Updated: 4/17/15

IRIS Participant-Hired Worker Paperwork

Participant-Hired Worker Forms Examples

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Note: Participant-Hired Worker may be abbreviated as PHW throughout this document.

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

Personal Allowances Worksheet: A-H
This worksheet is used to assist in determining the number of elections for this form.

Employee's Withholding Allowance Certificate: This is the portion that will need to be turned in. Some PHWs may separate the form here to keep the worksheet (top) for their records.

Box 1: The legal first name, middle initial, and last name of the PHW – as well as his/her home address, city, state, and ZIP code.

Box 2: The PHW's Social Security number.

Box 3: Check the box that best describes the PHW's marital status.

Box 4: Check if the PHW's last name is different than what is shown on his/her Social Security card.

Box 5: Enter the number of allowances the PHW is claiming. This is typically the same number as is found on Line H of the Personal Allowances Worksheet but may differ.

Box 6: Enter any additional amount the Participant-Hired Worker

Box 7: Enter "Exempt" if claiming an exempt status.

Employee's Signature: The signature of the Participant-Hired Worker

Date: The date the form was signed.

EXAMPLE: W-4
Employee Withholding Allowance Certificate

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . **A** #

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . **B** #

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . **C** #

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . **D** #

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . **E** #

F Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** #
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . . . **G** #

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** #

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

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

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074 — **2015**

1 Your first name and middle initial	Last name	2 Your social security number
PHW First Name and Middle Initial	Participant-Hired Worker Last Name	###-##-####

Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
Participant-Hired Worker Street Address	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☑
City, State and ZIP Code	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** #

6 Additional amount, if any, you want withheld from each paycheck . . . **6** $

7 I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . ▶ **7**

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

Employee's signature
(This form is not valid unless you sign it.) ▶ Participant-Hired Worker Signature **Date** ▶ mm/dd/yyyy

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2015)

Special Instructions for Claiming "Exempt"

If the Participant-Hired Worker is claiming "Exempt," Box 5 should be left blank and "Exempt" should be written in Box 7. When claiming "Exempt," the Participant-Hired worker will need also need to complete Form W-T4.

*Both Form W-4 and Form W-T4 will need to be **completed annually** (by February) if the Participant-Hired Worker wishes to remain at "Exempt" status from year to year.*

EXAMPLE: W-T4
Employee's WI Withholding Exemption Certificate

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

EMPLOYEE'S SECTION

Employee's Legal Name: The Participant-Hired Worker's legal name in last name, first name and middle initial format.

Social Security Number: The Participant-Hired Worker's Social Security Number.

Check Boxes: Check the box that best describes the Participant-Hired Worker's marital status.

Employee's Address, City, State, and Zip Code: The Participant-Hired Worker's street address, city, state, and ZIP Code.

Date of Birth: The Participant-Hired Worker's birthdate in mm/dd/yyyy format.

Date of Hire: If the Participant-Hired Worker's start date has been issued by the time this form is completed, enter it in mm/dd/yyyy format. Otherwise, it can be left blank to be completed by the FEA.

Lines 1a-c: Determine the number of exemptions claimed for each line.

Line 1d: Enter the total from Lines 1a-c.

Line 2: Enter any additional amount per pay period to be deducted.

Line 3: Enter "Exempt" if the criteria from the instructions is met.

Signature: The Participant-Hired Worker's Signature

Date Signed: The date the form was completed by the PHW – written out. *For example: April 15, 2015*

EMPLOYER'S SECTION

Employer's Name: The IRIS Participant's full legal, printed name.

Federal Employer ID Number: This is the Employer Identification Number issued by the IRS after the Participant/Employer submits form SS-4. If he/she has not yet been issued this number, this box can be left blank.

Employer's Payroll Address, City, State, and ZIP Code: The Participant/Employer's street address, city, state, and ZIP Code.

Completed by: The printed name of the Participant/Employer or his/her representative completing the form.

Title: "HHCSR" if being completed by the Participant/Employer or "POA" or "Guardian" if being completed by his/her representative.

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

Employee's legal name (last, first, middle initial)			Social security number	
PHW Last Name, First Name and Middle Initial			###-##-####	☑ Single
Employee's address (number and street)			**Date of birth**	☐ Married
Participant-Hired Worker's Street Address			mm/dd/yyyy	☐ Married, but withhold at higher Single rate.
City	**State**	**Zip code**	**Date of hire**	Note: If married, but legally separated, check the Single box.
City	State	ZIP Code	mm/dd/yyyy	

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: Participant-Hired Worker Signature   Date Signed: Month Day, Year

EMPLOYEE INSTRUCTIONS:

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

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

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

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

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

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

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

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

Employer's Section

Employer's name				Federal Employer ID Number
Participant/Employer's Name				#########
Employer's payroll address (number and street)		**City**	**State**	**Zip code**
Participant/Employer Address		City	State	#####
Completed by	**Title**	**Phone number**	**Email**	
Participant/Employer or Representative Name	HHCSR, POA, or Guardian	(###) ###-####	Participant/Employer Email Address	

EMPLOYER INSTRUCTIONS for Department of Revenue:

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

EMPLOYER INSTRUCTIONS for New Hire Reporting:

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

W-204 (R. 1-14)   Wisconsin Department of Revenue

When to Complete Form W-T4

Form W-T4 only needs to be completed if the Participant-Hired Worker is claiming "Exempt" on the W-4. This form will be sent to them by the FEA to be completed.

