Start-up form guidelines

iLIFE

Choice. With Confidence.

Participant-hired Worker Start-up Checklist

Use this optional sheet to ensure that all paperwork is completed in a timely manner for enrollment processing.

- ☐ IRIS Participant-hired Worker Set-up (F-01201)
- ☐ IRIS Participant-hired Worker Relationship Identification
- ☐ (F-01201A) Form W-4 (2017)
- ☐ Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting (WT-4)
- ☐ Form I-9
- ☐ Wisconsin Medicaid Program Provider Agreement and Acknowledgment of Terms of Participation (F-00180B)
- ☐ Background Information Disclosure Addendum - IRIS (F-01246)
- ☐ Background Information Disclosure (BID) (F-82064)
- ☐ IRIS Participant Employer/Participant-hired Worker Agreement (F-01201C)
- ☐ Participant-hired Worker Payment Election Form
- ☐ IRIS Supportive Home Care/Self-directed Personal Care/Respite Care Training Verification (F-01201B)
- ☐ Text

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-01201 (05/2015)

STATE OF WISCONSIN

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) Caregiver fills out this section

Name – Participant-Hired Worker (Last, First, MI)		Gender ☐ Male ☐ Female	Date of Birth
Mailing Address	City	Phone Number	
State	Zip	Email Address	

SECTION II – PARTICIPANT EMPLOYER DEMOGRAPHICS (all fields must be filled) You fill out this section

Name – Participant Employer (Last, First, MI)		Date of Birth	Master Client Index (MCI) Ask your consultant
Mailing Address	City	Phone Number	
State	Zip	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 Caregiver signs here	Date Signed
SIGNATURE – Participant Employer You sign here	Date Signed

DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-01201A (10/2015)

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) Caregiver	Name – Participant Employer (Last, First) You
Date of Birth – Participant-Hired Worker Caregiver	

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

RELATIVE (BIOLOGICAL)

- ☐ Parent * ±
- ☐ Son/Daughter (over 21) *
- ☐ Son/Daughter (under 21) * ±
- ☐ Adopted Child *

Adoption date:

- ☐ Grandparent *
- ☐ Grandchild *
- ☐ Brother / Sister
- ☐ Uncle / Aunt
- ☐ Nephew / Niece
- ☐ Cousin

RELATIVE (BY MARRIAGE/PARTNERSHIP)

- ☐ Spouse * ±
- ☐ Domestic Partner * ∓

Marriage date:

- ☐ Step Parent *
- ☐ Step Child *
- ☐ Step Grandchild
- ☐ Step Brother / Step Sister
- ☐ Parent-in-Law
- ☐ Child-in-Law
- ☐ Brother-in-Law / Sister-in-Law

NON-RELATED RELATIONSHIPS

- ☐ Friend
- ☐ Neighbor
- ☐ Worker
- ☐ Ex-Husband / Ex-Wife

Divorce date:

Check here or here if the person is new to you

* 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.

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

☐ 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 Caregiver signs	Date Signed
SIGNATURE – Participant Employer You sign	Date Signed

Caregiver. If caregiver is unsure, reference a W4 from previous employment

Form W-4 (2017)

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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total 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 don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't 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 2017. 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're single and have only one job; or • You're married, have only one job, and your spouse doesn't 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 (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
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 $70,000 ($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 $70,000 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.

Caregiver

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

2017

1	Your first name and middle initial	Last name	2 **Your social security number**
	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.	
	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.** ▶ ☐	
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 2017, 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.) ▶ Caregiver signs

Date ▶

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) You	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** (2017)

Leave blank/ask consultant

Caregiver. If caregiver is unsure, reference a W4 from previous employment

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)		1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"		2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet		3	
Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.				
4	Enter the number from line 2 of this worksheet	4		
5	Enter the number from line 1 of this worksheet	5		
6	**Subtract** line 5 from line 4		6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here		7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed		8	$
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck		9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. 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 who claims no withholding allowances; 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.

Caregiver. If caregiver is unsure, reference a W4 from previous employment

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	☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note**: If married, but legally separated, check the Single box.
Employee's address *(number and street)*			Date of birth	
City	State	Zip code	Date of hire	

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

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

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.

Caregiver signs

Signature _____ Date Signed _____ , _____

EMPLOYEE INSTRUCTIONS:

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

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

  You may file a new Form WT-4 any time you wish to change the amount of withholding from your paychecks, providing the number of exemptions you claim does not exceed the number you are entitled to claim.

- **UNDER WITHHOLDING:**
  If sufficient tax is not withheld from your wages, you may incur additional interest charges under the tax laws. In general, 90% of the net tax shown on your income tax return should be withheld.

- **OVER WITHHOLDING:**
  If you are using Form WT-4 to claim the maximum number of exemptions to which you are entitled and your withholding exceeds your expected income tax liability, you may use Form WT-4A to minimize the over withholding.

- **WHEN TO FILE IF YOUR EXEMPTIONS CHANGE:**
  You must file a new certificate within 10 days if the number of exemptions previously claimed by you DECREASES.

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

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

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

  (c) Dependents – Those persons who qualify as your dependents for federal income tax purposes may also be claimed as dependents for Wisconsin purposes. The term "dependents" does not include you or your spouse. Indicate the number of dependents that you are claiming in the space provided.

- **LINE 2:**
  Additional withholding – If you have claimed "zero" exemptions on line 1, but still expect to have a balance due on your tax return for the year, you may wish to request your employer to withhold an additional amount of tax for each pay period. If your employer agrees to this additional withholding, enter the additional amount you want deducted from each of your paychecks on line 2.

