



**Fiscal Assistance, Inc.**

4646 S. Biltmore Lane

Madison, WI 53718

Phone (855) 201-4230

Fax: (608) 842-0115

## Managed Care Organization 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  
**\*\*Refer to instructions and Sample I-9\*\***
  - 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)**
    - 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
- 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.

### If you have questions, please contact:

<b>Renaë Huffman</b>	<b>Scarlett Russell</b>	<b>Theresa Chard</b>
Enrollment and Outreach Director	Enrollment and Outreach Coordinator	Enrollment and Outreach Coordinator
Direct Phone: 608-819-7748	Direct Phone: 608-733-6237	Direct Phone: 608-733-6243
<a href="mailto:RenaëH@fiscalassistance.org">RenaëH@fiscalassistance.org</a>	<a href="mailto:ScarlettR@fiscalassistance.org">ScarlettR@fiscalassistance.org</a>	<a href="mailto:TheresaC@fiscalassistance.org">TheresaC@fiscalassistance.org</a>

### **Return Packet to:**

**Fiscal Assistance, Inc.**

**4646 S. Biltmore Lane**

**Madison, WI 53718**

**Phone: 1-855-201-4230**

**General Fax: 608.842.0115 or 1-844-727-7533 (toll free)**

**Email: [enrollment@fiscalassistance.org](mailto: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](http://www.fiscalassistance.org).

*Fiscal Assistance is not open on state or federal holidays.*

## Employer Agent Team

Service	Contact Information						
<ul style="list-style-type: none"> <li>○ Payroll Questions/Concerns</li> <li>○ Timesheet Confirmation</li> <li>○ Wage Verification</li> <li>○ Budget Authorizations</li> <li>○ More Timesheets Needed</li> <li>○ New Employee Packet</li> <li>○ Change of address/phone #</li> </ul>	<table border="1"> <tr> <td> <b>CARE WI &amp; My Choice</b>                      Payroll Specialist                      (Service Code 4111 or 8111)                 </td> <td>                     Direct: 608-819-7752  <a href="mailto:payroll@fiscalassistance.org">payroll@fiscalassistance.org</a> </td> </tr> <tr> <td> <b>iCare</b>                      Payroll Specialist                      (Service Code 9111)                 </td> <td>                     Direct: 608-819-7734  <a href="mailto:payroll@fiscalassistance.org">payroll@fiscalassistance.org</a> </td> </tr> <tr> <td> <b>CLTS/Children's</b>                      Payroll Specialist                      (Service Code 3111 or 7111)                 </td> <td>                     Direct: 608-819-7739  <a href="mailto:payroll@fiscalassistance.org">payroll@fiscalassistance.org</a> </td> </tr> </table>	<b>CARE WI &amp; My Choice</b> Payroll Specialist (Service Code 4111 or 8111)	Direct: 608-819-7752 <a href="mailto:payroll@fiscalassistance.org">payroll@fiscalassistance.org</a>	<b>iCare</b> Payroll Specialist (Service Code 9111)	Direct: 608-819-7734 <a href="mailto:payroll@fiscalassistance.org">payroll@fiscalassistance.org</a>	<b>CLTS/Children's</b> Payroll Specialist (Service Code 3111 or 7111)	Direct: 608-819-7739 <a href="mailto:payroll@fiscalassistance.org">payroll@fiscalassistance.org</a>
	<b>CARE WI &amp; My Choice</b> Payroll Specialist (Service Code 4111 or 8111)	Direct: 608-819-7752 <a href="mailto:payroll@fiscalassistance.org">payroll@fiscalassistance.org</a>					
	<b>iCare</b> Payroll Specialist (Service Code 9111)	Direct: 608-819-7734 <a href="mailto:payroll@fiscalassistance.org">payroll@fiscalassistance.org</a>					
<b>CLTS/Children's</b> Payroll Specialist (Service Code 3111 or 7111)	Direct: 608-819-7739 <a href="mailto:payroll@fiscalassistance.org">payroll@fiscalassistance.org</a>						
Payroll Manager	Direct: 608.733.6241 TF: 1.855.201.4230 ext. 16 <a href="mailto:payroll@fiscalassistance.org">payroll@fiscalassistance.org</a>						
Executive Director – Carol Richards	Direct: 608.819.9309 TF 1.855.201.4230 ext. 11 <a href="mailto:CarolR@fiscalassistance.org">CarolR@fiscalassistance.org</a>						

