CLTS

Children's Long-Term Support

iLIFE Employee Packet

iLIFE

Choice. With Confidence.

Introduction

iLIFE provides fiscal employer agent (FEA) services to families receiving CLTS Waiver funding. When using the self-direction method of employing an individual to work with your child, your child becomes the employer. You, as your child's parent/guardian, then take on all employer responsibilities. iLIFE can assist you with this process.

As your FEA, iLIFE will run background checks, process payroll for your employees, make the required tax withholdings, and provide reporting on budget utilization, among other duties. This packet will detail what your responsibilities are as the employer and what responsibilities you are designating to iLIFE as your FEA.

Please read the following information carefully and contact us with any questions.

Contacting iLIFE

iLIFE Financial Management Services
2020 West Wells Street
Milwaukee WI 53233

Phone: 888-490-3966
Fax: 414-918-8130

Email: fiscal@iLIFE.org
Website: iLIFE.org

Forms Checklist for Employees Using iLIFE

Please return ALL of the forms listed below, including this checklist, to iLIFE, and may be returned via mail, fax, or email. You are encouraged to make copies of anything you sign before mailing. You may also contact iLIFE for copies of your paperwork if needed.

Each employee you hire will receive an Employee Handbook. It will have two releases of information for you to sign: one to allow your employee and Waukesha County to share information, and one for your employee and iLIFE. There will also be several forms for both you and the employee to sign.

iLIFE
PO Box 80455
Milwaukee, WI 53208

Fax: 414-918-8130
Email: fiscal@iLIFE.org
Phone Number: 1-888-490-3966

Scans or pictures of your documents need to be clearly legible.

- ☐ Forms Checklist - page 3
- ☐ Employee Information - page 4
- ☐ Participant Specific Training Certification - page 5
- ☐ Relationship Disclosure Form - page 6
- ☐ Statement of Understanding - page 7
- ☐ Client Worker Interest Availability - page 10
- ☐ Form W-4 - Employee's Withholding Certificate - page 11
- ☐ Form WT-4 - Withholding Exemption Certificate - page 16
- ☐ Form I-9 - Employment Eligibility Verification - page 18
- ☐ Copy of Social Security Card (optional) - page 22
- ☐ Wisconsin Medicaid Agreement - page 23
- ☐ Background Information Disclosure - page 25
- ☐ Employer/Client and Employee Agreement - page 28
- ☐ Direct Deposit Authorization - page 29
- ☐ Mileage Log - page 32
- ☐ Status Change Form - page 33

Fiscal Employer Agent Employee Information Form

Instructions: 1. Employee completes top half, and Employer/Client completes bottom.
2. Both Employee and Employer/Client sign at the bottom.
NOTE: Employee can work after Employee receives official notification to begin working.

Employee Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Birth Date: _____ Social Security Number: _____

Email: _____

Primary Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Alternative Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Preferred Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other: _____

Employer/Client Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Birth Date: _____ Social Security Number: _____

Primary Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Alternative Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Preferred Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other: _____

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

Employee Signature: _____ Date: _____

Employer/Client Signature: _____ Date: _____

Participant Specific Training Certification

This form is completed for those who provide in-home services such as Child Care, Daily Living Skills, Mentoring, and/or Respite. The Parent/Employer is to train the Employee/Provider on the below topics.

Based on experience, education, and/or training, _____(employee) meets the knowledge and skill level required for direct services through a fiscal agent to enable them to competently work with the Participant to meet the objectives and goals.

Please check the boxes below to indicate the training completed. Any box/skill left blank must result in training before employment may start. Return completed form to fiscal@iLIFE.org.

Name of Child Receiving Services: _____

Knowledge/skill level required	Complete:
Policies, procedures, and expectations of the employer, including training on participant and provider rights and responsibilities; record keeping and reporting; and other information deemed necessary and appropriate.	☐
Information specific to disabilities, abilities, needs, functional deficits, and strengths of the population to be served. This training should be person-specific for the child or youth named above.	☐
Recognizing and appropriately responding to all conditions that might adversely affect the person's health and safety including how to respond to emergencies and critical incidents.	☐
Developing interpersonal and communications skills that are appropriate and effective for working with the child or youth named above.. These skills include understanding the principles of person-centered services; person rights; respect for age; cultural, linguistic, and ethnic differences; active listening, responding with emotional support and empathy; ethics in dealings with people including: family and other providers; conflict resolution skills; and other topics relevant to the specific population to be served.	☐
Understanding of all confidentiality and privacy laws and rules.	☐
Understanding work place injuries and Workers Compensation	☐
Understanding of procedures for handling complaints.	☐
Understanding of the person who needs support, including personal hygiene needs, preferences, and techniques for assisting with activities of daily living including, where relevant, bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.	☐
Understanding the personal health and wellness-related needs of the person needing supports including nutrition, dietary needs, exercise needs, and weight monitoring and control.	☐
Any other training or notes: _____ _____	

We the Employer and Employee agree that the above training has been completed.

_____ Parent/Employer Signature

_____ Employee Signature

_____ Date

Relationship Disclosure Form

Employee Name: _____

Employee Date of Birth: _____

Employer/Client Name: _____

Check one box to indicate your legal relationship to the Employer/Client. For example, if the Employer/Client is your grandmother, you are the Employer/Client's grandchild.

Relative (Biological)
- ☐ Parent*±
- ☐ Son/Daughter (over 21)*
- ☐ Son/Daughter (under 21)*±
- ☐ Grandparent *
- ☐ Grandchild *
- ☐ Adopted Child*
  Adoption Date: _____

Non-Related Relationships
- ☐ Friend
- ☐ Neighbor
- ☐ Worker
- ☐ Ex-Spouse
  Divorce Date: _____

Relative (By Marriage or Partnership)
- ☐ Spouse*±
- ☐ Domestic Partner*‡
  Marriage Date: _____

Other Relative (By Marriage or P'ship)
- ☐ Step Parent*
- ☐ Step Child*
- ☐ Step Grandchild
- ☐ Step Brother/Step Sister
- ☐ Parent-in-Law
- ☐ Child-in-Law
- ☐ Brother-in-Law/Sister-in-Law

Other Relative (Biological)
- ☐ Brother/Sister
- ☐ Uncle/Aunt
- ☐ Nephew/Niece
- ☐ Cousin

*Due to your relationship with the Employer/Client and current legislation, you are exempt from payroll taxes for unemployment insurance (SUTA). If your employment with the Employer/Client is terminated, you will not receive unemployment benefits. Any applicable exemptions cannot be waived.

