COMPLETE AND RETURN

Employee Packet

Employee and Employer Agreement

_____ has been hired by _____

Employee- name as shown on social security card

Member/Employer- name as shown on social security card

The employee will provide care services through the self-directed services program to the member/employer.

LKiChoice, a division of Lori Knapp Richland, Inc. has been chosen to assist the member/employer with administrative tasks, enrollment setup, and payroll services.

As the employee, I agree to:

- Complete all documents that are required to be an employee of a fiscal member, your employer.
- I will not start working until all required paperwork from LKiChoice has been completed, returned, processed, and approved. Once approved, I will be contacted with a start date from LKIchoice or the care managed organization.
- Aid in the correction of any errors that may occur with processing payroll.
- Work with my employer to provide the best care and outcome possible.
- Stay within the guidelines of what is authorized for hours worked and tasks required.
- Follow HIPAA and confidentiality requirements.
- Follow standard precautions and perform all work-related tasks in a safe manner.
- Accurate timesheet reporting. Failure to do this could result in fraud and/or abuse reporting.
- Follow processes and procedures of EVV (Electronic Visit Verification) if applicable to my member/employer.
- Report concerns of safety, health, or well-being of the person I am caring for to the member/employer's Care Manager.
- Report current charges or pending allegation of abuse or neglect to the member/employer's Care Manager or LKiChoice.
- Report any convictions that occur after my start date to the member/employer and LKiChoice.
- Report work-related injury within 24 hours to LKiChoice at 1-844-534-7225.
- Notify LKiChoice, if I do not work within 60 days.
- Notify and send an updated form to LKiChoice, of changes to my mailing address.
- Notify and send an updated form to LKiChoice, of changes to my direct deposit information (direct deposit information will not be updated without a completed form on file). Changes to direct deposit information need to be made 5 business days before the payment dates.
- Notify and send an updated form to LKiChoice of any changes to my state or federal deductions. This will require an updated W4 or WT4 form completed.
- Notify and send an updated form to LKiChoice, if my name changes.

COMPLETE AND RETURN

Employee Packet

Employee and Employer Agreement

I understand that my timesheet needs to be turned in according to the Time Report and Pay Schedule provided. Submission of late timesheets and non-use Electronic Visit Verification (EVV) system properly (if it's relevant to your job), could delay pay until the next pay period. Non-compliance with EVV (if applicable) could lead to disenrollment in SDS FEA.

I understand LKiChoice is not responsible for payment of services if I provide duties to the member/employer that are not approved, work more hours than approved by the funding source, or if the member/employer is no longer eligible for services under this program.
EXAMPLE: member is hospitalized or admitted to a facility for a period of time.

I understand that if no person is designated on my employer's member authorization form from LKiChoice to sign off on timesheets due to my member/employer's incapacitation or death, that I will need to wait to be paid until a person from their estate is deemed legally responsible to sign the timesheets.

I understand I am the employee of _____. (Enter member/employer name.)

I understand my member/employer is responsible for all employment actions which might include orientation, training, supervising, disciplinary action, termination, management, and other member/employer - related functions.

I understand that LKiChoice **is not** my employer but provides the payroll services and administrative tasks for my member/employer. If I have employment concerns, I need to discuss these with my member/employer.

Employee signature: _____ Date: _____

Member signature: _____ Date: _____

Relationship Questionnaire

EMPLOYEE NAME: _____

MEMBER/EMPLOYER NAME: _____

Please answer the questions below to determine appropriate tax-exempt status.

1. LIVE IN: Do you permanently reside in the same residence as your Member/Employer?

☐ No ☐ Yes - You are exempt from overtime.

2. What is your legal relationship to your Member/Employer? I am the Member/Employer's: (check only one box)

		☐	Other_____		
☐	Child/Step under 21 years old (S,F,FI)	☐	Child/Step over 21 years old (S)		
☐	Domestic Partner* (S)	☐	Grandchild (S)	☐	Grandparent (S)
☐	Parent/Step (S,F,FI)	☐	Sibling	☐	Spouse (S,F,FI)

Per Wisconsin Statue 770.05, Domestic Partnership mean you and your same sex partner have filed for Domestic Partnership and have a certified copy of your Declaration of Domestic Partnership.* ***Please submit proof of Domestic Partnership to claim this relationship.*

3. Are you under the age of 18 or will turn 18 this year?

☐ Yes – I am under the age of 18 or will turn 18 this year. Date of Birth: _____/_____/_____

☐ No – I am not under the age of 18.