**\*\*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: 608-842-0115 or**  
**1-844-727-7533 (toll free)**  
**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/](http://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

**Employee Name:**

**Employer Name:**

## Relationship to employer ~ Are you related to the employer?

\_\_\_\_\_ **Yes**                      \_\_\_\_\_ **No** (if no- you can skip to sign and date)

**If yes** how are you related to the employer? **Please check only one-** for example if the employer is your grandmother, you are the grandchild) ... check grandchild

<input type="checkbox"/> Spouse (Exempt) <input type="checkbox"/> Parent (Exempt) <input type="checkbox"/> Child under 21 (Exempt) <input type="checkbox"/> Domestic Partner(Exempt)	<input type="checkbox"/> Grandparent (SUTA exempt) <input type="checkbox"/> Grandchild (SUTA exempt) <input type="checkbox"/> Child over 21 (SUTA exempt) <input type="checkbox"/> Sibling <input type="checkbox"/> Other _____
---	---

**\*Please mark exempt on W-4.**

**Exempt-** Due to your relationship with the employer and current legislation, you are exempt from payroll taxes for Social Security and Medicare (FICA), and Unemployment insurance (FUTA and SUTA) which means you are not earning Social Security work credits and you will not receive unemployment benefits if your employment is terminated. (for more info please see IRS Publication 15- Family Employees at [www.irs.gov](http://www.irs.gov))

**SUTA exempt-** Due to your relationship with the employer and current legislation, you are exempt from unemployment insurance payroll taxes (SUTA). If your employment is terminated, you will not receive unemployment benefits.

**Note:** It is the employee’s responsibility to notify Fiscal Assistance Inc. if this relationship or living arrangement should change.

**I am a Live in:** I permanently reside in the same residence as my employer.\* ***Exempt on W-4***

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

**Signature** \_\_\_\_\_

**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.**

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Employee / Contractor (including new applicant)                                  | <input type="checkbox"/> Household member (lives on premises, but is not a client) |
| <input type="checkbox"/> Applicant for a license, certification, or registration (including continuation or renewal) | <input type="checkbox"/> 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>
--------------------------------	---------------	-------------

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
--	-------------------------	--

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
--	------------------------

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
<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/>	<input type="checkbox"/>

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.

---

<b>Name – Person Completing This Form</b>
---

<b>Date Submitted</b>
-----------------------

---

# FA Employer Agent Program

## Form I-9 Instructions

### Employee Steps:

- 1.) Complete Section 1
  - a. Name (Last, First, Middle Initial, and Other Name(s), if applicable)
  - b. Address (Street – no PO Boxes, City, State, and Zip Code)
  - c. Date of Birth
  - d. Social Security Card
  - e. E-mail Address
  - f. Telephone Number
- 2.) Answer citizen status question by checking the box that applies to you, the employee.
- 3.) Sign and date.

**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) SAMPLE	First Name (Given Name) SALLY	Middle Initial L.	Other Last Names Used (if any)
Address (Street Number and Name) 124 W. HOLUM STREET	Apt. Number	City or Town DEFOREST	State WI      ZIP Code 53532
Date of Birth (mm/dd/yyyy) 05/01/1970	U.S. Social Security Number 1 2 3 - 4 5 - 6 7 8 9	Employee's E-mail Address sally.sample@gmail.com	Employee's Telephone Number (608) 846-1234

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 checked="" 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>	
<p><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></p> 1. Alien Registration Number/USCIS Number: _____ <b>OR</b> 2. Form I-94 Admission Number: _____ <b>OR</b> 3. Foreign Passport Number: _____ Country of Issuance: _____	

Signature of Employee <i>Sally L. Sample</i>	Today's Date (mm/dd/yyyy) 08/01/2019
--	--------------------------------------

**Employer Steps:**

**\*\*The below steps must be completed by the employer or a representative of the employer. They cannot be completed by the employee\*\***

- 1.) Complete Section 2
  - a. Enter the employee's name under the Section 2 heading.
  - b. Employer must physically examine employee documents and print details under appropriate list(s).
    - i. One document from List A OR (Ex. Passport or Permanent Resident Card)
    - ii. One document from both List B and List C.  
(Ex. of list B = **Photo ID AND** List C = **SS Card or Birth Certificate**)
  - c. Sign your name, date, enter your title (Employer), and print your name and address.

