Fiscal Assistance, Inc.
4646 S. Biltmore Lane
Madison, WI 53718
Phone (608) 846-7058
Fax: (608) 842-0115

Checklist and Forms for Self Direction Employers

*** Employer must complete each form, sign, date and return to FA, Inc. ***

This packet contains the necessary forms and instructions that will authorize FA, Inc. to act on your behalf as your fiscal/employer agent.

- ❑ Employer Acknowledgment Form
- ❑ HIPAA Privacy Notice
- ❑ Form SS-4 - Application for Employer Identification Number
  - ❖ Form SS-4 allows FA, Inc. to request a Federal Employer Identification Number from the IRS for you.
- ❑ Form 2678 - Employer/Payer Appointment of Agent
  - ❖ Form 2678 allows FA, Inc. to file your employment tax forms.
- ❑ Court Guardianship Papers
  - ❖ A copy of court guardianship papers/POA must be sent to FA, Inc. only if you have a court appointed Guardian/activated POA in place.

If you have questions, please contact:

Renae Huffman	Scarlett Russell	Theresa Chard
Enrollment and Outreach Director	Enrollment and Outreach Coordinator	Enrollment and Outreach Coordinator
Phone: 608.846.7058 ext. 24	Phone: 608.846.7058 ext. 12	Phone: 608.846.7058
RenaeH@fiscalassistance.org	ScarlettR@fiscalassistance.org	TheresaC@fiscalassistance.org

Return Packet to:

Fiscal Assistance, Inc.
4646 S. Biltmore Lane
Madison, WI 53718
Phone: 608.846.7058 or 1-855-201-4230 (toll free)
Fax: 608.842.0115 or 1-844-727-7533 (toll free)
Email: Enrollment@fiscalassistance.org

Rev. 08/2019

For your information

New Employer/Participant Information

You are now an Employer!

Welcome to the Self-Directed employment model. You will now manage and direct the services you receive. In this employer model you, or a representative who you appoint, are the employer and you direct the work of your employee.

The Role of Fiscal Assistance as Your Fiscal/Employer Agent

Fiscal Assistance, Inc. (FA) will serve as your Fiscal/Employer Agent to support you and complete many of the administrative employer obligations. This means that FA will process your timesheets, conduct criminal background checks on potential employees, manage your employer tax responsibilities, apply for worker's compensation insurance, and pay your employees.

Roles and Responsibilities Chart

Your Role ***(as Employer)***	**Employee's Role** ***(as Employee)***	**Fiscal Assistance's Role** ***(as Fiscal/Employer Agent)***
Select and hire an employee Schedule employees (staying within your authorized budget) Train employees Sign timesheets Review employees job performance	Meet your requirements for hiring Complete required employment paperwork Pass a background check Submit timesheets to FA	Assist with paperwork, as needed Establish you as an employer Establish your worker as your employee Conduct criminal background checks
Dismiss employees Establish clear boundaries Let your employee know what the rules are and what their responsibilities are Prevent fraud	Respect employer's boundaries, rules and responsibilities Provide home care services to your employer as directed by your employer Prevent fraud	Provide payroll services Prepare and disburse payroll checks Pay employer taxes Prepare year-end tax statements Apply for and secure Workers Compensation insurance on behalf of the employer

The hiring process

Fiscal Assistance, Inc. (FA) will assist you, as needed, with all of the paperwork necessary to establish you as an employer and establish your worker as your employee.

Payroll services

Fiscal Assistance, Inc. (FA) will prepare and disburse payroll checks and year-end tax statements. In addition, FA will pay all employer taxes, withhold employee taxes, and submit tax withholding statements to the appropriate government agencies. If your employee ever needs employment verification FA will handle that as well.

Contact Information

You can remove this page from the packet and post it somewhere prominent so you always have the information you need to contact the resources you need.

Fiscal Assistance staff is available for support Monday through Friday from 7:30am to 4:00pm and can be reached at **608.846.7058 or 1-855-201-4230** (toll free) or Website www.fiscalassistance.org.

Fiscal Assistance is not open on state or federal holidays.

