Updated: 12/20/2023

Fiscal Agent Employee Paperwork for Children's Waiver Programs

Children's Waiver Programs Employee Forms Examples

- Fiscal Agent New Employee Set-up Form
- Relationship Disclosure Form
- W-4: Employee Withholding Allowance Certificate (2024)
- WT-4: Employee's WI Withholding Exemption Certificate
- Form I-9
- F-02364: Wisconsin Medicaid Children's Long-Term Support (CLTS) Waiver Program Provider Agreement and Acknowledgment of Terms of Participation for Sole Proprietor or Individual Waiver Service Providers
- F-82064: Background Information Disclosure (BID) for Entity Employees and Contractors
- Fiscal Agent Employer/Client and Employee Agreement
- Fiscal Agent Employee Direct Deposit Authorization

EXAMPLE:
Fiscal Agent New Employee Set-up Form

INSTRUCTIONS

EMPLOYEE SECTION:

Employee Name: The Employee's full, legal name in last name, first name, middle initial format.

Street Address: The Employee's street address.

City, State, and ZIP: The Employee's city, state, and ZIP code.

Phone Number: The Employee's phone number with Area Code.

Male/Female Check Boxes: Check the box that best describes the Employee's gender (Male or Female).

Email: The Employee's email address.

Birth Date: The Employee's birth date in mm/dd/yyyy format.

Social Security Number: The Employee's Social Security number.

EMPLOYER/CLIENT SECTION:

Program: The name of the county program in which the Employer/Client is enrolled.

Employer/Client Name: The Employer/Client's full, legal name in last name, first name, middle initial format.

Street Address: The Employer/Client's street address.

City, State, and ZIP: The Employer/Client's city, state, and ZIP code.

Phone Number: The Employer/Client's phone number with Area Code.

Birth Date: The Employer/Client's birth date in mm/dd/yyyy format.

Email: The Employer/Client's email address.

Employee Signature: The Employee's signature.

Date: The date the Employee signed this form.

Employer/Client Signature: The Employer/Client, Guardian, or POA's signature.

Date: The date the Employer/Client signed this form.

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Fiscal Agent
New Employee Set-up 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 Section

Employee Name (print): **Employee's Last Name, First Name and Middle Initial**

Street Address: **Employee's Address**

City: **City** State: **State** ZIP: **ZIP Code**

Phone Number: (**###**) **###** - **####** ☑ Male ☐ Female

Email: **Employee's Email Address**

Birth Date: **mm** / **dd** / **yyy** Social Security Number: **###** - **##** - **####**

Employer/Client Section

Program: **Name of County Program in Which Employer/Client is Enrolled**

Employer/Client Name (print): **Employer/Client's Last Name, First Name, Middle Initial**

Street Address: **Employer/Client's Street Address**

City: **City** State: **State** ZIP: **ZIP Code**

Phone Number: (**###**) **###** - **####** Birth Date: **mm** / **dd** / **yyyy**

Email: **Employer/Client's Email Address**

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

Employee Signature: **Employee Signature** Date: **mm/dd/yyyy**

Employer/Client Signature: **Employer/Client, POA, or Guardian Signature** Date: **mm/dd/yyyy**

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

EXAMPLE:
Relationship Disclosure Form

INSTRUCTIONS

Employee Name: The Employee's name in last name, first name format.

Employee Date of Birth: The Employee's date of birth.

Employer/Client Name: The Employer/Client's name.

Check one box to indicate your legal relationship to the Employer/Client: Place a check next to the box that indicates the Employee's legal relationship to the Employer/Client.

Example: If the Employee is the Employer/Client's mother or father, he/she would check "Parent."

Residency Disclosure: Check either "Yes" to indicate the Employer/Client and Employee live in the same home or "No" to indicate they do not.

Employee Signature: The Employee's signature.

Date Signed: The date the Employee signed this form.

Employer/Client Signature: The Employer/Client's signature.

Date Signed: The date the Employer/Client (or their representative) signed this form.