± Due to your relationship with the Employer/Client 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.

Residency Disclosure

☐ Yes ☐ No Do the Employer/Client and Employee live in the same home?

NOTE: It is the Employee's responsibility to notify iLIFE should their living situation change.

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

Employee Signature: _____Date: _____

Employer/Client Signature: _____ Date: _____

Choosing a Fiscal Agent: Statement of Understanding

Using the Fiscal Agent method of employing one or more individuals to work with a child receiving CLTS Waiver services makes the child the employer. iLIFE does not have any authority over the job performance of any such employee – nor does the county authorizing the child's CLTS services (hereafter known as the CLTS Waiver Agency). That means the child's parent/guardian will act as the employer representative and must voluntarily accept the responsibilities that an employer would have. Those include:

- ☐ Recruiting, interviewing, and hiring the employee
- ☐ Providing initial and ongoing training regarding the care needs of the child and their job-related responsibilities
- ☐ Providing training regarding confidentiality concerns and expectations
- ☐ Setting the employee's wage (within the limits of what the waiver will reimburse for the particular service the employee performs and with the approval of iLIFE and the CLTS Waiver Agency),realizing that **wages will be withheld** if employee and parent/employer representative are not compliant with iLIFE and CLTS guidelines and timelines
- ☐ Supervising employee performance, providing feedback as appropriate
- ☐ Setting and enforcing expectations with regard to professionalism in the home, scheduling changes or conflicts, types of acceptable communication, amount of notice requested for vacating the position, etc.
- ☐ Preparing a back-up plan in the event that the scheduled employee is not able to meet the needs of the child/family
- ☐ **Ensuring that the employee does NOT work over 40 hours/week** (unless employee is authorized)
- ☐ Disciplining and terminating the employee, if parent/employer feels that to be appropriate and necessary
- ☐ Considering insurance coverage/implications in the event that the employee is injured while providing care. Employees will be eligible for Worker's Compensation under iLIFE.
- ☐ Ensuring that all paperwork (both employer's and employee's) is submitted to iLIFE and approved by iLIFE prior to the employee's first date of service to the child
  __No services provided prior to iLIFE's approval date will be paid.__**

Choosing a Fiscal Agent: Statement of Understanding

Please be clear that neither iLIFE nor the CLTS Waiver Agency is the employer. In many cases, iLIFE and the CLTS Waiver agency do not even know these prospective privately retained service providers. iLIFE and the CLTS Waiver agency do not hire, train, supervise, discipline, or terminate these individuals; nor do they verify the employment history or check references of these individuals. It is up to the family hiring the individual to ask for references (personal and professional) and to verify those references prior to employment.

Parent/guardian: If iLIFE or your CLTS Service Coordinator provides you with names of people who are willing to work in your community, it remains your responsibility to interview them and make your own judgment as to their appropriateness to work in your home with your child. Neither iLIFE nor your Service Coordinator are endorsing or recommending these people for employment. Rather, they are merely putting you in touch with individuals who have expressed a willingness to work with children with disabilities. iLIFE's role is limited to completing the employee's criminal background check, ensuring the employee's ongoing training is completed, processing the employee's payroll, and completing end of year federal tax processes for the employee. The CLTS Service Coordinator's role is to determine the authorized number of hours for the child.

Employers are not able to offer benefits such as vacation, sick time, etc. The waiver can only reimburse for hours actually provided to the recipient. Additionally, the employer is responsible for the final approval of hours worked by the employee to be paid through iLIFE. Employers should verify hours worked as listed on the timesheet before signing it. The employee cannot work more than 40 hours for the same employer/child in a work week (Sunday-Saturday).

Parent/guardian and service provider: If you have any questions about any of these responsibilities, or about using iLIFE, please contact iLIFE or the CLTS Service Coordinator. If you have any questions that are of a legal nature about the employer/employee relationship, you are encouraged to seek the advice of an attorney.

Choosing a Fiscal Agent: Statement of Understanding

As an employer-representative of a fiscal agent worker, I understand the stated information and accept responsibility. **I understand that all employee paperwork including the 'Participant Specific Training Certification' must be completed and received by iLIFE PRIOR to working with the client.

**As an employee, I understand the role of my employer and the CLTS Waiver requirements.

_____
Parent/Employer Signature

_____
Employee Signature

_____
Date

_____
Name of child receiving services

CLTS Worker Interest & Availability Form

For Potential Matches with CLTS Participants

Worker Name: _____

Employee ID (if applicable): _____

Phone Number: _____

Email Address: _____

Interest in Supporting CLTS Participants

☐ Yes, I am interested in being contacted regarding opportunities to provide services to CLTS participants.

☐ No, I am not interested at this time.

Availability

Days Available:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Hours Available:

☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight

Maximum Weekly Hours Preferred: _____

Population Experience / Preferences

☐ Children (birth–17)

☐ Young Adults (18–21, if applicable under CLTS transition)

☐ No Preference

Experience Supporting Individuals With:

☐ Physical Disabilities

☐ Developmental Disabilities

☐ Behavioral/Emotional Needs

☐ Complex Medical Needs

☐ Other: _____

_____

Important Acknowledgments

I understand that participation in the CLTS Program is based on participant and family choice, and completing this form does not guarantee referral or selection.

Worker Signature: _____ Date: _____

iLIFE

P.O. Box 80455 | Milwaukee, WI 53208 | Phone: 1-888-490-3966
Fax: 1-414-918-8130 | Email: fiscal@iLIFE.org | Website: iLIFE.org

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

2026

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | **(b) Social security number**

Address

City or town, state, and ZIP code

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) ☐ **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.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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 the 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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

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 unless otherwise noted.

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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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 16, 2027.