- **LINE 3:**
  Exemption from withholding – You may claim exemption from withholding of Wisconsin income tax if you had no liability for income tax for last year, and you expect to incur no liability for income tax for this year. You may not claim exemption if your return shows tax liability before the allowance of any credit for income tax withheld. If you are exempt, your employer will not withhold Wisconsin income tax from your wages.

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

Employer's Section

You

Leave blank/ask consultant

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

EMPLOYER INSTRUCTIONS for Department of Revenue:

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

EMPLOYER INSTRUCTIONS for New Hire Reporting:

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

The address will be displayed appropriately in a left window envelope.

DEPARTMENT OF WORKFORCE DEVELOPMENT
NEW HIRE REPORTING
PO BOX 14431
MADISON WI 53708-0431

Employment Eligibility Verification

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

Caregiver

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one): Leave section blank in most cases

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

Caregiver

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

Caregiver fills out with license and Social Security card info

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

You **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
You sign		Mr./Ms./etc,
Last Name of Employer or Authorized Representative	**First Name of Employer or Authorized Representative**	**Employer's Business or Organization Name**
		Leave blank
Employer's Business or Organization Address (Street Number and Name)	**City or Town**	**State** / **ZIP Code**
Your address		

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**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. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
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		**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		

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

Refer to the instructions for more information about acceptable receipts.

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) Caregiver		Telephone Number	
Address – Street	City	State	Zip Code

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

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

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

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

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

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

☐ Yes ☐ No

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

NAME – Provider (Typed or Printed) Caregiver	
SIGNATURE – Provider Caregiver signs	Date Signed
SIGNATURE – Waiver Agency Representative You sign	Date Signed
Print Name – Waiver Agency Representative You	

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

Caregiver

Name – (Last, First, MI)	Date of Birth

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)

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.

Current Address	City	State	Zip Code	County
Previous Address	City	State	Zip Code	County
Previous Address	City	State	Zip Code	County
Previous Address	City	State	Zip Code	County

Mother's Maiden Name	Mother's Current Name – (Last, First, MI)

Father's Name – (Last, First, MI)

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
Caregiver signs	

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)

For Instructions, see F-82064A.
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. Caregiver

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.) **Participant-hired Worker**
Any Other Names By Which You Have Been Known (Including Maiden Name)		Birth Date / Gender (M / F)
Race ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown		Social Security Number(s)
Home Address	City	State / Zip Code
Business Name and Address – Employer or Care Provider (Entity)		

You

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

Last Name –

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION Caregiver	YES	NO
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.	☐	☐
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 Caregiver signs	Date Signed

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)
Caregiver	You

Date of Birth – Participant-Hired Worker

Caregiver

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

You. You don't have to go into too much detail. Just give a general idea of what cares you will need the worker to perform

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

List all cares described on the previous line.

You **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:

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

Can fill out more than one row

Service	Pay Rate	Unit Type (per hour, per day, etc.)	Units/Week
Supportive Home Care (SHC)			
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.		

If "Other", please explain:

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 Caregiver signs	Date Signed
SIGNATURE – Participant Employer You sign	Date Signed

Direct deposit form. Optional

Participant-hired Worker Payment Election Form

Instructions: 1. Participant-hired worker completes all information and signs at the bottom.
2. Attach required documents and return form to iLIFE.
NOTE: To be effective for the pay date, submit at least five business days before the pay date.

Caregiver

Participant-hired Worker Name: _____

Participant-hired Worker Number: _____ Last four digits of PHW Social Security number: __ __ __ __ Caregiver

Participant Employer Name: _____ You _____

☐ **iLIFE Pay Card**

No additional documentation required. iLIFE is not responsible for lost or stolen cards or funds. By choosing this option, you agree that you have read and accept the terms of this card, which may be found at http://www.ilifefinancialmanagement.com/iLife/Pay-Cards/terms-and-conditions-flyer.pdf

Street Address: _____

City: _____ State: _____ ZIP: _____

NOTE: iLIFE pay cards cannot be mailed to P.O. boxes.

OR

Direct Deposit

☐ **Checking Account**	☐ **Savings Account**
Attach either a voided check or a typed letter from the bank (on bank letterhead) that has the routing and account numbers. Starter checks may not be used.	Attach a typed letter from the bank (on bank letterhead) that has the routing and account numbers.

Caregiver must attach a void check if this option is chosen

Name of Financial Institution: _____

Routing Number: _____ Account Number:_____

I hereby authorize iLIFE to initiate credit entries, debit entries and adjustments to the financial institution account type or pay card option noted above.

This authorization is to remain in full force and effect until iLIFE receives written notice from me of its termination, in such time and manner as to allow iLIFE and the financial institution a reasonable opportunity to act on it.

Caregiver signs

Participant-hired Worker Signature: _____ Date: _____

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) Caregiver	Name – Participant Employer (Last, First) You
Date of Birth – Participant-Hired Worker Caregiver	Anticipated Employment Start Date

SECTION II – SUPPORTIVE HOME CARE REQUIRED TRAINING You

☐ 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 is familiar with homemaking/household services. ☐ 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: Simply put the date that the training occurred. If unsure, you can put the start date.

SECTION III – SELF-DIRECTED PERSONAL 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:

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:

***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 Caregiver signs	Date Signed
SIGNATURE – Participant You sign	Date Signed