Both Form W-4 and Form W-T4 will need to be ***completed annually*** *(by February) if the Participant-Hired Worker wishes to remain at "Exempt" status from year to year.*

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

SECTION 1

Completed by the Participant-Hired Worker.

Last Name, First Name, Middle Initial: Participant-Hired Worker's full, legal name in last name, first name, middle initial format.

Other Names Used (if any): Include any names that the PHW has used including maiden names. If there are no other names, write "N/A."

Address, Apt. Number, City or Town, State, ZIP Code: Participant-Hired Worker's current address, city, state, and ZIP code. _Note: P.O Boxes are not acceptable._

Date of Birth: Participant-Hired Worker's birthdate in mm/dd/yyyy format.

U.S. Social Security Number: Participant-Hired Worker's Social Security Number

E-mail Address: Participant-Hired Worker's email Address

Telephone Number: Participant-Hired Worker's telephone number with Area Code.

I attest, under penalty of perjury, that I am: Check the box that best describes the Participant-Hired Worker's citizenship status. Include additional required information if specified for that selection.

Signature of Employee: The PHW's signature.

Date: The date that the form was completed by the Participant-Hired Worker.

Preparer and/or Translator Certification: This section is only completed if the PHW uses a translator to complete this form.

Continued on Page 8

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. **Read instructions carefully before completing this form. The instructions must be available during completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 Names Used _(if any)_
PHW Last Name	PHW First Name	Middle Initial	Other Names the PHW has used.

Address _(Street Number and Name)_	Apt. Number	City or Town	State	Zip Code
PHW Street Number and Street Name	#	City/Town	State	#####

Date of Birth _(mm/dd/yyyy)_	U.S. Social Security Number	E-mail Address	Telephone Number
##/##/####	###-##-####	PHW's Email Address	(###) ###-####

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):

- [x] A citizen of the United States
- [ ] A noncitizen national of the United States _(See instructions)_
- [ ] A lawful permanent resident (Alien Registration Number/USCIS Number): ____________
- [ ] An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) ____________. Some aliens may write "N/A" in this field. _(See instructions)_

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: ____________

OR

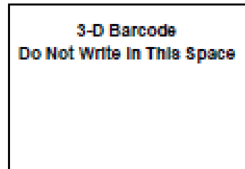
2. Form I-94 Admission Number: ____________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ____________

Country of Issuance: ____________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. _(See instructions)_



Signature of Employee: Participant-Hired Worker's Signature	Date _(mm/dd/yyyy)_: mm/dd/yyyy

Preparer and/or Translator Certification _(To be completed and signed if Section 1 is prepared by a person other than the employee.)_

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

Signature of Preparer or Translator:	Date _(mm/dd/yyyy)_:

Last Name _(Family Name)_	First Name _(Given Name)_

Address _(Street Number and Name)_	City or Town	State	Zip Code

STOP _Employer Completes Next Page_ STOP

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

SECTION 2
Completed by the Participant/Employer or his/her Representative.

Employee Last Name, First Name, Middle Initial: Participant-Hired Worker's full, legal name in last name, first name and middle initial format.

List A or **List B and List C:** Documents chosen to be used for I-9 documentation must be from the Lists of Acceptable Documents, found on page 9 of the I-9 packet.

- If a PHW provides an identifying document from List A, it is the only identification need for this form.
- If the PHW does not provide an item from List A, then he/she will need to provide any combination of identification from both lists B & C.

Complete **each field** under the List that is being completed. If a field is not applicable, write "N/A."

This example depicts the most common documentation used: Social Security Care and Driver's License. Please note that these are not the only documentation that can be used.

Employee's first day of employment: This can be left blank as it will be completed by the FEA.

Signature of Employer: The IRIS Participant/Employer's signature or signature of his/her POA or Guardian if they are completing this form on the Participant/Employer's behalf.

Date: The date this form was signed by the Participant/Employer or his/her representative.

Title of Employer: "Employer" if the Participant/Employer is completing the form or "Employer's POA" or "Employer's Guardian" if applicable.

Last Name and First Name: The last and first name of the Participant, or his/her POA or Guardian, completing this form.