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Relationship Disclosure Form

Employee Name: **Employee Last Name, First Name**

Employee Date of Birth: **mm** / **dd** / **yyyy**

Employer/Client Name: **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: _____

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

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

Non-Related Relationships
- ☐ Friend
- ☐ Neighbor
- ☐ Worker
- ☐ Ex-Husband/Ex-Wife
  Divorce Date: _____

* 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: **Employee Signature** Date: **mm/dd/yyyy**

Employer/Client Signature: **Employer/Client (or Representative) Signature** Date: **mm/dd/yyyy**

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

EXAMPLE: W-4
Employee Withholding Allowance Certificate

INSTRUCTIONS

Employee's Withholding Allowance Certificate: The Form W-4 is used to withhold the correct amount of Federal income tax from pay. This is the portion that will need to be turned in. Some Employees may separate the form here to keep the worksheet (page 3, not included here) for their records.

Step 1a: The full name of the Employee – as well as their home address, city, state, and ZIP code.

Step 1b: The Employee's Social Security number. If the Employee's name does not match the name on their Social Security card, they should contact the SSA at 800-772-1213 or go to www.ssa.gov.

Step 1c: Check the box that best indicates the Employee's filing status.

Complete Steps 2 through 4 of the Form W-4 ONLY if they apply to the Employee.

Step 2: Estimate withholding using options (a) and (b), or check the box for option (c).

Step 3: Enter amounts for each line, add them together, and write the total in box 3.

Step 4: Enter amounts for (a) Other Income, (b) Deductions, and (c) Extra withholding.

Step 5: The signature of the Employee and the date the form was signed.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074
2024

Step 1: Enter Personal Information

(a) First name and middle initial: Employee First Name and Initial
Last name: Employee Last Name
(b) Social security number: XXX-XX-XXXX
Address: Employee Street Address
City or town, state, and ZIP code: City, 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.)

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

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 Signature — **mm/dd/yyyy**

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)

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10220Q Form **W-4** (2024)

Special Instructions for Claiming "Exempt"

If the Employee meets both conditions noted on the Form W-4, they can write "Exempt" in the space below Step 4(c) and complete steps 1 and 5 to claim exempt. No other steps on the Form W-4 should be completed.

The Form W-4 will need to be completed annually (by February) if the Employee wishes to remain at "Exempt" status from year to year.

EXAMPLE: WT-4
Employee's WI Withholding Exemption Certificate

INSTRUCTIONS

EMPLOYEE'S SECTION

Employee's Legal Name: The Employee's legal name in last name, first name and middle initial format.

Social Security Number: The Employee's Social Security Number.

Check Boxes: Check the box that best describes the Employee's marital status.

Employee's Address, City, State, and Zip Code: The Employees street address, city, state, and ZIP code.

Date of Birth: The Employee's birthdate in mm/dd/yyyy format.

Date of Hire: If the Employee's start date has been issued by the time this form is completed, enter it in mm/dd/yyyy format. Otherwise, it can be left blank to be completed by the FEA.

Lines 1a-c: Determine the number of exemptions claimed for each line.

Line 1d: Enter the total from Lines 1a-c.

Line 2: Enter any additional amount per pay period to be deducted.

Line 3: Enter "Exempt" if the criteria from the instructions is met.

Signature: The Employee's signature.

Date Signed: The date the form was completed by the Employee – written out. *For example: April 15, 2015*

EMPLOYER'S SECTION

Employer's Name: The Employer/Client's full legal, printed name.

Federal Employer ID Number: This is the Employer Identification Number issued by the IRS after the Employer/Client submits form SS-4. If they have not yet been issued this number, this box can be left blank.

Employer's Payroll Address, City, State, and ZIP Code: The Employer/Client's street address, city, state, and ZIP code.

Completed by: The printed name of the Employer/Client or their representative completing the form.

Title: "HHCSR" if being completed by the Employer/Client or "POA" or "Guardian" if being completed by their representative.

Save | Print | Clear

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	
Employee Last Name, First Name and Middle Initial	###-##-####	☑ 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	
Employee's Street Address	mm/dd/yyyy	
City / State / Zip code	Date of hire	
City / State ZIP Code	mm/dd/yyyy	

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 Employee Signature Date Signed Month Day , Year

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/Client's Name			#########
Employer's payroll address (number and street)	City	State	Zip code
Employer/Client's Address	City	State	ZIP Code
Completed by / Title	Phone number		Email
Participant/Employer or Representative Name / HHCSR, POA, or Guardian	(### ###-####		Employer/Client Email Address

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.

