Acumen Fiscal Agent
Innovation • Opportunity • Freedom

Statement of Compliance To IRS Notice 2014-7 (Difficulty of Care Payments)

This form is to inform Acumen that I ☐ qualify ☐ no longer qualify for Difficulty of Care.

All three of the following statements MUST be true to claim the Difficulty of Care Payment income exclusion under IRS Notice 2014-7.

1) I provide services to the care recipient (Participant) in my home.
2) I do not have a separate home where I reside.
3) This is the home where I reside and regularly perform the routines of private life, including shared meals and holidays with family.

INDIVIDUAL CARE PROVIDER (EMPLOYEE):
Per the above rules, the undersigned hereby declares:

Under penalties of perjury, I declare that I am an individual care provider receiving payments under a state Medicaid Home and Community-Based Services waiver program for care I provide to _____ (Participant) who lives in my home under the care recipient's plan of care.

I am not required to report income earned under this program. Federal, and if my state allows, state income taxes should not be withheld from my paycheck. This means that, following the submission of this form, Federal and applicable state withholding will cease being withheld from my paychecks. This also means that any wages earned following the submission of this form will not be reported to the Internal Revenue Service (IRS) and applicable state taxing authorities on IRS Form W2 in box 1 and box 16.

If non-taxable wages have been reported by Acumen Fiscal Agent in Box 1 of my Form W-2, I can deduct the nontaxable wages from my taxable income as directed in IRS Notice 2014-7 when I file my tax return. See IRS Q&A link below.

If I no longer qualify for IRS Notice 2014-7, I will notify Acumen Fiscal Agent in advance of the change. At that time, the federal and state income tax withholding, if applicable, will resume. By signing below, I understand it is my responsibility to notify Acumen Fiscal Agent within three (3) business days of moving; if I move from the home or the Participant no longer lives with me.

All of the following information is required:

Employee's Signature:_____

Employee's Printed Name:_____ Date:_____

Employee ID#:_____ Social Security # (last 4):_____

Employer's Attestation:
Under penalties of perjury, I declare that the employee named above receives payments under a state Medicaid Home and Community-Based Services waiver program for care provide to the Participant named above and cohabitate in the home under the care recipient's plan of care.

Employer's Signature:_____ Date:_____

For more information on the Difficulty of Care Payment income exclusion, please visit the IRS website.
IRS Notice 2014-7: https://www.irs.gov/pub/irs-drop/n-14-07.pdf
IRS Q&A: https://www.irs.gov/individuals/certain-medicaid-waiver-payments-may-be-excludable-from-income

5416 E Baseline Rd., Ste. 200
Mesa, AZ 85206
Fax: (877) 901-5827
nccapagents@acumen2.net