3a. If Yes:

Is this job or performing household services your principal occupation? If you are a student, check "No".

☐ Yes – This job or performing household services <u>is</u> my principal occupation and I am NOT a student.

☐ No – I am a student, providing household services, which <u>is not</u> considered my principal occupation.

By signing, I acknowledge I have truthfully answered the above questions. I understand my Employer is a Household Employer according to the IRS. Payroll is processed according to IRS Publication 926, which may indicate I am exempt for certain payroll taxes. I understand according to Wisconsin Department of Workforce Development, Unemployment Insurance Division, my Member/Employer is a Sole Proprietor and Domestic Employer. I understand I may not be eligible to State Unemployment Benefits as indicated in UBC-201-P. I also understand exemptions and/or unemployment eligibility-based on my relationship with the Member/Employer is not optional.

Employee Signature: _____ Date: _____

LKiChoice
Part of the AssuranceSD family

106 S. Beaumont Rd, Prairie du Chien, WI 53821 Fax: 844-634-7225 Phone: 608-326-0434

Payroll Information

As show on Social Security Card

PRINT Name: _____ Pronouns: _____

Phone Number: _____ County: _____

Mailing Address: _____

Physical Address: (if different than above) _____

REQUIRED- Email Address: _____

***Reminder: you will receive your paystub via email.

Please check all that apply:

☐ **Secure Email** - Allows you to send timesheets or other information securely.

☐ **Web Entry-** Online payroll entry. Both member and employee will need an email address, as well as access to the internet.

Direct Deposit Information

Complete section(s) below with your banking account information.

Name of Bank: _____

Action to be taken: ☐New deposit authorization. ☐Change from previous authorization.

Type of Account: ☐Checking ☐Savings ☐ Pay Card Amount: _____%

Account #: _____ 9-Digit Routing #: ☐☐☐☐☐☐☐☐☐

***For Multiple Accounts:**

Name of Bank: _____

Action to be taken: ☐New deposit authorization. ☐Change from previous authorization.

Type of Account: ☐Checking ☐Savings ☐ Pay Card Amount: _____%

Account #: _____ 9-Digit Routing #: ☐☐☐☐☐☐☐☐☐

LKiChoice, a division of Lori Knapp Richland, Inc., is authorized to directly deposit my pay to the account(s) identified in this document, which include my signature and date. Authorization will remain in effect until I modify, cancel in writing, or employment terminates.

Changes to your payroll information may take up to one week to be processed and take effect on your employee profile. Please call to verify that your account information is changed.

Employee Signature: _____ Date: _____

LKiChoice
Part of the AssuranceSD family

106 S. Beaumont Rd, Prairie du Chien, WI 53821 Fax: 844-634-7225 Phone: 608-326-0434

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 ☐ Student / Volunteer
☐ Contractor ☐ 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*

Other Names (including prior to marriage)

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

Home Address	City	State	Zip Code

Business Name and Address – Employer (Entity)

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

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

(a) First name and middle initial	Last name	(b) Social security number
Address		**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*.
City or town, state, and ZIP code		

(c) ☐ **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**

(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

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 $ _____

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

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

(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)** $

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.

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

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

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

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

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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

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

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

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

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

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . **3** _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $ _____

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $ _____

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 with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories 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.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

COMPLETE AND RETURN

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	☐ 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

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)* 106 South Beaumont Road		City Prairie du Chien	State WI	Zip code 53821
Completed by Natalie Freymiller	Title Fiscal Agent	Phone number (608) 326-0434	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.