**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.")*

<b>Employee Info from Section 1</b>	Last Name (Family Name) SAMPLE	First Name (Given Name) SALLY	M.I. L.	Citizenship/Immigration Status CITIZEN
<b>List A</b>	<b>OR</b>	<b>List B</b>	<b>AND</b>	<b>List C</b>
<b>*PASSPORT</b> Identity and Employment Authorization	<b>*PHOTO ID</b>	<b>Identity</b>	<b>*SS CARD</b>	<b>Employment Authorization</b> <b>OR BIRTH CERT.</b>
Document Title	Document Title DRIVER LICENSE	Document Title SOCIAL SECURITY CARD		
Issuing Authority	Issuing Authority WISCONSIN	Issuing Authority SOCIAL SECURITY ADMIN.		
Document Number	Document Number 5522-9876-5662-05	Document Number 123-45-6789		
Expiration Date (if any)(mm/dd/yyyy)	Expiration Date (if any)(mm/dd/yyyy) 05/01/2020	Expiration Date (if any)(mm/dd/yyyy)		
Document Title	Additional Information		QR Code - Sections 2 & 3 Do Not Write in This Space	
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
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 <i>Member Murphy</i>	Today's Date (mm/dd/yyyy) 08/01/2020	Title of Employer or Authorized Representative EMPLOYER/GUARDIAN/POA/PARENT
Last Name of Employer or Authorized Representative MURPHY	First Name of Employer or Authorized Representative MEMBER	Employer's Business or Organization Name
Employer's Business or Organization Address (Street Number and Name) 123 MAIN STREET	City or Town DEFOREST	State WI
		ZIP Code 53532



**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	
<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>	
<p><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></p> <p>1. Alien Registration Number/USCIS Number: _____  <b>OR</b>          2. Form I-94 Admission Number: _____  <b>OR</b>          3. Foreign Passport Number: _____          Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">           QR Code - Section 1            Do Not Write In This Space         </div>	

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





**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.")*

<b>Employee Info from Section 1</b>	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.

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	Additional Information	
Issuing Authority		
Document Number		
Expiration Date (if any)(mm/dd/yyyy)		
Document Title	QR Code - Sections 2 & 3 Do Not Write In This Space	
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.)*

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
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.

<b>LIST A</b> <b>Documents that Establish Both Identity and Employment Authorization</b>	OR	<b>LIST B</b> <b>Documents that Establish Identity</b>	AND	<b>LIST C</b> <b>Documents that Establish Employment Authorization</b>
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security</li> </ol>

**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.**

# Employee's Withholding Certificate

OMB No. 1545-0074

▶ Dr o srgvg Gr to a .5 ur vj cv-ř wt go srr -gt ecp y kj j r r f vj g erttgevřgf gtcnřper o g vc- ltr o -ř wt sc-ř  
▶ Hřkg Gr to a .5 vr -ř wt go srr -gt1  
▶ br wt y kj j r r f řpi ku uvdřgevř tgřkřgy d-vj g Jř Wř

**2020**

<b>Step 1:</b> <b>Enter</b> <b>Personal</b> <b>Information</b>	(a) <b>First name and middle initial</b>	<b>Last name</b>	(b) <b>Social security number</b>
	<b>Address</b>		▶ Er gu -ř wt pco g o cvej vj g pco g r p -ř wt ur elcn ugewřk-ectř A If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	<b>City or town, state, and ZIP code</b>		
	(c) <input type="checkbox"/> Wpi rg r t N cttřgf Hřpi ugsctcvgn- <input type="checkbox"/> N cttřgf Hřpi řr řpn--(or Qualifying widow(er)) <input type="checkbox"/> I gcf r hj r wřgj r r ř (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

**Dr o srgvg Wřgsu 3 5 POMB řhv j g-cssn-vr -ř wřr vj gty kug-unřs vr Wřgs : 1** See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

**Wřgs 3;** 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.  
**N wřřrg řr du r t Wřr wřg a r tmř**  
Do r pn-r pg of the following.  
**řc,** Use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) for most accurate withholding for this step (and Steps 3-4); **ř t**  
**řd,** Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **ř t**  
**ře,** 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 . . . . . ▶   
**řR;** To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

**Dr o srgvg Wřgsu 4 5) d, r p Gr to a .5 řr t r pn-POF ř hv j gug řr duř** 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.)

