Participant Hired Worker Packet

Date of Completion: _____

Estimated Start Date: _____

Participant Hired Worker Packet Forms and Form Explanations

Fill out ALL Sections for each form.
Signatures are required.

FORM	PURPOSE
Start Up Checklist	This form lists all of the forms that must be completed to enroll with the participant FEA and the IRIS program. The checklist can be used as a guide to make sure no forms are forgotten.
IRIS Participant Hired Worker Set-Up	This form is to be filled out by employee and participant; it is required under the IRIS program.
I-9 Form	This form confirms your identity and your eligibility to work in the United States. You must complete section 1 of this form. The participant completes section 2 by examining your supporting documents from either list A or lists B and C. **Please attach the supporting documents.**
W4 Form	This form is for federal tax purposes and taxes are withheld based on how you complete this form.
WT-4 Form	This form is used for state tax purposes. Depending on how you complete this form, the FEA will withhold taxes according to your selection.
IRIS Participant Hired Worker Relationship Disclosure Identification	Please fill this form out based on your relationship with the participant. This is used for exemptions in payroll taxes if you are related to the participant.
Direct Deposit Authorization/Pay Selection Options	This form is 2 pages and is used for pay selection options (Pay Card or Direct Deposit).
Background Information Disclosure Addendum – IRIS	This is required by the IRIS program. It is for completion of the background check.
Background Information Disclosure (BID)	This form will need to be filled out using employee information and will be used to complete a background check on each employee. All employees will need to be cleared in order to start working.
WI Medicaid Program Provider Agreement	This form is used to acknowledge the terms under IRIS for working with the participant.
Participant Hired Worker Agreement	By Signing this form, you understand that you may not charge in excess of the amount authorized in the participant employer's plan.

Please return all accurate and completed forms
by email, fax or mail:

Email: outreach.wi@outreachfiscalagent.com
Fax: 800-687-3121
Mail: 204 3rd. Ave., Suite 110, Osceola, WI 54020

Participant Hired Worker (PHW)
Enrollment Packet Checklist

happy	Day	Only	Sample
First	Last	First	Last
Print Participant Name		Print Name of Employee	

This checklist is used as a guide to make sure all forms are completed. Please initial by each item when the form is complete and return with the Enrollment Packet.

If you have any questions please call toll free 1-877 901-5826.

	Participant	PHW
1. Start Up Checklist		
2. Form F-01201 IRIS Participant-Hired Worker Set-Up		
3. Form I-9 Employment Eligibility Verification		
4. Form W-4 & Form WT-4 (Federal & State Taxes)		
5. Participant-Hired Worker Relationship Identification		
6. Direct Deposit Authorization/Pay Selection Options		
7. Background Information Disclosure Addendum		
8. Background Information Disclosure (BID)		
9. Wisconsin Medicaid Program Provider Agreement		
10. Participant Employer/Participant Hired-Worker Agreement		

My signature indicates that the following forms have been explained to me.

Participant/Legal Guardian Signature Date

PHW Signature Date

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01201 (09/2020)

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 for this purpose and the electronic visit verification enumeration process. As a result, all participant-hired workers must provide their email address in order for this form to be processed.

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 (**Required**)
Sample	Only	Z	☐ Male ☑ Female	01/01/2023
Mailing Address	City		Phone Number	
123 sample Road	Osceola		715-715-7150	
State	Zip		Email Address (**Required**)	
WI	55020		thisisonlyasample@gmail.com	

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

Name – Participant Employer (Last, First, MI)		Date of Birth	Master Client Index (MCI)
Day	happy	01/01/2023	000000000
Mailing Address	City	Phone Number	
0000 The Road	Osceola	715-7150000	
State	Zip	Email Address	
WI	54020	sample@gmail.com	

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

SIGNATURE – Participant Employer	Date Signed

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)
EMPLOYEE	JANE	E	

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
123 HAPPY VALLEY RD		ANYTOWN	AZ	55555

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
01/01/1990	555555555	EMAIL@EXAMPLE.COM	(555) 555-5555

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- [x] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States (See Instructions.)
- [ ] 3. A lawful permanent resident (Enter USCIS or A-Number.)
- [ ] 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee: EMPLOYEE SIGNATURE — Today's Date (mm/dd/yyyy): 08/05/2023

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box. See the Instructions.