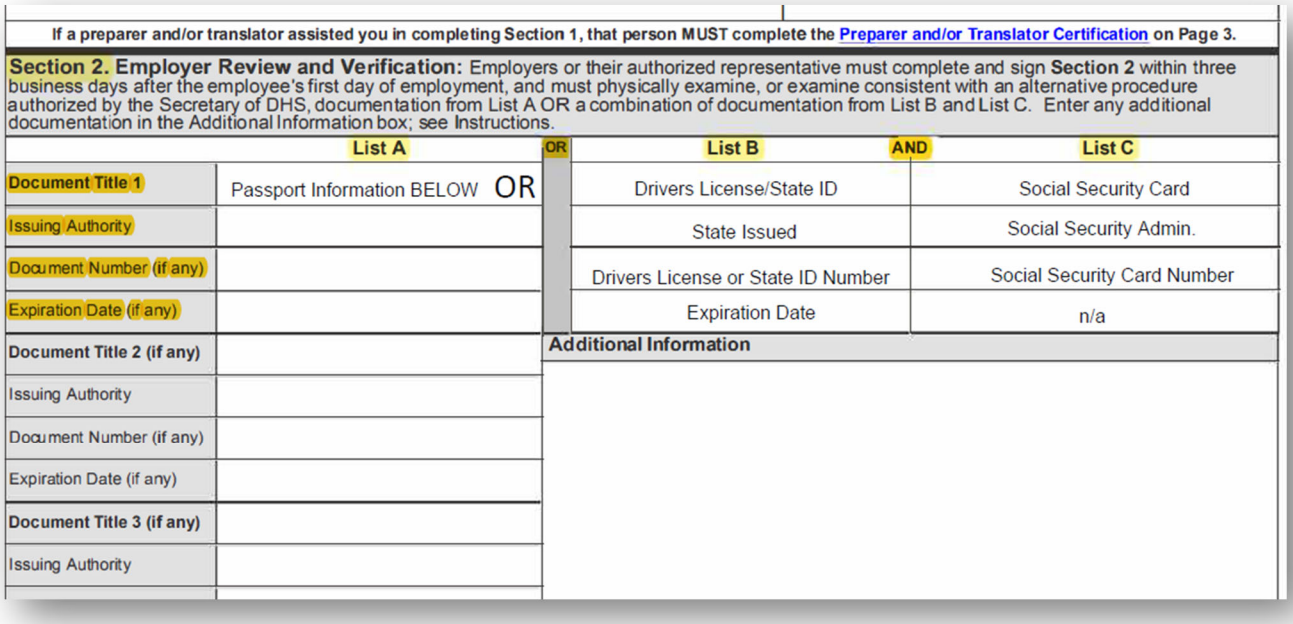
EMPLOYER INSTRUCTIONS for New Hire Reporting:

- 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.

Example to help you with the next page.

Please call 608-326-0434 for assistance

Needed employee information highlighted yellow.

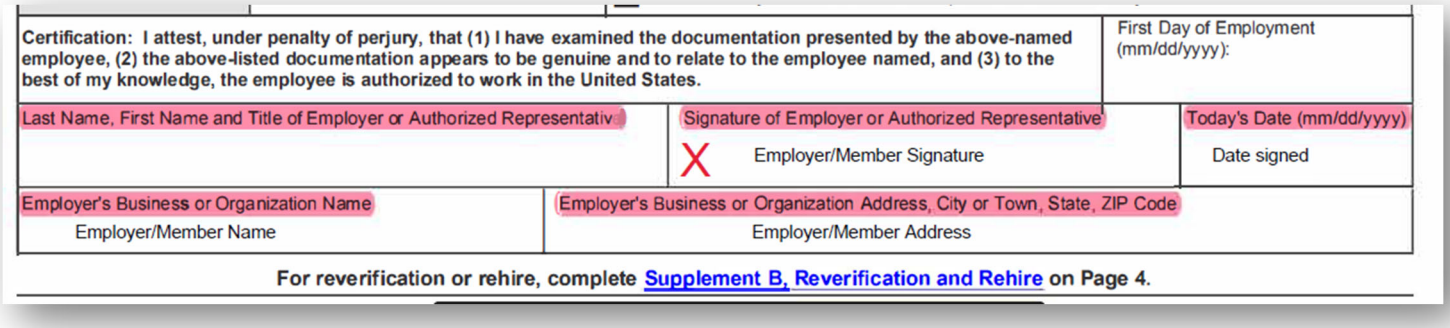


If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

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 Instructions.