W-204 (R. 8-23) Wisconsin Department of Revenue

INSTRUCTIONS

SECTION 1
Completed by the Employee.

Last Name, First Name, Middle Initial: Employee's full, legal name in last name, first name, middle initial format.

Other Names Used (if any): Include any names that the Employee has used, including maiden names. If there are no other names, write "N/A."

Address, Apt. Number, City or Town, State, ZIP Code: Employee's current address, city, state, and ZIP code. *Note: P.O. Boxes are not acceptable.*

Date of Birth: Employee's date of birth in mm/dd/yyyy format.

U.S. Social Security Number: Employee's Social Security Number.

E-mail Address: Employee's email address.

Telephone Number: Employee's telephone number with Area Code.

I attest, under penalty of perjury, that I am: Check the box that best describes the Employee's citizenship status. Include additional required information if specified for that section.

Signature of Employee: The Employee's signature.

Date: The date that the form was completed by the Employee.

Preparer and/or Translator Certification: This section is only completed if the Employee uses a translator to complete this form. Go to page 3 to complete information.

Employment Eligibility Verification

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

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

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)
PHW Last Name	PHW First Name	Middle Initial	Other Names the PHW has used

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

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

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

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

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

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

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

Signature of Employee	Today's Date (mm/dd/yyyy)
Participant-hired Worker Signature	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
Completed by the Employer/Client or his/her Representative.

List A or **List B and List C**: Documents chosen to be used for I-9 documentation must be from the Lists of Acceptable Documents, found on page 3 of the I-9.

– If a Employee provides an identifying document from List A, it is the only identification needed for this form.
– If the Employee does not provide an item from List A, then he/she will need to provide any combination of identification from both lists B and C.

Complete **each field** under the List that is being completed. If a field is not applicable, write "N/A."

This example depicts the most common documentation used: Social Security Card and Driver's License. Please note that these are not the only documentation that can be used.

Employee's first day of employment: This can be left blank as it will be completed by the FEA.

Last Name, First Name, and Title of Employer or Authorized Representative: Authorized Representative's full, legal name in last name, first name, middle initial, title format.

Signature of Employer: The IRIS Participant/Employer's signature or signature of his/her POA or Guardian if they are completing this form on the Participant/Employer's behalf.

Date: The date this form was signed by the Participant/Employer or their representative.

Employer's Business or Organization Name: "HCSR"

Employer's Business Address, City, State, and ZIP Code: The Participant/Employer's street address, city, state and ZIP code.

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			Wisconsin Driver's License		Social Security Card
Issuing Authority			WI Department of Transportation		Social Security Administration
Document Number (if any)			###-####-####-##		###-##-####
Expiration Date (if any)			mm/dd/yyyy		N/A
Document Title 2 (if any)			Additional Information		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

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

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy): Leave Blank

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code			
HCSR	Business Street Number and Street Name	City	State	ZIP Code

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

Form I-9 Edition 08/01/23 Page 1 of 4

Check Every Time!
Make sure to refer to the document being used for each field. Titles, issuing authorities, etc. may change based on when/where the document was issued.

Examples:

- Department of Transportation vs. Department of Motor Vehicles
- Social Security Administration vs. Department of Homeland Security

Key Rules of Documenting Required Identification in SECTION 2
When documenting required identification, employers or their authorized representative must:
- The person who examines the documents must be the same person who signs Section 2.
- The examiner of the documents and the employee must both be physically present during the examination of the employee's documents.
- Employers cannot refuse to hire someone just because the document(s) presented by the employee /worker will expire soon. If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents.
- DO NOT USE abbreviations or acronyms.
- Documents cannot be expired.
- Employers CANNOT specify which document(s) they will accept from an employee.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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.

INSTRUCTIONS

Supplement A, Preparer and/or Translator Certification for Section 1 **Completed by the Preparer or Translator**

Last Name, First Name, Middle Initial: Employee's full, legal name in last name, first name, middle initial format.

Signature of Preparer or Translator: The Preparer or Translator's signature.