Employer's Business or Organization Name: "IRIS Participant"

Employer's Business Address, City, State, and ZIP Code: The Participant/Employer's street address, city, state, and ZIP code.

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1: PHW's Last Name, First Name and Middle Initial

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: Wisconsin Driver's License		Document Title: Social Security Card
Issuing Authority:		Issuing Authority: Wisconsin Department of Transportation		Issuing Authority: Social Security Administration
Document Number:		Document Number: ###-#####-####-##		Document Number: ###-##-####
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*: mm/dd/yyyy		Expiration Date *(if any)(mm/dd/yyyy)*: N/A
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

Check Every Time!
Make sure to refer to the document being used for each field. Titles, issuing authorities, etc. may change based on when/where the document was issued.

Examples:
- *Department of Transportation vs. Department of Motor Vehicles.*
- *Social Security Administration vs. Department of Homeland Security*

3-D Barcode
Do Not Write in This Space

Certification

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

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

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Participant/Employer or Representative Signature	mm/dd/yyyy	Employer, Employer's POA, or Employer's Guardian

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Participant/Employer Last Name	First Name	IRIS Participant

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
Participant/Employer's Street Number and Street Name	City	State	#####

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

Key Rules of Documenting Required Identification in SECTION 2

When documenting required identification, employers or their authorized representative must:

- The person who examines the documents must be the same person who signs Section 2.
- The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
- Employers cannot refuse to hire someone just because the document(s) presented by the employee/worker will expire soon. If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents.
- DO NOT USE Abbreviations or Acronyms.
- Documents cannot be expired.
- Employers CANNOT specify which document(s) they will accept from an employee.

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A
Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   - **a.** Foreign passport; and
   - **b.** Form I-94 or Form I-94A that has the following:
     - (1) The same name as the passport; and
     - (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

OR

LIST B
Documents that Establish Identity

1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C
Documents that Establish Employment Authorization

1. A Social Security Account Number card, unless the card includes one of the following restrictions:
   - (1) NOT VALID FOR EMPLOYMENT
   - (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
   - (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. Native American tribal document
6. U.S. Citizen ID Card (Form I-197)
7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
8. Employment authorization document issued by the Department of Homeland Security

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

Copy of Signed Social Security Card (Front and Back)

INSTRUCTIONS

- A copy of the Participant-Hired Worker's **signed** Social Security card is **required** before the Participant-Hired Worker's start date can be issued by the FEA.

- Include the copy along with the required Participant-Hired Worker forms to be sent to the FEA for set-up purposes.

- The Participant/Employer (or his/her representative) must verify the Participant-Hired Worker's legal name and Social Security number as they appear on the Social Security card for payroll and tax purposes.

- The Participant-Hired Worker must present the most current copy of their signed Social Security card.

- The name on the Social Security card must match that which is used on the rest of the Participant-Hired Worker Start-Up documents.

- Including a copy of the back side of the Participant-Hired Worker's Social Security card is helpful to identify the issuing authority and, in some cases, is where the card signature is located.

Note: the examples shown here are not all inclusive of every Social Security card type. The appearance of Social Security cards may differ based upon when and where the card was issued.

This card is the official verification of your Social Security number. Please sign it right away. Keep it in a safe place.

Improper use of this card or number by anyone is punishable by fine, imprisonment or both.

This card belongs to the Social Security Administration and you must return it if we ask for it.

If you find a card that isn't yours, please return it to:
Social Security Administration
P.O. Box 33008, Baltimore, MD 21290-3008

For any other Social Security business/information, contact your local Social Security office. If you write to the above address for any business other than returning a found card it will take longer for us to answer your letter.

Social Security Administration

Form SSA-3000 (6-99)

EXAMPLE: F-01201
IRIS Participant-Hired Worker Set-Up

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

SECTION I

Name – Participant-Hired Worker: Participant-Hired Worker's full, legal name in last name, first name, middle initial format.

Gender: Check the box that best describes the Participant-Hired Worker's Gender.

Date of Birth: The Participant/Hired Worker's birthdate in mm/dd/yyyy format.

Mailing Address, City, State, and ZIP: The Participant-Hired Worker's street address, city, state, and ZIP code.

Phone Number: The Participant-Hired Worker's telephone number with Area Code.

Email Address: The Participant-Hired Worker's email address.

SECTION II

Name – Participant/Employer: Participant/Employer's full, legal name in last name, first name, middle initial format.

Date of Birth: The Participant/Employer's birthdate in mm/dd/yyyy format.

Mailing Address, City, State, and ZIP: The Participant/Employer's street address, city, state, and ZIP code.

Phone Number: The Participant/Employer's telephone number with Area Code.

Email Address: The Participant/Employer's email address.

Signature – Participant-Hired Worker: The Participant-Hired Worker's Signature.