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. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

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

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

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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 of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) . . . . . **4** $

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** $

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** $

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	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

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)		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 August 23, 2023: 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

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 05/31/2027

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. An alien 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)					
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):

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

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, sex, 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, sex, 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.
		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		
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				

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.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Fiscal Agent Copy of Social Security Card (optional)

- To verify the Employee's identity and employment status, we recommend the Employee submit a copy of their signed Social Security card to iLIFE.
- Submitting a copy of the Social Security card helps prevent delays in paperwork processing and helps ensure correct tax reporting.
- Make sure copy of Social Security card is signed and has the Employee's current name.



Department of Health Services
Division of Medicaid Services
F-00180C (10/2026)

State of Wisconsin
Wis. Stat. § 49.45(2)(a)9
Wis. Admin. Code § DHS 105.01
42 C.F.R. §§ 431.107 and 438.602(b)

Wisconsin Medicaid

Provider Agreement and Acknowledgement of Terms of Participation

Standard agreement/acknowledgement for
Home and community-based waiver service (adult long-term care) providers

By signature of its authorized representative below, the provider identified below agrees to and acknowledges the conditions of participation and terms of reimbursement set forth in this agreement:

Note: The provider's name used below **must** exactly match the name used on **all** other Medicaid documents.

The provider's participation in Wisconsin Medicaid is subject to the following terms and conditions:

1. **Federal compliance:** Under 42 C.F.R. § 431.107 of the federal Medicaid regulations, the provider agrees to:
   a. Keep any records necessary to disclose the extent of services provided to waiver participants for a period of **ten (10) years** and to retain the records and documents according to the terms provided by Wis. Admin. Code chs. DHS 101–108, except for the retention period specified in Wis. Admin. Code § DHS 106.02(9)(e)2.
   b. On request, provide to the Wisconsin Department of Health Services (DHS), the Secretary of the U.S. Department of Health and Human Services (HHS), or the State Medicaid Fraud Control unit any information maintained under paragraph a. of this section and any information regarding payments claimed by the provider for furnishing services under Wisconsin Medicaid, including home and community-based waiver services.
   c. If the provider is a hospital, nursing facility, provider of home health care, personal care services, or hospice, comply with the advance directives requirements specified in 42 C.F.R. Part 489, Subpart I and 42 C.F.R. § 417.436(d).
   d. Provide DHS, the managed care organization (MCO), or the IRIS (Include, Respect, I Self-Direct) program with its National Provider Identifier (NPI), if eligible for an NPI.
   e. Include its NPI (if eligible for an NPI) on all claims submitted under Wisconsin Medicaid, including home and community-based waiver services.
   f. Comply with the disclosure requirements in 42 C.F.R. Part 455, Subpart B, which includes all disclosure requirements from 455.100 through 455.106.
      i. For the purposes of this agreement, the person with an ownership or control interest means a person or corporation that:
         a. Has an ownership interest totaling 5% or more in a disclosing entity.
         b. Has an indirect ownership interest equal to 5% or more in a disclosing entity.
         c. Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity.
         d. Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the provider if that interest equals at least 5% of the value of the property or assets of the disclosing entity.
         e. Is an officer or director of a disclosing entity that is organized as a corporation.



F-00180C

f. Is a partner in a disclosing entity that is organized as a partnership.

ii. The provider, any fiscal agent, or affiliated managed care entity shall furnish to DHS:

a. The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include, as applicable, the primary business address, every business location, and any P.O. Box address.

b. Date of birth and Social Security number (SSN) (in the case of an individual).

c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest.

d. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

e. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

f. The name, address, date of birth, and SSN of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

g. A provider must submit, within 35 days of the date on a request by the HHS or DHS, full and complete information about:

1. The ownership of any subcontractor with whom the provider has had any business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

2. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

h. The provider must disclose to DHS the entity of any person who:

1. Has ownership or controlling interest in the provider or is an agent or managing employee of the provider.

2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

iii. Disclosure, as required in this agreement, from any provider or disclosing entity is due at any of the following times:

a. Upon the provider or disclosing entity submitting the provider application.

b. Upon the provider or disclosing entity executing this agreement.

c. Upon request of DHS during the revalidation of enrollment process under 42 C.F.R. § 455.414.

d. Within 35 days after any change in ownership of the disclosing entity.

2. **Wisconsin Medicaid:** The provider's participation in Wisconsin Medicaid, including home and community-based waiver services, is subject to the following terms and conditions:

   a. **Laws, rules, regulations, and policies.** The provider agrees to comply with federal and state laws, rules, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program. This includes, but is not limited to, the caregiver background checks, a waiver participant's rights granted under federal and state law, including the right to refuse medication and treatment, and policy communications published by DHS.

   b. **Provider handbooks.** The provider agrees to comply with the applicable terms, conditions, and restrictions that are set forth in the internet-based Family Care, Family Care Partnership, Program of All-Inclusive Care for the Elderly (PACE), or IRIS service areas of the ForwardHealth Online Handbook, bulletins, Adult Long-Term Care Updates, and other communications regarding changes in state or federal law, policy, reimbursement rates and formulas, departmental interpretation, procedural directives such as billing and prior authorization procedures, and specific reimbursement changes, which are issued by DHS under Wis. Admin. Code § DHS 108.02(2) and (4). The Online Handbook, bulletins, and Adult Long-Term Care Updates are available to the provider through the ForwardHealth Portal (forwardhealth.wi.gov). The omission of any applicable term, condition, or restriction from this section does not excuse the provider from complying with that term, condition, or restriction.

   c. **Actual knowledge not required.** The provider agrees to comply with all applicable terms, conditions, and restrictions governing the provider's participation in Wisconsin Medicaid, including the home and community-based waiver programs, regardless of whether the provider has actual knowledge of those terms, conditions, and restrictions.

   d. **Claim submission.** The provider agrees to comply with all claim submission requirements as defined by the program that authorized the service, and from which the provider is seeking reimbursement. This includes, but is not limited to: DHS, the MCO, or IRIS fiscal employer agent (FEA), including electronic and web-based submission methodologies that require the input of secure and discrete access codes but not written provider signatures. The provider has the sole responsibility for maintaining the privacy and security of any access code used to submit information to DHS, the MCO, or IRIS FEA. Any person who submits information to DHS, the MCO, or IRIS FEA, using the provider's access code does so on behalf of the provider, regardless of whether the provider gave permission to use the access code, otherwise revealed the access code to the person, or had knowledge that the person knew the access code or used it to submit information to DHS, the MCO, or IRIS FEA.