Date: The date that the form was completed by the Preparer or Translator.

Last Name, First Name, Middle Initial: Preparer or Translator's full, legal name in last name, first name, Middle Initial format.

Address, Apt. Number, City or Town, State, ZIP Code: PEmployee's current address, city, state, and ZIP code. *Note: P.O. Boxes are not acceptable.*

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 07/31/2026

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

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)*
Preparer or Translator Signature	**mm/dd/yyyy**

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial *(if any)*
Preparer or Translator Last Name	**Preparer or Translator First Name**	**Middle Initial**

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

INSTRUCTIONS

Supplement B, Reverification and Rehire (formerly Section 3) **Completed by the Participant/ Employer or his/her Representative.**

Last Name, First Name, Middle Initial: Employee's full, legal name in last name, first name, middle initial format.

Date of Rehire: The date that the form was completed by the Participant-Hired Worker.

New Name: Rehire's full, legal name in last name, first name, middle initial format.

Document Title, Document Number: Title of document and the document number.

Expiration Date: The date that the document expires.

Name of Employer or Authorized Representative: Employer's or Authorized Representative's full, legal name.

Signature of Employer or Authorized Representative: The Employer's or Authorized Representative's signature.

Date: The date that the form was completed by the Participant-Hired Worker.

Additional Information: Any additional information that may be needed.

Click here if you used an alternative procedure authorized by DHS to examine documents: Check the box if you used any alternative procedure authorized by DHS.

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 07/31/2026

Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle Initial (if any) from Section 1.
PHW Last Name	PHW First Name	Middle Initial

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
mm/dd/yyyy	Rehire Last Name	Rehire First 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)
Document Title	Document Number	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)
Name of Employer or Authorized Representative	Employer or Authorized Representative Worker Signature	mm/dd/yyyy

Additional Information (Initial and date each notation.)
Additional Information

☐ 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.

EXAMPLE: F-02364

Wisconsin Medicaid Program Children's Long-Term Support (CLTS) Waiver Program Provider Agreement and Acknowledgment of Terms of Participation for Sole Proprietor or Individual Waiver Service Providers

Name – Provider – Sole Proprietor: The Employee's name.

Title – Owner/Operator: The Employee's title (if applicable).

Signature – Provider: The Employee's signature.

Date Signed: The date this form was signed by the Employee.

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
Employee Full Printed Name	**Employee's Title**
SIGNATURE – Provider	Date Signed
Employee Signature	**mm/dd/yyyy**

[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.

INSTRUCTIONS

Check the box that applies to you: Check "Applicant/Employee"

Full Legal Name – (First and Middle): The Employee's legal first and middle names.

Legal Name – (Last): The Employee's legal last name.

Other Names (including prior to marriage): Include any names that the Employee has been known by – including maiden name.

Position Title: Enter "Employee."

Birth Date: The Employee's birthdate in mm/dd/yyyy format.

Sex: Check the box that best describes the Employee's sex.

Home Address, City, State, and Zip Code: Enter the Employee's street address, city, state, and ZIP code.

Business Name and Address - Employer (Entity): The Employer/ Client's name and address (street address, city, state, and ZIP code).

SECTION A
For each question, check either "Yes" or "No." *Note: Some questions require additional information. Please read carefully.*

Continued on Page 2

DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-82064 (01/2022)

STATE OF WISCONSIN
Wis. Stat. § 50.065
Wis. Admin. Code § DHS 12.05(4)
Page 1 of 2

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

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

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

Check the box that applies to you.

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

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

Full Legal Name – *First*	*Middle*	*Last*
Employee's First Name	**Middle Name**	**Last Name**

Other Names (including prior to marriage)
Any other names the Employee has used

Position Title (applied for or existing)	Birth Date *(MM/DD/YYYY)*	Sex
Employee	**mm/dd/yyyy**	☑ Male ☐ Female

Home Address	City	State	Zip Code
Employee's Street Address	**City**	**State**	**ZIP Code**

Business Name and Address – Employer (Entity)
Employer/Client's Name and Address (Street Address, City, State, and ZIP Code)