Date Signed: The date the form was signed by the Participant-Hired Worker.

Signature – Participant/Employer: The Participant/Employer's Signature (or the signature of his/her Representative).

Date Signed: The date the form was signed by the Participant/Employer or his/her Representative.

DEPARTMENT OF HEALTH SERVICES — **STATE OF WISCONSIN**
Division of Long Term Care
F-01201 (01/2015)

IRIS PARTICIPANT- HIRED WORKER SET- UP

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS Program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. A participant-hired worker may not begin working for a participant before the IRIS start date, indicated in the participant's start date letter.

Personally identifiable information on this form is collected to verify that the application is complete, and will be used only for this purpose.

Completed forms should be submitted to the participant's Fiscal Employer Agent.

SECTION I – PARTICIPANT-HIRED WORKER DEMOGRAPHICS (all fields must be filled)

Name – Participant-Hired Worker (Last, First, MI)		Gender	Date of Birth
PHW Last Name, First Name and Middle Initial		☐ Male ☑ Female	mm/dd/yyyy
Mailing Address: PHW Address	City: City	Phone Number: (###) ###-####	
State: State	Zip: ZIP Code	Email Address: Participant-Hired Worker's Email Address	

SECTION II – PARTICIPANT EMPLOYER DEMOGRAPHICS (all fields must be filled)

Name – Participant Employer (Last, First, MI)		Date of Birth
Participant/Employer's Last Name, First Name and Middle Initial		mm/dd/yyyy
Mailing Address: Participant/Employer Address	City: City	Phone Number: (###) ###-####
State: State	Zip: #####	Email Address: Participant/Employer's Email Address

By signing below, I (we) agree the information on this form is accurate and I (we) have all supporting documentation in my possession. Both signers agree to only submit time reports within the hours authorized. Without prior approval, excess hours claimed above the authorization may be rejected for payment. Both signers also acknowledge that no hours worked prior to a passed background check will be authorized.

SIGNATURE – Participant Hired-Worker	Date Signed
Participant-Hired Worker Signature	mm/dd/yyyy
SIGNATURE – Participant Employer	Date Signed
Participant/Employer, POA, or Guardian Signature	mm/dd/yyyy

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

Name – Participant-Hired Worker: The Participant-Hired Worker's name in last name, first name format.

Name – Participant Employer: The Participant/Employer's name in last name, first name format.

Date of Birth – Participant-Hired Worker: The Participant-Hired Worker's birthdate in mm/dd/yyyy format.

Check your legal relationship to the participant… Place a check next to the box that indicates the Participant-Hired Worker's legal relationship to the Participant/Employer.

Example: if the Participant-Hired Worker is the IRIS Participant's Mother or Father, he/she would check "Parent."

The participant receiving nonmedical care lives in the participant-hired worker's home – Check either "Yes" to indicate the Participant/Employer lives in the Participant-Hired Worker's home or "No" to indicate the Participant/Employer does NOT live in the Participant-Hired Worker's home.

Signature – Participant-Hired Worker: The Participant-Hired Worker's Signature.

Date Signed: The date the Participant-Hired Worker signed this form.

Signature – Participant Employer: The date the Participant/Employer (or his/her representative) signed this form.

Date Signed: The date the Participant/Employer (or his/her representative) signed this form.

EXAMPLE: F-01201A
IRIS Participant-Hired Worker Relationship Identification

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-01201A (01/2015)

STATE OF WISCONSIN

IRIS PARTICIPANT-HIRED WORKER RELATIONSHIP IDENTIFICATION

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS Program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. Participant-hired worker may not begin working for participant employer until they have received a mailed start date letter.

Completed forms should be submitted to the participant's Fiscal Employer Agent.

Name – Participant-Hired Worker (Last, First)	Name – Participant Employer (Last, First)
Participant-Hired Worker Last Name, First Name	Participant/Employer Last Name, First Name
Date of Birth – Participant-Hired Worker mm/dd/yyyy	

Check your legal relationship to the participant. For example, if the participant is your grandmother, you are the participant's grandchild. Check one.

- [x] Parent * ±
- [ ] Son/Daughter (over 21) *
- [ ] Son/Daughter (under 21) * ±
- [ ] Spouse * ±
- [ ] Domestic Partner * Ŧ
- [ ] Step Parent *
- [ ] Step Child *
- [ ] Adopted Child *
- [ ] Grandparent *
- [ ] Grandchild *
- [ ] None of these

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

± Due to your relationship with the participant and current legislation, you are exempt from payroll taxes for Social Security and Medicare (FICA). By not paying into Social Security and Medicare (FICA), it means you are not earning Social Security work credits.

Ŧ Per Wis. Statute 770.05, Domestic Partnership means you and your partner have filed for Domestic Partnership, and have a certified copy of your Declaration of Domestic Partnership.