	List A	OR	List B	AND	List C
Document Title 1			DRIVER'S LICENSE		SOCIAL SECURITY CARD
Issuing Authority			ARIZONA DMV		SSA
Document Number (if any)			5555555A		555-55-5555
Expiration Date (if any)			05/05/2025		N/A
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

- [ ] Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy): 08/05/2023

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
EMPLOYER, ELAINE - HOUSEHOLD EMPLOYER	EMPLOYER SIGNATURE	08/03/2023

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
ELAINE EMPLOYER	123 MAIN ST, ANYTOWN, AZ, 55555

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

Physical Address Required (No P.O. Box)

(a) First name and middle initial	Last name	(b) Social security number
Jane E.	Employee	123-45-6789

Address: 111 Main St Apt 2

City or town, state, and ZIP code: Anytown, State 12345

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

(c)
- [X] **Single** or **Married filing separately**
- [ ] **Married filing jointly** or **Qualifying surviving spouse**
- [ ] **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

If applicable -->

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

Required field even if "0".

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ 0

Multiply the number of other dependents by $500 . . . . . $ 0

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $ 0

Step 4 (optional): Other Adjustments

Optional. Please refer to the instructions.

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

If filing exempt, leave Steps 2, 3 & 4 blank. Write EXEMPT here --->

Step 5: Sign Here

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

Jane E. Employee

Employee's signature (This form is not valid unless you sign it.)

01/03/2024

Date

Employers Only

Employer Name Here

Employer's name and address	First date of employment	Employer identification number (EIN)
Employer Name 222 Main St Anytown, State 12345		

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

Employee's legal name *(first name, middle initial, last name)*			Social security number	
Only	z	Sample	1 2 3 1 2 1 2 3 4	☐ 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	
123 sample Road			01/01/2023	
City	State	Zip code	Date of hire	
Osceola	WI	55020		

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

1. (a) Exemption for yourself – enter 1 . . . . . _____
   (b) Exemption for your spouse – enter 1 . . . . . _____
   (c) Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent . . . . . _____
   (d) Total – add lines (a) through (c) . . . . . _____
2. Additional amount per pay period you want deducted (if your employer agrees) . . . . . _____
3. I claim complete exemption from withholding (see instructions). Enter "Exempt" . . . . . _____

I CERTIFY that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming complete exemption from withholding, I certify that I incurred no liability for Wisconsin income tax for last year and that I anticipate that I will incur no liability for Wisconsin income tax for this year.

Signature _____ Date Signed _____ , _____

EMPLOYEE INSTRUCTIONS:

- **WHO MUST COMPLETE:**
  Effective on or after January 1, 2020, every newly-hired employee is required to provide a completed Form WT-4 to each of their employers. Form WT-4 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 provided to employers other than your principal employer so that the total amount withheld will be closer to your actual income tax liability.

  You must complete and provide your employer a new Form WT-4 within 10 days if the number of exemptions previously claimed DECREASES.

  You may complete and provide to your employer a new Form WT-4 at any time if the number of your exemptions INCREASES.

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

- **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.

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 complete and provide a new Form WT-4 to 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 completed and provided to your employer before that date.

Employer's Section

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 they are 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) 266-2772 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 https://dwd.wi.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.wi.gov/uinh/ for more information.

Applicable Laws and Rules

This document provides statements or interpretations of the following laws and regulations enacted as of July 5, 2022: sec. 71.66, Wis. Stats., and sec. Tax 2.92, Wis. Adm. Code.

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

IRIS PARTICIPANT-HIRED WORKER RELATIONSHIP IDENTIFICATION

FORM INSTRUCTIONS

This form is used by the fiscal employer agents (FEAs) to identify the following: exemptions from certain state and federal employer/employee taxes (Section B), exceptions to Electronic Visit Verification (EVV) requirements (Section C), and live-in caregiver exemptions from Fair Labor Standards Act overtime rules (Section C).

INSTRUCTIONS: Completion of this form is an IRIS program requirement. Both the participant-hired worker and the participant must sign and date the bottom to be considered complete. The participant-hired worker may not begin accumulating paid work hours prior to written notification in an official DHS IRIS start date letter. This form must be completed any time a live-in worker is added to the participant's plan, or the live-in worker or participant has an address change.

Verbal attestation of this information must be provided by the participant or legal decision maker annually at the time of the participant's plan renewal to continue live-in status.