   e. **Confidentiality.** The provider is subject to applicable federal and state laws regarding confidentiality and disclosure of medical records or other health information, including the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for all services, information, transactions (including electronic transactions), privacy, and security regulations.

   f. **Repayment.** The provider is responsible for repayment to DHS, the MCO, or IRIS program of any overpayment based on any information submitted by the provider or by any third party in the provider's name or NPI or using the provider's access code, with or without the provider's knowledge or consent, regardless of the manner in which the information was submitted.

   g. **Sanctions.** The provider is subject to sanctions that may be imposed by DHS under Wis. Stat. § 49.45(2)(a)13 and Wis. Admin. Code § DHS 106.08 based on information submitted by the provider or by any third party in the provider's name or NPI or using the provider's access code, with or without the provider's knowledge or consent, regardless of the manner in which the information was submitted.

3. **Written policies for employees:** An entity that receives or makes payments under a state Medicaid plan or any waiver of such plan totaling at least $5,000,000 annually shall establish written policies for all employees and contractors according to 42 U.S.C. § 1396a(68).

4. **Civil rights compliance:** The provider agrees to all of the following:

    a. In accordance with the provisions of Section 1557 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C. § 18116), Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 701 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.), and regulations implementing these Acts, found at 45 C.F.R. Parts 80, 84, 91, and 92, the provider shall not exclude, deny benefits to, or otherwise discriminate against any person on the basis of sex, race, color, national origin, disability, or age in admission to, participation in, in aid of, or in receipt of services and benefits under any of its programs and activities, and in staff and employee assignments to patients, whether carried out by the provider directly or through a sub-contractor or any other entity with which the provider arranges to carry out its programs and activities.

    b. The provider will comply with all assurance, notice, grievance procedures, and other requirements in the aforementioned federal regulations found at 45 C.F.R. Parts 80, 84, 91, and 92.

    c. The provider will ensure meaningful access to individuals with limited English proficiency (LEP) at no cost to the LEP individuals, in compliance with 42 U.S.C. § 2000d, et seq., and 42 U.S.C. § 18116, and 45 C.F.R. Parts 80 and 92.

    d. The provider will ensure that its communications with individuals with disabilities are as effective as its communications with others in its health programs and activities, including its electronic and information technology communications, and it provides appropriate auxiliary aids and services, in compliance with Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and 42 U.S.C. § 18116, and their respective implementing regulations found in 28 C.F.R. Part 35 and 45 C.F.R. Part 92.

    e. The provider agrees to cooperate with DHS, the MCO, or IRIS program, in any complaint investigations, monitoring, or enforcement related to civil rights compliance of the provider or its subcontractors.

5. **Terms of reimbursement:** Reimbursement of the provider for services and items properly provided under Wisconsin Medicaid, including the home and community-based waiver programs, is governed by this agreement and the terms of reimbursement as are now in effect in the Online Handbook and Adult Long-Term Care Updates, or as may later be amended. All claims are subject to post-payment audit and recoupment if the claim or the underlying transaction fails to comply with the applicable laws, regulations Online Handbook, Adult Long-Term Care Updates, or program guidance. Terms of reimbursement include, but are not limited to:

    a. The provider agrees to provide only the items or services authorized by the MCO or IRIS program.
    b. The provider agrees to accept the payment issued by the MCO or IRIS FEA as payment in full for provided items or services.
    c. The provider agrees to make no additional claims or charges for provided items or services.

6. **On-site inspections:** The provider must permit the Centers for Medicare & Medicaid Services, HHS, DHS, or their agents or designated contractors to conduct unannounced on-site inspections of any and all provider locations per 42 C.F.R. § 455.432.

7. **Submission of claims:** The provider understands and agrees that every time the provider signs and submits a claim, whether done electronically or otherwise, the provider certifies that:

    a. The claim complies with all federal and state Medicaid laws and regulations including, but not limited to, the Online Handbook, all Adult Long-Term Care Updates, and other program guidance.

    b. The claim is truthful, accurate, and complete and contains services and items that have been furnished or caused to be furnished in accordance with applicable federal and state Medicaid laws.

    c. The provider has not offered, paid, or received any illegal remuneration or any other thing of value in return for referring an individual to a person for the furnishing of any service or item, or for arranging for the furnishing of any service or item for which payment may be made in whole or in part under

Medical Assistance in violation of 42 U.S.C. § 1320a-7b, Wis. Stat. § 946.91(3), or any other federal or state anti-kickback statutes.

d. The provider has not engaged in or committed fraud or abuse. "Fraud" includes any act that constitutes fraud under applicable federal or state law.

e. The payment of claims will be from federal and state funds, or both; that compliance with the above requirements is a condition precedent to payment and conditioned upon compliance with all state and federal Medicaid laws, regulations, the Online Handbook, Adult Long-Term Care Updates, and all other program guidance, and therefore, no payment shall be made for services in violation of said requirements; any claim submitted or caused to be submitted or any statement made or used in violation of the above requirements constitutes a false or fraudulent claim for purposes of liability under 31 U.S.C. § 3729 and/or Wis. Stat. §§ 49.485 and 49.49; and that any false claim or statement of concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law.

8. **False claims:** Any acts or omissions by the provider's staff or any entity acting on the provider's behalf shall be deemed those of the provider, including any acts and/or omissions in violation of federal or state criminal and civil false claims statutes.

9. **Extrapolation to determine overpayment:** Extrapolation under Wis. Admin. Code § DHS 105.01(3)(f) may be used as a method to calculate the amount owed by the provider to Wisconsin Medicaid when it has been determined, as a result of an investigation or audit conducted by DHS, the Department of Justice (DOJ) Medicaid fraud control unit, HHS, the Federal Bureau of Investigation, or an authorized agent of any of these entities, based on a sample of claims, that the provider was overpaid.