- [x] Yes - [ ] No The participant receiving nonmedical care lives in the participant-hired worker's home.

NOTE: It is the participant-hired worker's responsibility to notify the participant's Fiscal Employer Agent should their living situation change.

By signing below, you agree the information on this form is accurate and you have all supporting documentation in your possession.

SIGNATURE – Participant-Hired Worker	Date Signed
Participant-Hired Worker Signature	mm/dd/yyyy
SIGNATURE – Participant Employer	Date Signed
Participant/Employer (or Representative) Signature	mm/dd/yyyy

EXAMPLE: F-01201B

IRIS Supportive Home Care/Self-Directed Personal Care/Respite Care Training Verification

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

NOTE: This form is required but does not need to be submitted with the start-up forms. Please complete *after* the Participant-Hired Worker's issued start date.

SECTION 1

Name – Participant-Hired Worker: The Participant-Hired Worker's name in last name, first name format.

Name – Participant Employer: The Participant/Employer's name in last name, first name format.

Date of Birth – Participant-Hired Worker: The Participant-Hired Worker's birthdate in mm/dd/yyyy format.

Anticipated Start Date: Enter the date the Participant-Hired Worker will likely start in mm/dd/yyyy format.

SECTION II-IV

Check the box(es) that best describe the required training that the Participant-Hired Worker will need.

Required training completed on: Enter the date the training was completed and any notes about what was covered in the training. **Note: this must be *after* the issued start date.**

PAGE 2

Signature – Participant-Hired Worker: The Participant-Hired Worker's Signature.

Date Signed: The date the Participant-Hired Worker signed this form.

Signature – Participant Employer: The date the Participant/Employer (or his/her representative) signed this form.

Date Signed: The date the Participant/Employer (or his/her representative) signed this form.

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-01201B (01/2015)

STATE OF WISCONSIN

IRIS SUPPORTIVE HOME CARE / SELF-DIRECTED PERSONAL CARE / RESPITE CARE TRAINING VERIFICATION

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS Program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. Participant-hired worker may not begin working for participant employer until they have received a mailed start date letter.

Please fill out the appropriate section(s) based on services that will be provided.

Completed forms should be submitted to the participant's Fiscal Employer Agent.

SECTION I – PARTICIPANT-HIRED WORKER DEMOGRAPHICS (all fields must be filled)

Name – Participant-Hired Worker (Last, First)	Name – Participant Employer (Last, First)
Participant-Hired Worker Last Name, First Name	**Participant/Employer Last Name, First Name**
Date of Birth – Participant-Hired Worker	Anticipated Employment Start Date
mm/dd/yyyy	**mm/dd/yyyy**

SECTION II – SUPPORTIVE HOME CARE REQUIRED TRAINING

- [x] Employee is oriented to participant's place of care.
- [x] Employee safely performs cares and duties.
- [x] Employee knows what to do in an emergency situation*.
- [ ] Employee works effectively with participants and respects their choices.
- [ ] Employee is familiar with homemaking/household services.
- [x] Employee uses gloves as appropriate while assisting with participant's cares.
- [ ] Employee understands participant's disability, diagnosis and related needs.
- [ ] Employee is familiar with participant's daily schedule, needs, and duties.
- [ ] Employee is aware of the participant's back-up plan.

Required training completed on: **mm/dd/yyyy**

Example: "Reviewed exits, showed where supplies are kept, Reviewed MyCares plan."

SECTION III – SELF-DIRECTED PERSONAL CARE REQUIRED TRAINING

- [ ] Employee is oriented to participant's place of care.
- [x] Employee safely performs cares and duties.
- [ ] Employee knows what to do in an emergency situation*.
- [ ] Employee works effectively with participants and respects their choices.
- [x] Employee uses gloves as appropriate while assisting with participant's cares.
- [ ] Employee understands participant's disability, diagnosis and related needs.
- [ ] Employee is familiar with participant's daily schedule, needs, and duties.
- [ ] Employee is aware of the participant's back-up plan.

Required training completed on: **mm/dd/yyyy**

Example: "Reviewed MyCares."

SECTION IV – RESPITE CARE REQUIRED TRAINING

- [ ] Employee is oriented to participant's place of care.
- [ ] Employee safely performs cares and duties.
- [ ] Employee knows what to do in an emergency situation*.
- [ ] Employee works effectively with participants and respects their choices.
- [ ] Employee uses gloves as appropriate while assisting with participant's cares.
- [ ] Employee understands participant's disability, diagnosis and related needs.
- [ ] Employee is familiar with participant's daily schedule, needs, and duties.
- [ ] Employee is aware of the participant's back-up plan.

Required training completed on: **mm/dd/yyyy**

Example: "I do not have a Respite Care Worker."