Live-In Exemption from Overtime Pay – The federal Department of Labor Fair Labor Standards Act (FLSA) requires household employers to pay employees overtime pay for any hours worked over 40 in a workweek. Exemptions to overtime rules apply to live-in caregivers who either:

- Live in the same home as their employer on a permanent basis.
- Live in the same home as their employer for extended periods of time, which is considered at least 5 consecutive days and nights per week and/or 120 hours or more per week.

If either of the above apply, select "Yes" in Section C, Live-In Exemption from Overtime Pay, on page 2. If not, select "No."

For more information about the FLSA live-in caregiver exemption, see Department of Labor Fact Sheet 79B – Live-in Domestic Service Workers under the FLSA available at: https://www.dol.gov/whd/homecare/factsheets.htm or contact the Department of Labor Wage and Hour Division Help Line at 1-866-487-9243.

Live-In Exemption to EVV Requirements – Participant-Hired Live-In Workers are not required to use EVV. Exemptions for the purposes of EVV apply to workers in the following situations:

- Worker permanently resides in the same residence as the participant receiving services.
- Worker permanently resides in a two-residence dwelling, like a duplex, where the participant receiving services lives in the other half of the dwelling AND is a relative of the participant receiving services. A relative is defined as a person related, of any degree, by blood, adoption, or marriage.
- Participant resides at regularly scheduled intervals at the separate homes of both parents or legal decision makers. Both parents or legal decision makers are considered live-in workers for purposes of EVV compliance.

If any of the above apply, select "Yes" in Section C, Live-In Exception to EVV Requirements on page 2. If not, select "No."

IRIS PARTICIPANT-HIRED WORKER RELATIONSHIP IDENTIFICATION

SECTION A: PARTIES

Name – Participant-Hired Worker (Last, First)	Name – Participant Employer (Last, First)
Sample Only	Day happy

Participant Medicaid Identification Number (MCI): 000000000

SECTION B: RELATIONSHIP

Participant-Hired Worker: Check the box that best identifies your legal relationship to the participant. For example, if the participant is your grandmother, you are the participant's grandchild. **Check only one**.

I am the participant's:

RELATIVE (BIOLOGICAL)
- ☒ Parent* ±
- ☐ Adult Child (age 21 or over)*
- ☐ Child (under age 21)* ±
- ☐ Adopted Child*
- ☐ Grandparent*
- ☐ Grandchild*
- ☐ Sibling
- ☐ Uncle/Aunt
- ☐ Nephew/Niece
- ☐ Cousin

RELATIVE (BY MARRIAGE/PARTNERSHIP)
- ☐ Spouse* ±
- ☐ Domestic Partner* ₸
- ☐ Step Parent*
- ☐ Step Child*
- ☐ Step Grandchild
- ☐ Step Sibling
- ☐ Parent-in-Law
- ☐ Child-in-Law
- ☐ Sibling-in-Law

NON-RELATED RELATIONSHIPS
- ☐ Friend
- ☐ Neighbor
- ☐ Former Spouse (divorce finalized)
- ☐ Worker

Notes:

* 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. Any applicable exemptions cannot be waived.	± 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. Any applicable exemptions cannot be waived.	₸ 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.

SECTION C: LIVING SITUATION (see instructions on page 1)

Live-In Exemption from Overtime Pay

- ☐ **Yes**, the employee is a live-in worker for purposes of this exemption. All hours over 40 in a workweek will be paid at the regular hourly rate.
- ☒ **No**, the employee is not a live-in worker for purposes of this exemption.

Live-In Exemption to EVV Requirements

- ☐ **Yes**, the employee is a live-in worker who qualifies for the EVV exemption. (Continue to Section D: **Electronic Visit Verification (EVV) Live-In Identification**)
- ☒ **No**, the employee does not qualify for the EVV exemption. (Skip Section D)

Shared Home Address

Street	City	State	Zip Code
		WI	

SECTION D: ELECTRONIC VISIT VERIFICATION (EVV) LIVE-IN IDENTIFICATION

Permanent residency is determined by the worker being able to produce documentation that shows the worker's name and current residential address. The address must satisfy the requirements for a live-in worker listed above. The worker may use one document from Column A or two types of documents from Column B. Check the box(es) next to the document(s) being submitted as proof of residence.