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

SECTION A – DISCLOSURES

		Yes	No
1.	Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts? If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located. You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.	☐	☐
2.	Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts? If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.	☐	☐
3.	Please note that Wis. Stat. § 48.981, *Abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect. Has any government or regulatory agency (other than the police) ever found that you committed **child** abuse or neglect? Provide an explanation below, including when and where the incident(s) occurred.	☐	☐
4.	Has any government or regulatory agency (other than the police) ever found that you abused or neglected **any person or client**? If **Yes,** explain, including when and where it happened.	☐	☐

SECTION A (continued)
For each question, check either "Yes" or "No." *Note: Some questions require additional information. Please read carefully.*

SECTION B
For each question, check either "Yes" or "No." *Note: Some questions require additional information. Please read carefully.*

Read and initial the following statement: The Employee's initials.

Name – The Person Completing This Form: The Employee's name.

Date Submitted: The date this form was signed by the Employee.

F-82064 Page 2 of 2

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

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

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

SECTION B – OTHER REQUIRED INFORMATION

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

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

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

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

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

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

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

Read and initial the following statement.

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

NAME – Person Completing This Form	Date Submitted
Employee's Name	**mm/dd/yyyy**

EXAMPLE:
Fiscal Agent Employer/Client and Employee Agreement

INSTRUCTIONS

_____(Employer/Client): The Employer/Client's name in first name, last name format.

_____(Employee): The Employee's name in first name, last name format.

... do hereby enter into the following agreement: State how often the Employee will work for the Employer/Client.

The Employer/Client requires the following tasks ...: List the tasks/ services the Employee will provide for the Employer/Client.

The Employee agrees to perform the tasks ...: Check the box next to each day the Employee will work. If the Employee's schedule is not set and he/should could work on any day, check every day.

Other: If the Employee will perform tasks on a different or rotating schedule, check the Other box and explain.

Example: Every other week.

Mileage: If the Employee will provide transportation, check the Mileage box and indicate how many miles per week.

Services Table: Check the Services Type and enter the Pay Rate, Unit Type, and Units per Week for each service the Employee will be providing. If the Service Type is not listed, use the "Other" field.

Employee Signature: The Employee's signature.

Date: The date the Employee signed this form.

Employer/Client Signature: The Employer/Client's signature.

Date: The date the Employer/ Client signed this form.

iLIFE
iLIFE, LLC Fiscal Agent

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's Name (first, last) (Employer/Client), hereafter referred to as Employer/Client, and

Employee's Name (first, last) (Employee), hereafter referred to as Employee, do hereby enter into the following agreement:

Example: "The Employee will provide services 3x per week."
The Employer/Client requires the following tasks and duties to be performed by the Employee:

Example: "Supportive home care (SHC), mileage trips, personal care, etc."

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): **25 miles**

✓	Service Type	Pay Rate	Unit Type (hour, day, etc.)	Units/Week
✓	Supportive Home Care (S)	$$.$$	Per Hour,"	#
✓	Companion/Personal Care (P)	$$.$$	Per Day,"	#
	Respite Care (R)			
	Chore: ☐Snow (CS) ☐Lawn (CL) ☐Other (C)			
	Daily Living Skills (DLS)			
✓	Mileage		etc.	
	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: **Employee Signature** Date: **mm/dd/yyyy**

Employer/Client Signature: **Employer/Client Signature** Date: **mm/dd/yyyy**

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

EXAMPLE:
Fiscal Agent Employee Direct Deposit Authorization

INSTRUCTIONS

Name of Financial Institution: The name of the financial institution affiliated with the checking or savings account to be used for direct deposit.

Routing Number: The routing number of the account to be used.

Account Number: The account number of the account to be used.

Type of Account: Check the box next to the type of account to be used (Checking or Savings).

Employee Name (printed): The Employee's name.

Employee Number: The Employee's iLIFE Employee Number.

Signature: The Employee's signature.

Date: The date the Employee signed this form.

Employer/Client Name (printed): The Employer/Client's name.

iLIFE
iLIFE, LLC Fiscal Agent

OPTIONAL

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: **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 Name** Employee Number: **######**

Signature: **Employee Signature** Date: **mm/dd/yyyy**

Employer/Client Name (printed): **Employer/Client Name**

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