*Emergency Response: employee knows how to evacuate the participant in an emergency, and knows how to respond to emergencies related to the participant's health and safety.

By signing below, you agree the information on this form is accurate. Both signers also acknowledge that no hours worked prior to a passed background check will be authorized.

SIGNATURE – Employee	Date Signed
Participant-Hired Worker Signature	**mm/dd/yyyy**
SIGNATURE – Participant	Date Signed
Participant/Employer (or Representative) Signature	**mm/dd/yyyy**

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

PAGE 1

Name – Participant-Hired Worker: The Participant-Hired Worker's name in last name, first name format.

Name – Participant Employer: The Participant/Employer's name in last name, first name format.

Date of Birth – Participant-Hired Worker: The Participant-Hired Worker's birthdate in mm/dd/yyyy format.

The participant requires… Enter the tasks the Participant-Hired Worker will provide.

The participant employer agrees… Enter the training the Participant/Employer will provide for the Participant-Hired Worker.

Participant-Hired Worker Schedule: Check the days of the week the Participant-Hired Worker will be providing services or enter an explanation of the schedule in the "Other" field.

Participant-Hired Worker Services: Enter the Pay Rate, Unit Type, and Units per Week for each service that the Participant-Hired Worker will be providing or an explanation in the "Other" field.

PAGE 2

Signature – Participant-Hired Worker: The Participant-Hired Worker's Signature.

Date Signed: The date the Participant-Hired Worker signed this form.

Signature – Participant Employer: The date the Participant/Employer (or his/her representative) signed this form.

Date Signed: The date the Participant/Employer (or his/her representative) signed this form.

IRIS Participant Employer/Participant-Hired Worker Agreement

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-01201C (01/2015)

STATE OF WISCONSIN

IRIS PARTICIPANT EMPLOYER / PARTICIPANT- HIRED WORKER AGREEMENT

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS Program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. Participant-hired worker may not begin working for participant employer until they have received a mailed start date letter.

Personally identifiable information on this form is collected to verify that the application is complete, and will be used only for this purpose.

Completed forms should be submitted to the participant's Fiscal Employer Agent.

Name – Participant-Hired Worker (Last, First)	Name – Participant Employer (Last, First)
Participant-Hired Worker Last Name, First Name	Participant/Employer Last Name, First Name

Date of Birth – Participant-Hired Worker
mm/dd/yyyy

The participant employer requires the following tasks and duties to be performed by the participant-hired worker:

Example: "Help with getting dressed and going to appointments."

The participant employer agrees to provide/arrange for worker training as described below:

Example: "On first day of employment, the employee will receive a schedule of my daily living activities and they will help me get dressed and get ready for the day."

Participant-Hired Worker Schedule – Indicate Day(s) of the Week Participant-Hired Worker Will Provide Service(s)

Service	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Supportive Home Care (SHC)	☐	☑	☐	☑	☐	☑	☐
Self-Directed Personal Care (SDPC)	☐	☐	☐	☐	☐	☐	☐
Respite Care (R)	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
Mileage	☐	☑	☐	☑	☐	☑	☐

If "Other", please explain:

Participant-Hired Worker Services – Indicate Which Service(s), Pay Rate(s), Unit Type(s) and Units Per Week the Participant-Hired Worker will Provide

Service	Pay Rate	Unit Type (per hour, per day, etc.)	Units/Week
Supportive Home Care (SHC)	$$.$$	"Per Hour," "Per Day," etc.	#
Self-Directed Personal Care (SDPC)			
Respite Care (R)			
Other			
Mileage	Indicate the rate and the number of miles per month the participant-hired worker is authorized to provide. $$.$$	Per Mile	#

If "Other", please explain:

F-01201C Page 2

BY SIGNING BELOW:

I (We) understand that the services are provided under Medicaid regulations and that I (we) may not charge in excess of the amount authorized on the participant employer's plan. After the participant-hired worker has performed the service(s) per this agreement, time reports are due to the participant's Fiscal Employer Agent.

Both signers agree to only submit time reports within the hours authorized. Without prior approval, excess hours claimed above the authorization may be rejected for payment.

SIGNATURE – Participant-Hired Worker	Date Signed
Participant-Hired Worker Signature	mm/dd/yyyy
SIGNATURE – Participant Employer	Date Signed
Participant/Employer (or Representative) Signature	mm/dd/yyyy

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

This form is used for Participant-Hired Workers and for Vendors.

Name of Provider: The full, legal name of the Participant-Hired Worker or the name of the Vendor being used.

Telephone Number: The Participant-Hired Worker or Vendor's telephone number with Area Code.

Address – Street, City, State, and ZIP Code: The Participant-Hired Worker or Vendor's street address, city, and ZIP Code.

Continued on Page 2

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

STATE OF WISCONSIN
42 CFR 431.107

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS – SELF-DIRECTED SUPPORTS[1]

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.