	List A	OR	List B	AND	List C
Document Title 1	Passport Information BELOW OR		Drivers License/State ID		Social Security Card
Issuing Authority			State Issued		Social Security Admin.
Document Number (if any)			Drivers License or State ID Number		Social Security Card Number
Expiration Date (if any)			Expiration Date		n/a
Document Title 2 (if any)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					

Member/guardian/POA will sign and date next to the RED X highlighted pink section.



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):

Last Name, First Name and Title of Employer or Authorized Representativ	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
	X Employer/Member Signature	Date signed

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Employer/Member Name	Employer/Member Address

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

IMPORTANT REMINDER: The I9 is a government document that LKIchoice cannot complete with the employee's information. If this document is not completed correctly, it will delay your start date. Call for assistance.

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)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

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.):

- ☐ 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	Today's Date (mm/dd/yyyy)

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 Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
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)			☐ 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):

Last Name, First Name and Title of Employer or Authorized Representativ	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
	X	

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
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.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
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		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

COMPLETE AND RETURN

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	
Address – Street	City	State	Zip Code

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

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

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

    b) The names and addresses of all persons who have a controlling interest in the provider;

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

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

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

12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.

13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.

14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

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

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

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

Children's Long-Term Support (CLTS) Waiver: Kenosha County Waiver Agency
Standards of Training Verification for Parent/Guardian Hired Providers (Non-licensed/certified)

Participants: Information:

Participant/Child's Name (First and Last)	Parent/Guardian Name: (First and Last)	Service Coordinator Name: (First and Last)

Service Type: (Check all that Apply)

☐ Daily Living Skills Training ☐ Mentoring ☐ Respite* ☐ Specialized Childcare ☐ Specialized Transportation

☐ Personal Supports-Supervision/Attendant* ☐ Personal Supports-Chores* ☐ Family/Unpaid Caregiver Supports and Services

*Training can take place before and during the first six months of employment.

Provider/Employee Information

Name- Last:	First:		M.I.	Date of Hire:
Address. Street:	City:	State:	Zip:	

Provider named above will complete background and other service qualification requirements. Additionally, providers will receive training with participant's parent/guardian and when necessary, county waiver agency support and service coordinator (SSC), on the following requirements, to ensure provider is qualified to deliver services to the participant through CLTS Waiver funding. All provider training must be completed within 3 months of hire date.

Date of Completion	Service Provision and/or Training Requirement

1. _____ 1. Provider is not listed on the Wisconsin Misconduct Caregiver Registry; does not have a substantiated finding of abuse, neglect, or misappropriation, and has not committed a crime that is substantially related to the provision of care or supervision of this service.

2. _____ 2. Provider is trained to safely deliver services, so as not to endanger the participant. Additionally, provider understands how to administer first aid for the participant when necessary.

Participant's safety plan is:

_____

_____

_____

3. _____ 3. Provider is trained to recognize and appropriately respond in the event of an emergency, including protocol for contacting local emergency response systems, and the prompt notification of the county waiver agency.

Any emergency situations or incidents where the participant's health or safety may have been compromised during a session, must be immediately reported to the participant's support and service coordinator (SSC)

SSC agency name, contact staff, and phone number: _____

4. _____ 4. Provider is trained on participant specific information, including individual needs, functional capacities, strengths, abilities, preferences, goals, and family/participant's culture. Additionally, provider has received in-depth training on the participant's individual daily living skills needs and level of assistance for bathing, grooming, toileting, eating, transfers, mobility, learning, communication, and other related tasks. If necessary, provider has also received training on using any adaptive aids or equipment the participant needs for day to day functions.

Detailed Information on the participant's specific information is outlined below:

Participants strengths, interests, and hobbies:

_____

_____

If provider will be conducting mentoring sessions: list how the participant's and provider's interests are similar and how will those interests be incorporated into sessions.