10. **Inactive status:** Failure by the provider to submit claims for payment for more than a 12 consecutive month period may result in the provider being placed on inactive status. A provider is not eligible for reimbursement for services provided while on inactive status. A provider placed on inactive status must reapply to Wisconsin Medicaid to reactivate their status.

11. **Licensure:** The provider certifies that the provider and each person employed by it for the purpose of providing services hold all licenses or similar entitlements and meet other requirements specified in federal or state statute, regulation, rule, or program authority for the provision of the service.

12. **Voluntary termination:** The provider may terminate its certification to participate in Wisconsin Medicaid as provided under Wis. Admin. Code § DHS 106.05.

13. **Involuntary termination:** DHS may terminate or suspend the provider's certification under this agreement as provided in Wis. Admin. Code § DHS 106.06.

14. **Duration:** This agreement will remain in full force and effect as long as the provider is certified to participate in Wisconsin Medicaid under Wis. Admin. Code ch. DHS 105 and/or in the Medicaid home and community-based services waiver programs under the IRIS Waiver or Family Care Waiver.

15. **Statement of material fact:** The provider acknowledges that any statement made in this agreement or in the provider application process constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made by the provider for a benefit or payment, or for use in determining rights to such benefit or payment. Under Wis. Stat. §§ 49.49(1d) and (4m), if any such statements or representations are false, the provider may be subjected to criminal or other penalties.

16. **Attestations:** The provider acknowledges and attests compliance to all statements below.

    a. Provider has written policies regarding testing for communicable diseases, as well as protocols in place for positive results, for all staff.

    b. Provider has documentation to support all attestations made within this application and agrees to provide DHS such documentation upon request.

    c. Provider has written policies and procedures in place to address staff shortages.

    d. Provider has a continuity of operations plan, specifically related to emergency or disaster preparedness.

e. If a member or participant experiences a medical emergency while in the presence of the provider, provider will call 911 to access emergency services and wait with the member or participant until the first responders are on-site, have assessed the situation, and have taken the member or participant into their care if needed.

f. Provider has policies and procedures in place for hiring that include review of Wisconsin DOJ results and the Background Information Disclosure (BID) form, F-82064 (dhs.wisconsin.gov/library/collection/f-82064). Provider's policies and procedures include action the provider will take based on results of the background check, in compliance with Wis. Stat. §§ 50.065(2)(bb), (br), and (2m) and Wis. Admin. Code §§ DHS 12.06 and 12.115.

g. Provider completes Wisconsin DOJ criminal and caregiver background checks at its own expense for all persons who will provide care to members and participants, whether an employee or contractor of an entity or a sole proprietor, prior to the person(s) providing direct services to a member or participant and at a minimum every four (4) years thereafter or any time the organization or agency has a reason to believe a new check should be performed.

h. Pursuant to Wis. Admin. Code chs. DHS 12 and 13, prior to providing services that result in direct contact with members or participants, provider verifies all persons who will provide care to members or participants, whether an employee or contractor of an entity or a sole proprietor do not appear on the list of excluded individuals on the DHS Wisconsin Misconduct Registry. The provider will remove any employee found on the Misconduct Registry (wi.tmutest.com/search) from any work related to any state or federal health care program.

i. Provider understands that the U.S. DOJ may impose civil monetary penalties on anyone who hires an excluded individual or entity. Provider agrees to check the HHS Office of Inspector General (OIG) online List of Excluded Individuals/Entities database (Exclusions Database) for all new hires and at least quarterly for existing employees to ensure that no excluded employees work in any capacity related to any state or federal health care program. The provider will remove any employee found in the OIG Exclusions Database (exclusions.oig.hhs.gov/) from any work related to any state or federal health care program.

j. As applicable, provider shall have written policy and train its staff to immediately report all allegations of misconduct, including abuse and neglect of a member or participant or misappropriation of a member's or participant's property.

k. Provider will require, via written policy and procedures, that persons, whether an employee or contractor of an entity or a sole proprietor, report criminal convictions or investigations to their immediate supervisor as soon as possible, but no later than the next working day per Wis. Admin. Code § DHS 12.07(1).

l. In compliance with Wis. Admin. Code § DHS 12.10, provider shall retain in its personnel files the following documents related to all persons providing direct care to members and participants: pertinent BID form, F-82064, and search results from the Wisconsin DOJ, DHS, and the Wisconsin Department of Safety and Professional Services, as well as out-of-state records, tribal court proceedings, and military records, in accordance with searches required in Wis. Stat. § 50.065(2) and Wis. Admin. Code § DHS 12.08. Provider shall make these documents available to DHS upon request.

m. Provider ensures staff is able to perform skills as required in their position description prior to initial performance.

n. Provider ensures and documents qualifications of each staff member, including academic preparation and relevant experience, verification of current license, certifications, and/or registrations to practice in Wisconsin that are applicable to, or required by, the staff member's duties. Upon request, the provider will supply any applicable documentation to DHS.

o. Provider ensures staff working with frail elders or disabled populations have documented experience with the population that the staff will work with or provider has plans to ensure staff is adequately trained.

p. Provider maintains a training plan for each staff member who provides or will provide direct care to members or participants and has a mechanism for ensuring that all necessary training has been completed prior to performing work and that completion of all training is documented.

q. Provider will maintain documentation that staff is trained annually on compliance, fraud, waste, and abuse.

r. Provider ensures staff is trained on DHS recording and reporting requirements for documentation, critical incident reporting, and other information and procedures necessary for the staff to ensure the health and safety of members and participants receiving supports. The applicable requirements are documented in the Family Care Contract, Family Care Partnership, and PACE: Managed Care Organization Contracts (dhs.wisconsin.gov/familycare/mcos/contract.htm) and the IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards, P-03071 (PDF) (dhs.wisconsin.gov/publications/p03071.pdf).

s. Provider ensures staff is trained on the needs of the target group they are serving.

t. Provider ensures staff is trained on the provision of the services being provided.

u. As applicable, provider ensures staff has been trained or will be trained on the needs, strengths, and preferences of the individual(s) being served, prior to providing direct care.

v. Provider ensures all staff are trained on rights and privacy provisions applicable to providers, members, and participants in Wisconsin, including rights and privacy provisions guaranteed under HIPAA, Wis. Stat. ch. 146, and the Family Care Contract, Family Care Partnership, and PACE: Managed Care Organization Contracts and the IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards.

w. Provider will refrain from influencing an individual to either not enroll in or to disenroll from another MCO or the IRIS program.