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Telephone Number	
Participant-Hired Worker or Vendor Name		**(###) ###-####**	
Address – Street	City	State	Zip Code
Participant-Hired Worker or Vendor's Street Address	**City**	**State**	**#####**

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

1. To provide only the services or items authorized by the local waiver administrative agency as directed by the waiver participant in amounts not to exceed the authorization.
2. To accept the payment issued by the local waiver administrative agency or its fiscal agent as payment in full for provided services or items.
3. To make no additional claims or charges for provided services or items.
4. To refund any overpayment to the waiver administrative agency or its fiscal agent.
5. To keep records of the services or items provided.
6. To provide, upon request by the local waiver administrative agency or the Department of Health Services (DHS) or its designee, information regarding the services or items provided.
7. To comply with all other applicable federal and state laws, regulations and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants for a period of 7 years and to furnish upon request to the Department, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. (For state policy related to record retention see DHS 106.02, Wis. Administrative Code or the DLTC numbered memo addressing record retention available at http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DSL/CY_2001/NMemo2001-07.htm .)
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the waiver agency and upon request, to the Department in writing:

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

Check Box: Check "Yes" to indicate the Participant-Hired Worker or Vendor will receive payment from the local waiver administrative agency.

Name – Provider: The Participant-Hired Worker or Vendor name.

Signature – Provider: The Participant-Hired Worker or Vendor signature.

Date Signed: The date this form was signed by the Participant-Hired Worker or Vendor.

Signature – Waiver Agency Representative: The Participant-Hired Worker's, or his/her representative's, signature.

Date Signed: The date this form was signed by the Participant/Employer or his/her representative.

Print Name – Waiver Agency Representative: The printed name of the Participant/Employer or his/her representative.

(a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;
(b) The names and addresses of all persons who have a controlling interest in the provider;
(c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;
(d) The names and addresses of any subcontractors who have had business transactions with the provider;
(e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

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

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

☑ Yes ☐ No

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

NAME – Provider (Typed or Printed)	
Participant-Hired Worker or Vendor' s Full Printed Name	
SIGNATURE – Provider Participant-Hired Worker or Vendor Name Signature	Date Signed mm/dd/yyyy
SIGNATURE – Waiver Agency Representative Participant/Employer (or Representative)'s Signature	Date Signed mm/dd/yyyy
Print Name – Waiver Agency Representative Participant/Employer (or Representative)'s Full Printed Name	

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

Check the box that applies to you: Check "Employee/Contractor (including new applicant)"

Name – (First and Middle): The Participant-Hired Worker's first and middle names.

Name – (Last): The Participant-Hired Worker's last name.

Position Title: Enter "Employee"

Any Other Names… Include any names that the Participant-Hired Worker has been known by – including maiden name.

Race: Check the box that best describes the Participant-Hired Worker's race.

Home Address, City, State, and Zip Code: Enter the Participant-Hired Worker's street address, city, state, and ZIP Code.

Business Name and Address: The Participant/Employer's name and address (street address, city, state, and ZIP code).

SECTION A

For each question, check either "Yes" or "No." *Note: Some questions required additional information. Please read carefully.*

Continued on Page 3

DEPARTMENT OF HEALTH SERVICES
Division of Enterprise Services
F-82064 (02/2014)

STATE OF WISCONSIN
Chapters 48.685 and 50.065, Wis. Stats.
DHS 12.05(4), Wis. Admin. Code

BACKGROUND INFORMATION DISCLOSURE (BID)

Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. 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 the instructions (F-82064A) on page 1 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.

PLEASE PRINT OR TYPE YOUR ANSWERS.

Check the box that applies to you.

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

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

Name – (First and Middle)	Name – (Last)	Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)
PHW's First and Middle Name	PHW's Last Name	Employee

Any Other Names By Which You Have Been Known (Including Maiden Name)	Birth Date	Gender (M / F)
Other names the Participant-Hired Worker has used.	mm/dd/yyyy	M or F

Race	Social Security Number(s)
☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☑ Unknown	###-##-####

Home Address	City	State	Zip Code
Participant-Hired Worker's Street Address	City	State	#####

Business Name and Address – Employer or Care Provider (Entity)
Participant/Employer's Name and Address (Street Address, City, State, and ZIP Code)

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have any criminal charges pending against you or 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.	☐	☐
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.) ➢ If Yes, list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.	☐	☐
3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked: ☐ (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.) ➢ If Yes, explain, including when and where it happened.	☐	☐

Last Name: The Participant-Hired Worker's last name.