_____

_____

Participant's and their family's relevant cultural needs and preferences:

_____

_____

Participant's cognitive abilities and concerns:

_____

_____

Participant's communication abilities, strengths, and concerns:

_____

_____

Participant's grooming, bathing, toileting, and dressing strengths and concerns:

_____

_____

_____

Participant's dietary concerns, eating habits, and need for eating/feeding assistance:

_____

_____

Participant's mobility strengths and concerns and need for assistance with transfers within home and community:

_____

_____

Participant requires specialized equipment that will be utilized by provider during sessions

☐ No ☐ Yes, equipment includes:

_____

_____

Participant's Goals:

☐ Provider reviewed a copy of participant's most recent CLTS Waiver Individualized Service Plan (ISP) Goals and Outcomes Page.

5. _____ 5. Provider is trained on the participant's specific positive behavioral support plan so provider is able to safely and appropriately respond to challenging and unexpected behaviors participant may display during services.

Current Positive Behavioral Supports and Strategies for Participant:

_____

_____

_____

_____

Participant has an active Behavior Intervention Plan through school, therapy service, or other agency?

☐ No ☐ Yes, and provider has reviewed this/these behavior intervention plan(s)

6. _____ 6. Provider acknowledges and agrees that the participant may not be put into isolation or seclusion and cannot be restrained in any way during sessions. Providers are prohibited from these actions except in cases where a specific participant behavior plan has received Department of Health Services (DHS) approval. All violations of this policy must be immediately reported to the county waiver agency.

Participant has an approved DHS restrictive measures plan

☐ No ☐ Yes: Provider has received comprehensive training on this plan by county waiver agency **AND** participant's parent/guardian.

7. _____ 7. Provider Is trained on county waiver agency/contract agency policies, procedures, and expectations for providers including confidentiality of participant information according to federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.

8. _____ 8. Provider received training on billing and payment processes, record keeping, incident and mandated reporting requirements, and name/contact information of the county waiver agency service coordinator as well as contract agency.

9. _____ 9. Provider will be providing transportation services to the participant

☐ No ☐ Yes

If Yes, parent/guardian has reviewed the following and copies are on file with the county waiver agency:

☐ Provider's has a valid driver's license
☐ Provider has valid car insurance coverage
☐ Parent/Guardian has reviewed the provider's vehicle and attests that it is in sound working order and provider will be able to safely and legally provide transportation services to the participant.

10. _____ 10. Provider has a professional license or meets Medicaid certification for personal care services or nursing

☐ No ☐ Yes and a copy of the _____license/certification has been received by the county waiver agency.

11. _____ 11. Provider has prior training related to the participant's specific disability of _____

or general training in ☐ developmental disabilities, ☐ mental health, and/or ☐ physical disabilities.

☐ **Prior training**

_____

_____

_____

☐ **No prior training**: Parent/Guardian exempts provider from needing prior training and feels provider can safely, ethically, and appropriately deliver services to the participant. Parent/Guardian has provided provider with training on participant's specific diagnosis by sharing the following information:

_____

_____

_____

12. _____ 12. Provider has received prior training on professional ethics and interpersonal skills as well as understanding and respecting participant direction, individuality, independence, and rights. Additionally, Provider has received prior training on how to handle conflicts and complaints with participants, respecting personal property, and understanding cultural differences and family relationships.

☐ **Prior training:**

_____

_____

_____

☐ **No prior training:** Parent/Guardian is exempting provider from needing this training. They feel that the provider will be able to safely, ethically, and appropriately provide services to the participant due to the following reasons:

_____

_____

_____

13. _____ 13. Provider has prior training on providing quality homemaking and household services, including understanding good nutrition, special diets, and meal planning and preparation. Provider has been trained on how to maintain a clean, safe, and healthy home environment. The provider is able to respect the participant's preferences in housekeeping, shopping and home making tasks.