Employer Agent Team

Service	Contact Info
**** Employer Agent Communications Specialist** ○ Payroll Questions/Concerns ○ Timesheet Confirmation ○ Wage Verification ○ Budget Authorizations ○ More Timesheets Needed ○ New Employee Packet ○ Change of address/phone #	PH: 608.846.7058 ext. 21 TF: 1.855.201.4230 ext. 21 Enrollment@fiscalassistance.org
Payroll Manager	PH: 608.846.7058 ext. 16 TF: 1.855.201.4230 ext. 16 Payroll@fiscalassistance.org
Executive Director – Carol Richards	PH: 1.855.201.4230 ext. 11 TF 1.855.201.4230 ext. 11 CarolR@fiscalassistance.org

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/

Employer Acknowledgment Form

I, _____, have read the "New Employer/Participant Information" and "Program Integrity and Fraud Prevention" documents provided by Fiscal Assistance, Inc.

I understand and accept my role or my designated representative's role as an employer in the Self- Directed employment model.

I acknowledge that I am the employer of any employee I may choose to hire to provide home health care service in the Self- Directed employment model.

I understand I am responsible for hiring, firing, training, and supervising my employees, as well as, maintaining program integrity by preventing and reporting fraud.

I understand and acknowledge that as a Fiscal/Employer Agent, Fiscal Assistance, Inc., **will not** act as the employer of any employee I may choose to hire through this program.

Signed,

_____ _____

Signature Date

For your information

Notice of Privacy Practices

If you have any questions about this Notice, please contact Carol Richards 608.846.7058 ext. 11.

Fiscal Assistance, Inc. is fully committed to ensuring the privacy and confidentiality of our clients' Protected Health Information (PHI) and supports the provisions of the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Notice of Privacy Practices describes how **Fiscal Assistance, Inc.,** (the Agency) may collect, use and disclose your protected health information to carry out treatment, payment or Agency operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. The terms of this Notice will remain in effect until the Notice is modified or replaced by Fiscal Assistance, Inc. If the terms of this Notice are modified or replaced, the terms in the new Notice will become effective for all Protected Health Information maintained by Fiscal Assistance at that time. In the event this Notice is modified or replaced, the new Notice will be made available to consumers and their associates on our website at http://fiscalassistance.org or at our offices at 4646 S. Biltmore Lane Madison, WI 53718.

1. Uses and Disclosures of Protected Health Information

The Agency is allowed to use and disclose your personal health information when that information is used in the areas of treatment, payment and operations.

Once you have authorized the use and disclosure of your protected health information for receiving services by signing this form, we will use or disclose your protected health information only as described in this Section 1. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the Agency's services.

The following are examples of the types of uses and disclosures of your protected health care information that the Agency is permitted to make once you have signed this form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided authorization.

- **Treatment:** We will use and disclose your protected health information to coordinate and/or manage your health care services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We will also disclose protected health information to other agencies, both public and private, that may be treating you when we have the necessary permission from you to disclose your protected health information.

- **Payment:** Your protected health information will be used as needed to obtain payment for your health care services. This may include certain activities that your health insurance plan may

undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to a private health plan or Wisconsin Medicaid agency to obtain approval for the hospital admission.

- **Agency Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of the Agency. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate which individual within the Agency you are visiting.

Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about the Agency and the services we offer. You may contact our Privacy Officer to request that these materials **not** be sent to you.

The Agency's use and disclosure of protected health information must be based upon your written Authorization.

Uses and disclosures of your protected health information for purposes other than treatment, payment, or Agency operations will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke the Authorization at any time, in writing, except to the extent that the Agency or your service provider has taken an action in reliance on the use or disclosure indicated in the Authorization.

You may authorize other uses and disclosures of your personal health information.

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then the Agency, using professional judgment, may determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your current situation will be disclosed.

- **Others Involved in Your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

- **Communication Barriers:** We may use and disclose your protected health information if your service provider or someone else within the Agency attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization.

- **Required By Law:** We may use or disclose your protected health information to the extent that the law requires its use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Health Oversight:** We may disclose protected health information to a health oversight agency authorized by law to conduct activities such as audits, investigations, and inspections, or any process for ensuring compliance with the rules of government health programs, such as Medicare or Medicaid.

- **Abuse or Neglect:** If we have cause to believe you are a victim of abuse or neglect, we may disclose your protected health information to a governmental authority that is authorized by law to receive reports of abuse or neglect. In this case, the disclosure will be made in full compliance with the requirements of applicable federal and state laws.

- **Judicial & Administrative Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Agency, and (6) medical emergency (not on the Agency's premises) and it is likely that a crime has occurred.

- **Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

- **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to a foreign military authority if you are a member of that foreign military armed services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

- **You may have the right to request that your service provider amend your protected health information that is being held in a designated record set.** In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and we will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your personal health information.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding any applicable disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations and you should contact our Privacy Officer if you have any questions about this accounting.