Column A (Choose **One**)

- ☐ Current and valid State of Wisconsin driver's license or state ID card
- ☐ Other current official ID card or license issued by a Wisconsin governmental body or unit
- ☐ Real estate tax bill or receipt for the current year
- ☐ Residential lease for current year
- ☐ Check or other document issued by a unit of government within the last three months

Column B (Choose **Two**)

- ☐ Current or past month's gas, electric, or phone service statement
- ☐ Current or past month's bank statement
- ☐ Current or past month's paycheck or paystub

SECTION E: ATTESTATIONS

Participant-Hired Worker: If I checked "Yes" in either category of Section C above, I shall notify the participant's Fiscal Employer Agent (FEA) within **seven (7) days** of a change in my living situation.

Participant-Employer (Check if applicable):

- ☐ I have examined the documentation above and attest that the address of the worker on the documentation provided matches that of the participant on this form.
- ☐ I attest that the documentation for the address provided is not an exact match to the participant, but the worker meets all criteria listed and required of a live-in relative.

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
SIGNATURE – Participant Employer	Date Signed

Pay Selection Options

I choose to receive my pay by (please check either Direct Deposit Or Pay Card below):

☐ **Direct Deposit (preferred method)**

To verify account information:**Please attach a voided check** or **bank letter** for checking accounts. For savings account, send a printout from your bank that provides the routing number and account information.

Primary Account 1 Account Type: ☐ **Checking** (Include a voided check or bank letter) ☐ **Savings** (Include routing & account information letter)	**Secondary Account 2** (Mandatory for Flat Dollar Option) Account Type: ☐ **Checking** (Include a voided check or bank letter) ☐ **Savings** (Include routing & account information letter)
☐ **Flat Dollar Amount** ☐ **Percentage**	☐ **Flat Dollar Amount** ☐ **Percentage**
Financial Institution Name	Financial Institution Name
Financial Institution Address	Financial Institution Address
Routing Number	Routing Number
Account Number	Account Number
☐ **Entire Paycheck** ☐ **-OR-** _____% ☐ **-OR-** $_____ Please note: If an option is not selected, or, the amount does not equal 100%, your selection will default to "Entire Paycheck."	All remaining funds exceeding Primary Account 1 allocations are deposited into this account.

Is your name on the account(s) listed above? ☐ **Yes** ☐ **No**

If "no," what is the name of the account holder? _____

If "no," employee agrees to have their funds deposited into this account._____

Employee Signature

☐ **Pay Card:** *this method should only be selected if you are unable to obtain a bank account.* ***You will need to activate the card with Money Network and then contact Acumen with your account information****. You will not receive payment until these steps are complete.*

AUTHORIZATION FOR DIRECT DEPOSIT or PAY CARD

I hereby authorize my FEA (herein after "Company") to deposit any amount owed to me for wages and/or reimbursements by initiation of credit entries to my account at the financial institution (hereinafter "Bank") handling my choice indicated above. Further, I authorize Bank to accept and credit any credit entries indicated by Company to my account. In the event that Company deposits funds erroneously into my account, I authorize Company to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until Company receives written notice from me of its termination in such time and in such a manner as to afford a reasonable opportunity to act on it.

Print Name _____ Social Security Number _____ Date of Birth _____

Email Address for Paystub Delivery _____ Signature _____ Date _____

Mailing Address for Paycard Delivery (street address, city, state, zip) _____

Return completed form by email outreach.wi@outreachfiscalagent.com, fax 800-687-3121 or mail to 204 3rd. Ave., Suite 110, Osceola, WI 54020

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01246 (01/2024)

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
Sample Only Z	01/01/2023

Please list all the cities and states in which you have lived in the past three years, and the name(s) 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
123 Sample Road	Osceola	WI	55020	
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)

SECTION III – ACKNOWLEDGEMENTS AND SIGNATURE

Applicant must check all boxes, sign, and date.

☐ I affirm that the information I have provided on this form is complete and accurate to the best of my knowledge.

☐ I authorize DHS IRIS partner agencies to conduct a background check now and to automatically conduct future background checks – without notice – every 4 years and *ad hoc* for as long as I provide paid IRIS services.

☐ I understand that an out-of-state or out-of-country background check may increase processing time.