☐ **Prior training:**

_____

_____

_____

☐ **No prior training:** Parent/Guardian has provided training on this topic to provider as it relates to the participant's dietary needs and family's household preferences. Expectations of provider for maintaining household needs during services includes: (*Chores to be done during SHC-Chores sessions must be explained in full)

_____

_____

_____

Signatures

Our signatures below indicate the named employee has met all required provider standards for this service at this time.

Signature of Employee	**Date**
Signature of Participant's Parent or Legal Guardian	**Date**
Signature of Support and Service Coordinator representing CWA	**Date**

Training Review

All providers must review this training information with the participant's parent/guardian every 4 years during the provider's renewal background check process. Significant changes to the participant's needs warrants a new verification of training form to be completed. Please indicate below dates of reviews and any minor updates to training that was warranted for the participant.

Date of Review	Additional Training Provided by Parent/Guardian	Initials for all parties

COUNTY OF KENOSHA

John T. Jansen, Director
Department of Human Services

Ron Rogers, Director
Division of Children & Family Services
Job Center / Human Services Building
8600 Sheridan Road, Suite 200
Kenosha, Wisconsin 53143-6512
(262) 697-4500
Fax: (262) 605-6570

Kenosha County Waiver Agency
Policies and Expectations for Providers paid by a Financial Management Service

Re: _____
(CLTS Participant Name)

This document outlines policies and expectations for providers who are utilizing a Financial Management Service (FMS) agency and have agreed to provide services for a child funded through a Children's Long-Term Support (CLTS) Medicaid Waiver. Below is a summary of what must be agreed to before you can provide services. You must also complete all necessary tasks with the identified FMS agency.

1. The CLTS Waiver client and their parent/guardian is your employer, not the CLTS Waiver agency or Kenosha County.

- I agree to involve the participant and/or guardian in decisions about the participant's care and services s/he receives from me.

2. Providers are unable to restrain, isolate, or seclude a child while they are providing services to a client.

- I agree to provide care/services in the least restrictive manner and setting necessary, while still ensuring the safety of the participant. Any breach in this policy must be reported to the service coordinator within 24 hours of the incident

3. Providers must contact the appropriate service coordinator and the client's parent/guardian to report all critical incidents that occur during a service within 24 hours.

- I agree to report any injuries to the client, injuries to the provider, emergency situations, suspected abuse or neglect of the client, medications errors, significant property damage, and any other concerning incidents or accidents that cause harm to the service coordinator in a detailed report.
- I further acknowledge that I am a mandated reporter and will report all concerns of abuse/neglect which could include sexual abuse, physical abuse, neglect and sexual activity between minors. These concerns will be reported to the client's service coordinator and to Child Protective Services (CPS). CPS can be reached Monday through Friday 8 am to 5 pm via Kenosha County's Access Line at (262) 605-6582. Report after hours concerns to 262-657-7188.

4. You must keep records of when you worked with the client for 7 years.

- I understand that I may be asked to produce records by Kenosha County Waiver Agency.

- I acknowledge that I may need to provide additional documentation as required for the service I am providing.

5. Providers' wages are based on the CLTS participant's needs and the rate standards created by Wisconsin Department of Health Services for each service performed.

6. Providers must engage with the client and their family in a professional capacity, should adhere to appropriate dress and language, and display a respectful demeanor toward the client and their family.

- I agree to be respectful of the family's cultural needs/preferences, rules of their home, and follow through on all required duties of the service I am performing.
- I agree to treat the participant, and their family members, with dignity and respect, free from any verbal, physical, emotional and/or sexual abuse.
- I agree to treat the participant fairly and will not discriminate based on race, national origin, gender, age, religion, disability, or sexual preference.

7. Providers should exercise a calm demeanor when in conflict with the client/family or other relevant providers the client engages with. Providers may contact the client's service coordinator for assistance with disputes between the provider and client/family or other relevant parties.

8. Providers must keep identifying information regarding the client you are working with confidential.

- I will keep the participant's information confidential, unless the law permits disclosure. I acknowledge this agreement remains in effect even after employment is terminated.
- I will not release any information regarding the participant without consent from the participant or his/her guardian. This includes taking pictures of the client without parent consent or posting client pictures/information online.
- This notice also serves as a release of information in order for me to discuss the participant with the CLTS Service Coordinator.