By signature, the provider or authorized representative swears or affirms under penalty of perjury that the information given in this agreement is true and accurate. By signature, the provider certifies that they have read the LTC Waiver Provider Online Handbook and all regulations.

Name – Provider: _____

NPI: _____ Medicaid-assigned provider ID: _____

Address (This is the provider's practice location address.)

Street address line 1: _____

Street address line 2: _____

City: _____ State: _____ ZIP+4 code: _____

Signature – Provider or authorized representative: _____

Date signed: _____

Title: _____

For DMS use only (Do not write below this line.)

Signature – Department of Health Services	Date
	2/21/2026

Note: All eight pages of this agreement must be returned together.

offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

7. Affirm each employed and/or sub-contracted individual that delivers CLTS waiver services to eligible participants, hold current licenses, registrations, certifications and/or similar entitlements, and meets the qualifications specified in the CLTS Waiver Manual, P-02256, as required by federal or state statute, regulation, or rule for the provision of the service. In addition, the provider has completed all required screening activities, including a search of the U.S. DHHS Office of Inspector General's List of Excluded Individuals/Entities (LEIE), and conducted Wisconsin caregiver background checks for all employees or sub-contractors with regular, direct access to CLTS waiver participants.[2]
8. Consent to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the provider to the Medicaid program as a result of an investigation or audit conducted by DHS, the Department of Justice Medicaid Fraud Control Unit, the U.S. Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these entities.
9. Submit to the CWA or DHS any information it requests to ensure qualified providers delivered prior authorized CLTS waiver allowed services to eligible participants. Failure to supply the information requested by DHS result in denial of CLTS Waiver Program payment or sanctions related to the provider's continued participation in the program.
10. Affirm any statement made in this document, or during the DHS registration and CWA qualified provider screening and verification process, constitutes a statement or representation of a material fact made in an application for a benefit or payment, or made for use in determining rights to such benefit or payment, that is knowingly and willfully made or caused to be made by provider, within the meaning of Wis. Stat. § 49.49 (1)(a) 1 and 2, which imposes criminal penalties for fraud committed in connection with a Medicaid Program.
11. Affirm claims are only submitted for allowable CLTS waiver services to participants, which were included on the eligible participant's Individual Service Plan (ISP), are prior authorized by the CWA, and delivered to the participant. With the exception of supplemental CLTS covered child care expenses, the provider agency is prohibited from billing the CLTS Waiver Program participant, or the participant's parent/guardian, for any portion of the cost of the prior authorized waiver service.
12. Accept as payment in full, amounts paid in accordance with the CLTS rate schedule established by DHS for in-scope services: https://www.dhs.wisconsin.gov/publications/p02184.pdf
13. Submit claims and receive direct payment from the DHS third party administration (TPA) CLTS claims processing vendor, Wisconsin Physician Services (WPS), pursuant to 42 CFR § 447.10(e). The service payment is based on the CWA's prior authorization of specified waiver services for each eligible CLTS waiver participant.
14. Submit all claims to the TPA within 120 days from the date of service, or in the instance of services covered by a private insurance carrier or Medicare, submit the service claims within 120 days from the date of the third party's explanation of benefit (EOB) statement.
15. Submit refunds to WPS for any overpayments identified by the CWA, WPS or DHS.
16. This agreement may be terminated as follows:
    a. By the provider as set forth at s. DHS 106.05, Wisconsin Administrative Code.
    b. By the Department upon grounds set forth at s. DHS 106.06, Wisconsin Administrative Code.
    c. Pursuant to terms set forth in the Wisconsin Medicaid Home and Community-Based Waivers Manual.
17. Unless terminated earlier, this agreement shall remain in full force and effect for a maximum of four years. This agreement shall not extend beyond the due date of the four year re-registration requirements. DHS will issue notification when the four-year re-registration requirement is due.

MODIFICATIONS TO THIS CLTS WAIVER PROGRAM AGREEMENT ARE NOT PERMITTED. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE TO ANOTHER PARTY.

Name – Provider – Sole Proprietor (Typed or Printed)	Title – Owner/Operator
SIGNATURE – Provider	Date Signed

[2] Qualified provider screening and credential verification and approval is a local county waiver agency function, whereby every four years, at a minimum, the agency must assess and ensure the provider continues to meet all applicable CLTS Waiver Program service standards.

Background Information Disclosure (BID) For Entity Employees and Contractors

Purpose: State and federal law require background checks for certain types of employment, contract, or other roles involving contact with vulnerable persons receiving care or treatment. The information you provide on this form will be used to verify your eligibility for such a role. Providing inaccurate or incomplete information on this form may result in a forfeiture or other sanction, as provided in Wis. Stats. § 50.065(6)(c).

Type

☐ Applicant/employee
☐ Contractor
☐ Student
☐ Volunteer
☐ Household member
☐ Other, specify: _____

Describe the position for which you are applying or renewing:

Applicant information

Name (First, Middle, Last): _____

Social Security number: _____ Date of birth (MM/DD/YYYY): _____

Sex: ☐ Male ☐ Female Phone number: _____

Address – Street: _____

City: _____ State: _____ ZIP code: _____

Have you had or used any other names, including prior to marriage?

☐ Yes ☐ No If yes, list each name fully: _____

Employer or organization verifying eligibility

Name of employer or organization that asked you to complete this form:

_____

Address – Street: _____

City: _____ State: _____ ZIP code: _____

Disclosures

If additional space is needed for answering the questions below, please use the additional page at the end of this form.

1. Pending criminal charges

Do you have any criminal charges pending against you, including in federal, state, local, military, and Tribal courts? ☐ Yes ☐ No

If **yes**, describe the charge and indicate the name of the court, the state, city, month and year you were charged.

2. Convictions for crimes

Were you ever convicted of any crime anywhere, including in federal, state, local, military, and Tribal courts, or in another country? ☐ Yes ☐ No

If **yes**, describe the crime and indicate the name of the court, the state, city, month and year you were convicted.