SIGNATURE – Applicant	Date Signed

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

- **PENALTY:** A person who provides false information on this form may be subject to forfeiture and sanctions, as provided in Wis. Stat. § 50.065(6)(c) and Wis. Admin Code § DHS 12.05(4).
- Completion of this form to verify your eligibility for employment/service as a "caregiver" is required by Wis. Stat. § 50.065 and Wis. Admin Code ch. DHS 12. Failure to complete this form may result in denial or termination of your employment, contract or service agreement.

Refer to DQA form F-82064A, *Instructions*, for additional information.

Reset

Check the box that applies to you.

☐ Applicant / Employee
☐ Contractor
☐ Student / Volunteer
☐ Other – Specify:

NOTE: This form should NOT be used by applicants for *entity operator approval* (license, certification, registration or other DHS approval) or by entities requesting approval for an individual to reside in entity facilities as a *non-client resident*. Applicants for *entity operator approval* or for a *non-client resident* background check must request an *entity* background check from the Division of Quality Assurance.

Full Legal Name – *First*	*Middle*	*Last*
Only		Sample

Other Names (including prior to marriage)

Position Title (applied for or existing)	Birth Date *(MM/DD/YYYY)*	Sex
	01/01/2023	☐ Male ☐ Female

Home Address	City	State	Zip Code
123 sample Road	Osceola	WI	55020

Business Name and Address – Employer (Entity)

happy	Day	0000 The Road	Osceola	WI	54020

Answering "NO" to all questions does not guarantee employment, a contract, or service agreement.
If more space is required, attach additional documentation to this form and indicate "see attached" in your answer.

SECTION A – DISCLOSURES

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.
   Yes ☐ No ☐

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.
   You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.
   Yes ☐ No ☐

3. Please note that Wis. Stat. § 48.981, *Abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.
   Has any government or regulatory agency (other than the police) ever found that you committed **child** abuse or neglect?
   Provide an explanation below, including when and where the incident(s) occurred.
   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.
   Yes ☐ No ☐

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? Yes ☐ No ☐
   If **Yes**, explain, including when and where it happened.

6. Has any government or regulatory agency (other than the police) ever found that you abused an **elderly person**? Yes ☐ No ☐
   If **Yes**, explain, including when and where it happened.

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? Yes ☐ No ☐
   If **Yes**, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes ☐ No ☐
   If **Yes,** explain, including when and where it happened.

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? Yes ☐ No ☐
   If **Yes,** explain, including when and where it happened and the reason.

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? Yes ☐ No ☐
   If **Yes**, indicate the year of discharge:
   Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. Have you resided outside of Wisconsin in the last three (3) years? Yes ☐ No ☐
   If **Yes**, list each state and the dates you resided there.

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? Yes ☐ No ☐
   If **Yes**, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years? Yes ☐ No ☐
   If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? Yes ☐ No ☐
   If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

☐ I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

NAME – Person Completing This Form	Date Submitted

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00180C (07/2017)

STATE OF WISCONSIN
42 CFR 431.107 & 42 CFR 438.602(b)

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Phone Number	
Only Sample			
Address – Street	City	State	Zip Code
123 sample Road	Osceola	WI	55020

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

1. To provide only the items or services authorized by the managed care organization or IRIS program.
2. To accept the payment issued by the managed care organization or IRIS program as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the managed care organization or IRIS program.
5. To keep any records necessary to disclose the extent of services provided consistent with the provider's business type.
6. To provide, upon request by the managed care organization, the IRIS program, or the Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program including the caregiver background check law.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants **for a period of ten (10) years** and to furnish upon request to the DHS, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. This requirement includes retaining all records and documents according to the terms provided by Wis. Admin. Code § DHS 106.02(a)-(d); (f)-(g).
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the managed care organization and upon request, to the Department in writing:

    a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;

d) The names and addresses of any subcontractors who have had business transactions with the provider;

e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.

12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.
13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.
14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

Modifications to this agreement cannot and will not be agreed to. Altering this agreement in any way voids the Department of Health Services' signature. This agreement is not transferable or assignable.

Name – Provider (Typed or Printed)	
Only	Sample
SIGNATURE – Provider	Date Signed

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)	
SIGNATURE – Department of Health Services	Date Signed
	8/14/17

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01201C (02/2017)

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)
Sample Only	Day happy

Date of Birth – Participant-Hired Worker
01/01/2023

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

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

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)			
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	Date Signed
SIGNATURE – Participant Employer	Date Signed