or its fiscal agent as payment in full for provided services or items.
3. To make no additional claims or charges for provided services or items.
4. To refund any overpayment to the waiver administrative agency or its fiscal agent.
5. To keep records of the services or items provided.
6. To provide, upon request by the local waiver administrative agency or the Department of Health Services (DHS) or its designee, information regarding the services or items 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.
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 7 years** and to furnish upon request to the Department, 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. (For state policy related to record retention see DHS 106.02, Wis. Administrative Code or the DLTC numbered memo addressing record retention available at http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DSL/CY_2001/NMemo2001-07.htm .)
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 waiver agency and upon request, to the Department in writing:

Turn over and complete-->>

¹ Note: This agreement is intended to be used for providers who are individuals employed by the waiver participant under a self-directed supports plan and paid by a fiscal agent and who are not employees of an agency that otherwise provides services to waiver clients.

- (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 XIX services programs since the inception of those programs.

Pursuant to 42 CFR § 447.10(e), I hereby voluntarily reassign my right to direct payment from the State to each local waiver administrative agency that has authorized me to provide waiver services to an individual waiver participant.

If you check yes, it means that you will receive payment from the local waiver administrative agency that is responsible for the participants to whom you are authorized to provide waiver services rather than directly from the State Medicaid Agency.

Yes No

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

NAME – Provider (Typed or Printed)



SIGNATURE – Provider	Date Signed
SIGNATURE – Waiver Agency Representative	Date Signed

Print Name – Waiver Agency Representative

SELF DIRECTED SUPPORTED HOME CARE TRAINING RESOURCES

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

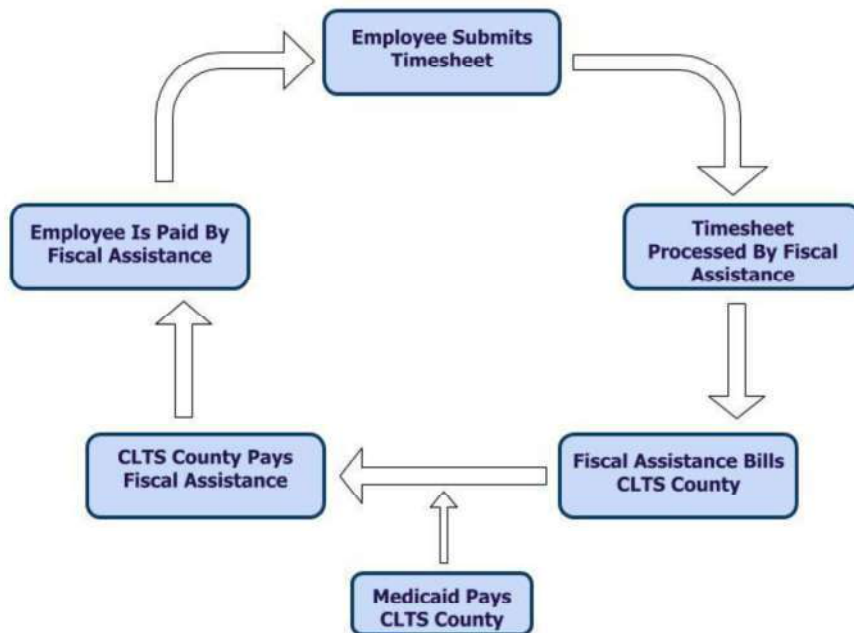
Providers of supportive home care and personal assistance services must meet the following DHS required minimum training and qualified provider standards to deliver services and receive payments using Medicaid funding. *Each member/employer is responsible for providing information and training to each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



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 case manager, Fiscal Assistance, or primary contacts.

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. 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. Share your individual needs as identified on your care plan.

Examples: how to run the washer/dryer, washing dishes, preparing meals, etc.

6. 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.

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.

Both signatures are required

TRAINING VERIFICATION FORM

Employee/Care Provider: This form must be completed by each employer you work for within **90 days** of hired. It is proof that both parties feel comfortable and confident with the specific training associated with the individual receiving care. This is not a formal training program; it is training you receive from your employer.

Employer/Participant: If you have any questions about your responsibility in training an employee, please contact Fiscal Assistance, Inc.

Employee Name:

Address:

Phone:

Employer Name:

Initial Date of Employment:

The following are the required minimum training for individuals who provide in home care services. Please date each section to verify training was completed. Each employer (or authorized individual) is responsible for providing information and training on his/her specific care needs. Your employee may be considered EXEMPT from numbers 4-6 if they have prior experience and knowledge in these areas. Please write "Exempt" for the date and note rationale in the space provided. Both the employee and the employer need to sign and date the form for it be considered complete.

Personal Services, Respite Services, Transportation Services, and Household/Chore Services – Required Training

1. Policies, Procedures, and expectations

Including HIPAA compliance and other confidentiality requirements, ethical standards, respecting personal property, scheduling and procedure/notice for needed time off, initiating back up services

Date Completed

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.

Date Completed

3. Recognizing & Responding to Emergencies

Protocols for contacting local emergency response systems. When to notify case manager, Fiscal Assistance, or primary contacts.

Date Completed

4. Member/Employer Specific Information

Member individual needs, medical conditions, strengths, abilities, preferences/rules, and expectations for providing care needs safely.

Date Completed

5. Homemaking/Household Services (if provided)

Expectations regarding diet & meals, maintaining clean & healthy environment.

Date Completed

6. Working Effectively with Employee/Participant

Expectations for professionalism, handling conflicts, modes of communication, etc.

Date Completed

Exemption Rational (if applicable for 4-6) use back of form if needed

Employee Signature

Date

Employer 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

Fill in your name. Check how your wages will be direct deposited. Sign and date.



Direct Deposit Authorization

Legal Name: _____

Bank Name: _____

Fiscal Assistance, Inc. requires 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 percentage of earnings you would like deposited to each account. **You need to provide verification information for each account you choose.**

Checking: _____ % Attach either a **voided check** or **a letter from the bank**

- 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 may not 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 written notice 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 CHANGE 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