3. Abuse or neglect of a child

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 a government or regulatory agency (other than the police) ever found that you abused or neglected a child? ☐ Yes ☐ No

If **yes**, describe the conduct and indicate the agency that made the finding, the state, city, month and year of the finding.

4. Abuse or neglect of an adult

Has a government or regulatory agency (other than the police) ever found that you abused or neglected an adult? ☐ Yes ☐ No

If **yes**, describe the conduct and indicate the agency that made the finding, the state, city, month and year of the finding.

5. Stealing or other misappropriation

Has a government or regulatory agency (other than the police) ever found that you stole or misappropriated (improperly took or used) a person's property (e.g., money, medications, etc.), identity, or financial information (e.g., credit card, checks, etc.)? ☐ Yes ☐ No

If **yes**, describe the conduct and indicate the agency that made the finding, the state, city, month and year it occurred.

6. Restriction on credentials

Do you have a government issued credential that is not current or has been revoked, suspended, or that limits you in any way from providing care to clients? ☐ Yes ☐ No

If **yes**, identify the type of credential and indicate the credentialing agency, the restriction, and the state, city, month and year it was issued.

7. Denial, revocation, or limitation on license, certification, or registration

Has a government or regulatory agency ever denied, revoked, or limited your license, certification, or registration to provide care, treatment, or educational services? ☐ Yes ☐ No

If **yes**, indicate the license, certification, or registration type and indicate the issuing agency. Include a description of the denial, revocation, or limitation, and the state, city, month and year it was issued.

8. Denial, revocation, or limitation on ability to reside on certain premises

Has a government or regulatory agency ever denied, revoked or limited your ability to live on the premises of a facility that provides care or treatment? ☐ Yes ☐ No

If **yes**, describe the denial, revocation, or limitation and identify the issuing agency, the state, city, month and year issued.

9. Rehabilitation review

Have you ever requested a rehabilitation review from the Wisconsin Department of Health Services, a county department, private child placing agency, school board, or DHS-designated Tribe? ☐ Yes ☐ No

If **yes**, indicate the agency that conducted the review, the outcome, month, and year of the review.

Note: You must provide a copy of your rehabilitation review letter to your employer or organization. Your employer or organization must verify your status with the agency that issued the decision.

10. Armed forces

Have you been discharged from a branch of the US Armed Forces, including any reserve component? ☐ Yes ☐ No

If **yes**, indicate the month and year of discharge.

Note: You must provide your DD214 to your employer/agency, if you were discharged within the last three (3) years.

11. Out-of-state residence

Have you resided outside of Wisconsin in the last three (3) years? ☐ Yes ☐ No

If **yes**, list each state, city, and the dates you resided there.

12. Government employee

Are you applying or renewing eligibility to work as a government employee for the State of Wisconsin (e.g. a state agency, treatment facility, institute, etc.)? ☐ Yes ☐ No

If **no**, skip to the attestation below. If **yes**, have you resided outside of Wisconsin in the last seven (7) years? ☐ Yes ☐ No

If **yes**, list each state, city, and the dates you resided there.

Review your responses and the following attestation carefully before signing.

Attestation

I have completed and reviewed this form. The information I provided is accurate and complete. I understand that providing inaccurate or incomplete information on this form may result in a forfeiture or other sanction, as provided in Wis. Stats. § 50.065(6)(c).

Signature — Person completing this form: _____

Date signed: _____

Fiscal Agent Employer/Client and Employee Agreement

Instructions: 1. Employer/Client completes the form.
2. Employer/Client and Employee sign at the bottom.

_____ (Employer/Client), hereafter referred to as Employer/Client, and _____ (Employee), hereafter referred to as Employee, do hereby enter into the following agreement:

The Employer/Client requires the following tasks and duties to be performed by the Employee: _____

_____

_____

The Employee agrees to perform the tasks as outlined above according to the following schedule:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

☐ Other: _____

☐ Mileage (miles per week): _____

✓	**Service Type**	**Pay Rate**	**Unit Type** (hour, day, etc.)	**Units/ Week**
	Daily Living Skills (DLS)			
	Respite Care (R)			
	Mentoring (M)			
	Child Care (C)			
	Other:			

We understand that we may not charge in excess of the amount authorized on the Employer/Client's plan. After the Employee has performed the services per this agreement, timesheets are due to iLIFE according to the Payment Schedule. Both signers agree to only submit timesheets within the hours authorized. Without prior approval, excess hours claimed above the authorization may be rejected for payment.

Employee Signature: _____ Date: _____

Employer/Client Signature: _____ Date: _____

Fiscal Agent Employee Direct Deposit Authorization

Instructions: 1. Complete, sign, and date this form
2. Attach required documents.
NOTE: To be effective for the pay date, submit this form at least five business days before the pay date.

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____

Type of Account: ☐Checking ☐Savings

Required Documents

Attach either a voided check or a letter from the bank.

- Starter checks may not be used.
- Must have the routing and account numbers for the account.
- Must be typed.
- Letter must be printed on bank letterhead and state type of account (checking or savings) and account holder's name.

I hereby authorize iLIFE to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries in error to my bank account at the financial institution noted above.

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

Employee Name (printed):_____

Employee Number: _____

Signature: _____ Date: _____

Employer/Client Name (printed): _____

iLIFE Fiscal Agent Employee Timesheet

Service Provider/Employee Name

Employee Number

Program

Pay Period End Date: _____

Employer/Client Name and Address

DATE WORKED	START TIME	END TIME	# HOURS WORKED	DAILY RATE	SERVICE TYPE
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			

iLIFE Fiscal Agent Employee Timesheet

Service Provider/Employee Name
John Smith

Employee Number
123456

Program
CLTS

Pay Period End Date: 3/23/2019

Employer/Client Name and Address
John Doe
987 Main Street
Milwaukee, WI 12345

DATE WORKED	START TIME	END TIME	# HOURS WORKED	DAILY RATE	SERVICE TYPE
3/10/2019	8:00 AM	11:00 AM	3		S
3/12/2019	8:00 AM	11:00 AM	3		S
3/14/2019	8:00 AM	12:00 PM	4		S
3/14/2019	3:00 PM	6:15 PM	3.25		S
3/17/2019	3:00 PM	6:30 PM	3.50		S
3/18/2019	8:00 AM	4:00 PM		1	R
3/21/2019	8:00 AM	11:15 AM	3.25		S
3/23/2019	8:00 AM	12:15 PM	4.25		S
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			

SAMPLE

Hours must be recorded in 15-minute increments. For example 1:00 PM, 1:15 PM, 1:30 PM, 1:45 PM.