<b>Wřgs 4;</b> <b>Dřclo</b> <b>Egs gpf gpwř</b>	If your 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 . . . . . <b>4</b> \$ _____		
<b>Wřgs 5</b> <b>řr svř pcrj;</b> <b>Př j gt</b> <b>Cf řwřvo gpwř</b>	<b>řc, Př j gt řper o g řpr v řtr o řr duř</b> 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 . . . . . <b>5)c,</b> \$ _____		
	<b>řd, Egf wvřř puř</b> 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 . . . . . <b>5)d,</b> \$ _____		
	<b>ře, F-vřc y kj j r r ř řpi 1</b> Enter any additional tax you want withheld each <b>sc-sgřk f</b> . . . . . <b>5)e,</b> \$ _____		
	<b>Claim exempt ---&gt;</b>		

**Step 5:** Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

**Sign Here**

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

<b>Fo srr -gtu</b> <b>Ppn-</b>	Employer's name and address	First date of employment	Employer identification number (EIN)
-----------------------------------	-----------------------------	--------------------------	--------------------------------------



## Hgpgtcn.ɸutwekr pu

### Gwwtg Egxgrr so gpw

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

### Rwtsr ug r hGr to

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

**F-go svkr p ltr o y kj j r rf lpi 1** You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **cpf** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. **If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.**

**br wt stlkrce-1** If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

**a j gp vr wug vj g guvko cvr t1** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

**Wgrh go srr -e gpv1** Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to figure the amount to have withheld.

**Or ptgulr gpvcr1gp1** If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

## Wsgtkle ɸutwekr pu

**Wgs 2)e,1** Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

**Wgs 31** Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **jc**, most accurately calculates the additional tax you need to have withheld, while option **jd**, does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **je**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



**Multiple jobs.** Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

**Wgs 41** Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **r vj gt vc- etgf ku** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

### Wgs 5 )r svkr pcn1

**Step 4(a).** Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

**Step 4(b).** Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

**Step 4(c).** Enter in this step any additional tax you want withheld from your pay **gcej sc-sgtr f**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Wgs 3)d, Nwnlgr Lr du a r tmuj ggv (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on r pn-POF Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Or vg; If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

2 Yy r lr du1 If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, unls to line 3 . . . . . 2 \$ \_\_\_\_\_

3 Yj tgg lr du1 If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

c Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 3c \$ \_\_\_\_\_

d Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 3d \$ \_\_\_\_\_

e Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 3e \$ \_\_\_\_\_

4 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . 4 \_\_\_\_\_

5 Ekf g the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Wgs 5)e, of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 5 \$ \_\_\_\_\_

Wgs 5)d, Egf wekr pu a r tmuj ggv (Keep for your records.)



2 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income . . . . . 2 \$ \_\_\_\_\_

3 Enter: { • \$24,800 if you're married filing jointly or qualifying widow(er) • \$18,650 if you're head of household • \$12,400 if you're single or married filing separately } . . . . . 3 \$ \_\_\_\_\_

4 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . . . . 4 \$ \_\_\_\_\_

5 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information . . . . . 5 \$ \_\_\_\_\_

: Cf f lines 3 and 4. Enter the result here and in Wgs 5)d, of Form W-4 . . . . . : \$ \_\_\_\_\_

Rtlkce-Cev cpf Rcs gty r tmT gf wekr p Cev Or veg1 We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

# Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

**WT-4**

**Employee's Section** (Print clearly)

Employee's legal name <i>(last, first, middle initial)</i>			Social security number		<input type="checkbox"/> Single <b>**Please check one box</b> <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note:</b> If married, but legally separated, check the Single box.
Employee's address <i>(number and street)</i>			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.

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 \_\_\_\_\_

<p><b>EMPLOYEE INSTRUCTIONS:</b></p> <ul style="list-style-type: none"> <li>• <b>WHO MUST FILE:</b> 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.</li> <li>• <b>UNDER WITHHOLDING:</b> 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.</li> <li>• <b>OVER WITHHOLDING:</b> 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.</li> <li>• <b>WHEN TO FILE IF YOUR EXEMPTIONS CHANGE:</b> 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.</li> </ul>	<p><b>WT-4 Instructions</b> – Provide your information in the employee section.</p> <ul style="list-style-type: none"> <li>• <b>LINE 1:</b> (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.</li> <li>• <b>LINE 2:</b> 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.</li> <li>• <b>LINE 3:</b> 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.</li> </ul>
--	--