- **You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.**

3. Complaints

You may complain to Fiscal Assistance or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by Fiscal Assistance. You may file a complaint with us by notifying Carol Richards of your complaint. Please be assured that we will not retaliate against you for filing a complaint. If you have any questions about filing a complaint, you should feel free to contact Carol Richards, 608.846.7058 ext. 11, Carolr@fiscalassistance.org.

Receipt of Notice of Privacy Practices

HIPAA Privacy Notice

I, _____, have read or been informed of Fiscal Assistance, Inc.'s privacy practices and understand the provisions contained therein.

I hereby authorize Fiscal Assistance to use and disclose my Protected Health Information according to the provisions set forth in this Notice of Privacy Practices.

Signed,

_____ _____

Signature Date

Note: This section is optional.
Any request must state the specific restriction(s) requested and to whom each restriction applies in order to be considered valid.

I hereby request the following restrictions to be placed on the use and/or disclosure of my Protected Health Information:

_____

_____

fa,inc.

Initial Employer Information Form

NAME OF EMPLOYER (Individual Receiving Care)

Employer Name:	
Address:	
Phone:	
Date of Birth:	
Social Security #:	
Email:	

FEIN (if previously used):	
Case Management Agency:	
Case Manager/Care Manager:	
MCI #:	
Fund Code: (FA completes)	

ADDITIONAL INFORMATION

Guardian/POA/Parent of Minor (if applicable)

Guardian/POA/Parent of Minor:	
Address:	
Phone:	
Email:	

Form **SS-4**
(Rev. January 2010)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

▶ **See separate instructions for each line.** ▶ **Keep a copy for your records.**

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested
, HHCSR

2 Trade name of business (if different from name on line 1)
Fiscal Assistance Inc.

3 Executor, administrator, trustee, "care of" name
Fiscal Assistance Inc.

4a Mailing address (room, apt., suite no. and street, or P.O. box)
4646 S. Biltmore Lane

5a Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)
Madison, WI 53718

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located
, Wisconsin

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? ☐ Yes ☑ No

8b If 8a is "Yes," enter the number of LLC members ▶

8c If 8a is "Yes," was the LLC organized in the United States? ☐ Yes ☑ No

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN) ___
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ▶ ___
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶ ___
- ☑ Other (specify) ▶ HHCSR
- ☐ Estate (SSN of decedent) ___
- ☐ Plan administrator (TIN) ___
- ☐ Trust (TIN of grantor) ___
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ▶

9b If a corporation, name the state or foreign country (if applicable) where incorporated

State

Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ▶ ___
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) ▶ HHCSR
- ☐ Banking purpose (specify purpose) ▶ ___
- ☐ Changed type of organization (specify new type) ▶ ___
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶ ___
- ☐ Created a pension plan (specify type) ▶ ___

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year **December**

13 Highest number of employees expected in the next 12 months (enter -0- if none).

If no employees expected, skip line 14.

Agricultural	Household	Other
0	0	0

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note.** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶ N/A

16 Check **one** box that best describes the principal activity of your business.

☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Accommodation & food service ☐ Wholesale-agent/broker ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) HHCSR

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HHCSR

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☑ No
If "Yes," write previous EIN here ▶

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name
Scarlett Russell or Renae Huffman or Theresa Chard ~ Fiscal Assistance Inc.

Designee's telephone number (include area code)
(608) 846-7058

Address and ZIP code
4646 S. Biltmore Lane Madison, WI 53718

Designee's fax number (include area code)
(608) 842-0459

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

Name and title (type or print clearly) ▶

Applicant's telephone number (include area code)
( )

Signature ▶

Date ▶

Applicant's fax number (include area code)
( )

Form **2678** (Rev. June 2011)

Employer/Payer Appointment of Agent

Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

Part 1: Why you are filing this form...

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 **Employer identification number (EIN)** ☐☐ – ☐☐☐☐☐☐☐

2 **Employer's or payer's name** (not your trade name)

3 **Trade name** (if any)

4 **Address**

Number Street Suite or room number

City State ZIP code

5 **Forms for which you want to appoint an agent or revoke the agent's appointment to file.** (*Check all that apply.*)

	For ALL employees/ payees	For SOME employees/ payees
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☑	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☑	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944-PR, 944-SS, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	☐	☐

*Generally you cannot appoint an agent to report, deposit, and pay taxes reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA taxes for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

X **Sign your name here**

Date / /

Print your name here

Print your title here HHCSR

Best daytime phone

Now give this form to the agent to complete.