Service Types:
Daily Living Skills = DLS Respite = R Mentoring = M Child Care = C

DATE WORKED	START TIME	END TIME	# HOURS WORKED	DAILY RATE	SERVICE TYPE
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	AM / PM	AM / PM			
	TOTALS:		24.25		S / R

Service Types:
Daily Living Skills = DLS Respite = R Mentoring = M Child Care = C

The Employee and Employer/Client/Representative certify that the information provided on this form is a true and accurate statement of the services provided. The Employee and Employer/Client/Representative understand that payment for services provided are subject to payroll taxes.

ONLY ONE PAY PERIOD PER TIMESHEET

Late timesheets are processed the next pay period.

IMPORTANT:
Timesheets must be submitted within 60 days of service. Timesheets for services provided more than 60 days ago will not be paid.

Service Provider/Employee's Signature	Date
John Smith	3/23/2019

Employer/Client/Representative's Signature	Date
John Doe	3/23/2019

iLIFE
iLIFE, LLC Fiscal Agent

Mail this timesheet to:
iLIFE Fiscal Agent
P.O. Box 80455
Milwaukee, WI 53208

Email: fiscal@iLIFE.org
Fax Number: 414-918-8130
For additional forms, go to iLIFE.org

Please call iLIFE at 888-490-3966 with questions on how to fill out this form.

Fiscal Agent Mileage Log

Instructions: 1. Employee completes one entry for each trip, supplying all requested information.
2. Employee and Employer/Client sign at the bottom.
NOTE: Employee can work after Employee receives official notification begin working.

Service Month: _____ Employee Number: _____

Employee Name (printed): _____

Employer/Client Name (printed): _____

Date	From (address, city, state, & ZIP)	To (address, city, state, & ZIP)	Purpose/ Description	Medical? (Y/N)	Total Miles

Employee Signature: _____ Date: _____

Employer/Client Signature: _____ Date: _____

Fiscal Agent Employer/Client Status Change Form

Instructions: Complete only the sections the Employer/Client needs changed.

Employer/Client Name: _____

Fill out only the sections you need changed.	
☐	New Name: _____ Please attach a copy of your updated, signed Social Security card.
☐	New Address: _____ City: _____ State: _____ ZIP: _____
☐	New Phone Number: (_____) _____ - _____ Cell Home Work
☐	New Email Address: _____
☐	On Hold Starting This Date: _____Off Hold Starting This Date: _____ On Hold Reason: _____
☐	No longer receiving services. Reason: _____ Last Day of Service: _____
☐	Other: _____

Fill out only the sections your Employee needs changed.	
Employee Name: _____	
☐	Send check or check stub to Employer/Client instead of Employee.
☐	Employment Termination Date: _____ Write the last day the Employee worked. Reason for Termination: _____
☐	New Employee Name: _____

Employer/Client or Case Manager Signature: _____
Date: _____

Employee Street Address: _____
Apt #: _____ City: _____ State:_____ Zip Code:_____

Employee Phone Number: _____

iLIFE

iLIFE, LLC Fiscal Agent

2026 Fiscal Agent Payroll Payment Schedule

Pay Period	Pay Period Start Date Sunday at 12:00 AM	Pay Period End Date Saturday at 11:59 PM	Due Date (Friday)	Pay Date (Friday)
P1	12/07/25	12/20/25	**12/26/25**	1/9/26
P2	12/21/25	1/3/26	**1/9/26**	1/23/26
P3	1/4/26	1/17/26	**1/23/26**	2/6/26
P4	1/18/26	1/31/26	**2/6/26**	2/20/26
P5	2/1/26	2/14/26	**2/20/26**	3/6/26
P6	2/15/26	2/28/26	**3/6/26**	3/20/26
P7	3/1/26	3/14/26	**3/20/26**	4/3/26
P8	3/15/26	3/28/26	**4/3/26**	4/17/26
P9	3/29/26	4/11/26	**4/17/26**	5/1/26
P10	4/12/26	4/25/26	**5/1/26**	05/16/25
P11	4/26/26	5/9/26	**5/15/26**	5/29/26
P12	5/10/26	5/23/26	**5/29/26**	6/12/26
P13	5/24/26	6/6/26	**6/12/26**	6/26/26
P14	6/7/26	6/20/26	**6/26/26**	7/10/26
P15	6/21/26	7/4/26	**7/10/26**	7/24/26
P16	7/5/26	7/18/26	**7/24/26**	8/7/26
P17	7/19/26	8/1/26	**8/7/26**	8/21/26
P18	8/2/26	8/15/26	**8/21/26**	9/4/26
P19	8/16/26	8/29/26	**9/4/26**	9/18/26
P20	8/30/26	9/12/26	**9/18/26**	10/2/26
P21	9/13/26	9/26/26	**10/2/26**	10/16/26
P22	9/27/26	10/10/26	**10/16/26**	10/30/26
P23	10/11/26	10/24/26	**10/30/26**	11/13/26
P24	10/25/26	11/7/26	**11/13/26**	11/27/26
P25	11/8/26	11/21/26	**11/27/26**	12/11/26
P26	11/22/26	12/5/26	**12/11/26**	**12/24/26**

- Each pay period begins on the listed Sunday at 12:00 AM and ends two weeks later on the listed Saturday at 11:59 PM.
- Timesheets may be submitted from the pay period end date to the due date.
- Please make sure the timesheet is complete and correct before submitting it to iLIFE.

Submit Timesheets via:

Email: fiscal@iLIFE.org
Fax: 414-918-8130
Mail: P.O. Box 80455, Milwaukee, WI 53208

(10/2025)