**Employer's Section**

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

<p><b>EMPLOYER INSTRUCTIONS for Department of Revenue:</b></p> <ul style="list-style-type: none"> <li>• If you do not have a Federal Employer Identification Number (FEIN), contact the Internal Revenue Service to obtain a FEIN.</li> <li>• 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.</li> <li>• 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.</li> </ul>	<p><b>EMPLOYER INSTRUCTIONS for New Hire Reporting:</b></p> <ul style="list-style-type: none"> <li>• 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 <a href="http://dwd.wisconsin.gov/uiuh">http://dwd.wisconsin.gov/uiuh</a> to report new hires.</li> <li>• 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.</li> <li>• If you have questions about New Hire requirements, call toll free (888) 300-HIRE (888-300-4473). Visit <a href="http://dwd.wisconsin.gov/uiuh">dwd.wisconsin.gov/uiuh</a> for more information.</li> </ul>
--	---

**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;

**DEPARTMENT OF HEALTH SERVICES**

Division of Medicaid Services  
F-00180C (07/2017)

**STATE OF WISCONSIN**

42 CFR 431.107 & 42 CFR 438.602(b)

- 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

# 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

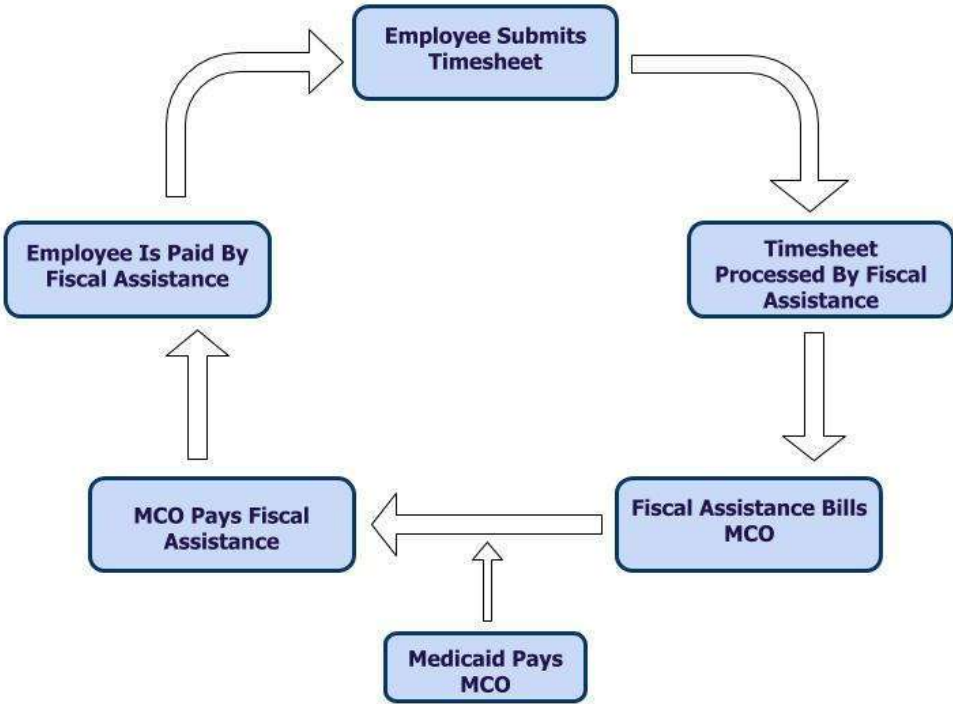
Providers of supportive home care and personal assistance services must meet the following DHS required minimum training and qualified provider standards to deliver services and receive payments using Medicaid funding. *Each member/employer is responsible for providing information and training to each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

- |   |   |
|---|---|
| <input type="checkbox"/> Licensed Practical Nurse (LPN)     | <input type="checkbox"/> Registered Nurse (RN)              |
| <input type="checkbox"/> Certified Nursing Assistant (CNA)  | <input type="checkbox"/> Physical or Occupational Therapist |
| <input type="checkbox"/> Physical or Occupational Assistant |   |

**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.

<b>Employee/care provider</b>	<b>Date</b>
<b>Employer/ Representative Signature</b>	<b>Date</b>

**Return Form 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



## 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:** \_\_\_\_\_

**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**