SECTION A (continued)
For each question, check either "Yes" or "No." *Note: Some questions required additional information. Please read carefully.*

SECTION B
For each question, check either "Yes" or "No." *Note: Some questions required additional information. Please read carefully.*

Last Name – **Participant-Hired Worker's Last Name**

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? ➢ 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? ➢ 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**? ➢ 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? ➢ If Yes, explain, including credential name, limitations or restrictions, and time period.	☐	☐

SECTION B – OTHER REQUIRED INFORMATION	YES	NO
1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? ➢ 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? ➢ 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? ➢ If yes, indicate the year of discharge: ______ ➢ Attach a copy of your DD214 if you were discharged within the last 3 years.	☐	☐
4. Have you resided outside of Wisconsin in the last 3 years? ➢ If Yes, list each state and the dates you lived there.	☐	☐

Last Name: The Participant-Hired Worker's last name.

SECTION B (continued)
For each question, check either "Yes" or "No." *Note: Some questions required additional information. Please read carefully.*

Signature: The Participant-Hired Worker's Signature

Date Signed: The date this form was signed by the Participant-Hired Worker.

Last Name – Participant-Hired Worker's Last Name

SECTION B – OTHER REQUIRED INFORMATION	YES	NO
5. Have you had a caregiver background check done within the last 4 years? ➢ 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.	☐	☐
6. 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? ➢ If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.	☐	☐

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

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to $1,000.00 and other sanctions as provided in DHS 12.05 (4), Wis. Adm. Code.

SIGNATURE	Date Signed
Participant-Hired Worker's Signature	mm/dd/yyyy

EXAMPLE: F-01246
Background Information Disclosure Addendum

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

SECTION I

Name: The Participant-Hired Worker's name in last name, first name, middle initial format.

Date of Birth: The Participant-Hired Worker's birthdate in mm/dd/yyyy format.

Address, Years at Residence, and Any Other Names: For the Past 3 Years, list:

- The Participant-Hired Worker's Address (street address, city, state, and ZIP code)
- The number of years at that residence
- Any other names that the PHW went by while at that location.

Report for each prior address until the total years at residence listed is equal to at least 3 years.

SECTION II

If the PHW has lived outside of Wisconsin in the past 3 years, this section will need to be completed. If the PHW has NOT lived outside of Wisconsin for the past 3 years, skip to the Signature and Date Signed fields.

Section II includes:

- **Current Address/Previous Address, City, State, Zip Code, and County:** For the Past 3 Years, list:
  - The PHW's Address (street address, city, state, and ZIP code)
  - The number of years at that residence
  - Any other names that the PHW went by while at that location.
  - Repeat for each prior address until the total years at residence listed is equal to at least 3 years.
- **Mother's Maiden Name:** The PHW's mother's maiden name.
- **Mother's Current Name:** The PHW's mother's current name in last name, first name, middle initial format.
- **Father's Name:** The PHW's name in last name, first name, middle initial format.

Signature: The PHW's signature

Date Signed: The date this form was signed by the PHW

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-01246 (06/2014)

STATE OF WISCONSIN
Wisconsin Statutes
§ 48.685 and 50.065
Administrative Rule
DHS 12.05(4)

BACKGROUND INFORMATION DISCLOSURE ADDENDUM—IRIS

INSTRUCTIONS: Completion of this form is required under the provisions of Chapters 48.685 and 50.065 Wis. Stats. Failure to comply may result in a denial or termination of your employment.

Personally identifiable information on this form is collected to verify your identity and that the form is complete.

SECTION I – APPLICANT INFORMATION

Name – (Last, First, MI)	Date of Birth
PHW's Last Name, First Name, Middle Initial	mm/dd/yyyy

Please list all the cities and states in which you have lived in the past three years, and the name by which you were known (if different from your name now). Please indicate the number of years you lived there.

Address – (Address, City, State, Zip Code)	Years at Residence	Any Other Names By Which You Have Been Known (Including Maiden Name)
Participant-Hired Worker's Street Address, City, State, and ZIP Code	#	Any other names the Participant-Hired Worker has used.

SECTION II – ADDITIONAL APPLICANT INFORMATION

Completion of this section is only required for applicants who have lived outside the state of Wisconsin in the past three years.

Address	City	State	Zip Code	County
Current Address: PHW's Current Address	City	State	#####	County
Previous Address: PHW's Previous Address	City	State	#####	County
Previous Address				
Previous Address				

Mother's Maiden Name	Mother's Current Name – (Last, First, MI)
Participant-Hired Worker's Mother's Maiden Name	PHW's Mother's Current Name in Last Name, First Name, Middle Initial Format

Father's Name – (Last, First, MI)
Participant-Hired Worker's Father's Name in Last Name, First Name, Middle Initial Format

I acknowledge that the information on this form is accurate to the best of my knowledge. By signing below, I agree to have a background check run.

I further acknowledge that an out-of-state background check may increase processing time, if applicable.

SIGNATURE – Applicant	Date Signed
Participant-Hired Worker's Signature	mm/dd/yyyy