I, _____, understand that as a paid Children's Long-Term
(Print name)
Support (CLTS) Waiver provider, I am required to follow all policies and expectations as outlined in this document. I further acknowledge that failure to follow these policies may result in my termination or denial of payment.

_____ _____
Provider Signature Date

_____ _____
Parent/Guardian Signature Date

COUNTY OF KENOSHA

John T. Jansen, Director
Department of Human Services

Ron Rogers, Director
Division of Children & Family Services
Job Center / Human Services Building
8600 Sheridan Road, Suite 200
Kenosha, Wisconsin 53143-6512
(262) 697-4500
Fax: (262) 605-6570

Request for Child Protective Services ACCESS Employee Search Request

The purpose of this form is to gather information and authorization to complete Child Protective Services (CPS) background checks from the following and is not for re-release except to the subject of the record.

- Child Protective Services Background Check (includes the use of the State of Wisconsin's automated EWiSACWIS system and/or CPS case files).

This completed form should be faxed to Kenosha County Division of Children and Family Services (KCDCFS), to fax number 262-697-4585. The form should be to the attention of Access.

A separate form must be completed for each individual background check request. You should receive a response within 10 business days of the date the request was received. If you haven't received a response within this time frame, please contact Access at 262-605-6582, and include the name of the person you submitted a request for.

The purpose of this request is a CPS background check of Wisconsin record for Children's Long-Term Support (CLTS) Waiver program providers.

Information for individual the request is on:

Name (Last, First, Middle): _____

Social Security Number: _____ Birthdate: _____

Provide all other legal names (maiden, married, hyphenated) and include names used that were not legal changes, alternate spellings and initials used.

Agency Requesting Contact Information (Information can be returned to):

CLTS Agency Contact Person: Beth Flansburg-LKIchoice as FEA

Email: beth.flansburg@lkichoice.com Requesting CLTS Agency: KCDCFS-LKIchoice as FEA

Telephone: 608-326-0434 FAX: 1-844-634-7225

My signature hereby authorizes KCDCFS to conduct the search and release the information to the above listed CLTS agency.

Signature of individual the request is on:

_____ Date: _____

Printed name of individual the request is on: _____

FOR ACCESS OFFICE USE ONLY:

Individual background check is cleared and this individual can be hired:

☐ YES ☐ NO

KENOSHA COUNTY

John Jansen, Director
Department of Human Services

Ron Rogers, Director
Division of Children & Family Services
Job Center / Human Services Building
8600 Sheridan Road, Suite 200
Kenosha, Wisconsin 53143-6512
(262) 697-4500
Fax: (262) 605-6570

Request for Child Protective Services ACCESS Employee Search

The purpose of this form is to gather information and authorization to complete Child Protective Services (CPS) background checks from the following and is not for re-release except to the subject of the record.

- Child Protective Services Background Check (includes the use of the State of Wisconsin's automated eWiSACWIS system and/or CPS case files).

This completed form should be emailed to: Backgrounds@kenoshacountywi.gov

A separate form must be completed for each individual background check request. You should receive a response within 10 business days of the date the request was received. If you haven't received a response within this time frame, please contact Access at 262-605-6582, and include the name of the person you submitted a request for.

The purpose of this request is a CPS background check of Wisconsin record for Children's Long-Term Support (CLTS) Waiver program providers.

Information must be returned to (DO NOT LEAVE BLANK):

CLTS Agency Contact Person: _____

Requesting CLTS Agency: _____

Email: _____Telephone: _____

Information for individual the request is on:

Name (Last, First, Middle):_____

Social Security Number: _____ Birthdate: _____

Provide all other legal names (maiden, married, hyphenated) and include names used that were not legal changes, alternate spellings and initials used:_____

My signature hereby authorizes KCDCFS to conduct the search and release the information to the above listed CLTS agency. Signature of individual the request is on:

_____ Date: _____

Printed name of individual the request is on: _____

FOR ACCESS USE ONLY:

Individual background check is cleared and this individual can be hired:

☐ YES ☐ NO