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## IRIS Participant-Hired Worker Paperwork

# Participant-Hired Worker Forms Examples

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- F-01201A: IRIS Participant-Hired Worker Relationship Identification
- W-4: Employee Withholding Allowance Certificate (2026)
- WT-4: Employee's WI Withholding Exemption Certificate
- Form I-9
- F-00180C: Wisconsin Medicaid Program Provider Agreement and Acknowledgment of Terms of Participation – For Waiver Service Provider Agencies or Individuals
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- F-01201C: IRIS Participant Employer/ Participant-Hired Worker Agreement
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- F-01201B: IRIS Supportive Home Care/Self-Directed Personal Care/Respite Care Training Verification

**Note: Participant-Hired Worker may be abbreviated as PHW throughout this document.**

**INSTRUCTIONS**

*Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.*

**SECTION I**

**Name – Participant-Hired Worker:** The PHW’s full, legal name in last name, first name, middle initial format.

**Gender:** Check the box that best describes the Participant-Hired Worker’s gender.

**Date of Birth:** The PHW’s birthdate in mm/dd/yyyy format.

**Mailing Address, City, State, and ZIP:** The Participant-Hired Worker’s street address, city, state, and ZIP code.

**Phone Number:** The Participant-Hired Worker’s telephone number with Area Code.

**Email Address:** The Participant-Hired Worker’s email address.

**SECTION II**

**Name – Participant/Employer:** The PHW’s full, legal name in last name, first name, middle initial format.

**Date of Birth:** The Participant/Employer’s birthdate in mm/dd/yyyy format.

**Master Client Index (MCI):** Participant/Employer’s MCI number.

**Mailing Address, City, State and ZIP:** The Participant/Employer’s street address, city, state, and ZIP code.

**Phone Number:** The Participant/Employer’s telephone number with Area Code.

**Email Address:** The Participant/Employer’s email address.

**Signature – Participant-Hired Worker:** The PHW’s signature.

**Date Signed:** The date the form was signed by the Participant-Hired Worker.

**Signature – Participant/Employer:** The Participant/Employer’s signature (or the signature of their representative).

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

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

STATE OF WISCONSIN

**IRIS PARTICIPANT-HIRED WORKER SET-UP**

**INSTRUCTIONS:** Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. A participant-hired worker may not begin working for a participant before the IRIS start date, indicated in the participant’s start date letter.

Personally identifiable information on this form is collected to verify that the application is complete, and will be used for this purpose and the electronic visit verification enumeration process. As a result, all participant-hired workers must provide their email address in order for this form to be processed.

Completed forms should be submitted to the participant’s fiscal employer agent.

**SECTION I – PARTICIPANT-HIRED WORKER DEMOGRAPHICS (all fields must be filled)**

Name – Participant-Hired Worker (Last, First, MI)		Gender	Date of Birth (Required)
<b>PHW Last Name, First Name and Middle Initial</b>		<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	<b>mm/dd/yyyy</b>
Mailing Address	City	Phone Number	
<b>PHW Address</b>	<b>City</b>	<b>(###) ### - ####</b>	
State	Zip	Email Address (Required)	
<b>State</b>	<b>ZIP Code</b>	<b>Participant-Hired Worker’s Email Address</b>	

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

Name – Participant Employer (Last, First, MI)		Date of Birth	Master Client Index (MCI)
<b>Participant/Employer’s Last Name, First Name, Middle Initial</b>		<b>mm/dd/yyyy</b>	<b>#####</b>
Mailing Address	City	Phone Number	
<b>Participant/Employer Address</b>	<b>City</b>	<b>(###) ### - ####</b>	
State	Zip	Email Address	
<b>State</b>	<b>ZIP Code</b>	<b>Participant/Employer’s Email Address</b>	

By signing below, I (we) agree the information on this form is accurate and I (we) have all supporting documentation in my possession. Both signers agree to only submit time reports within the hours authorized. Without prior approval, excess hours claimed above the authorization may be rejected for payment. Both signers also acknowledge that no hours worked prior to a passed background check will be authorized.

<b>SIGNATURE – Participant Hired-Worker</b>	Date Signed
<b>Participant-Hired Worker Signature</b>	<b>mm/dd/yyyy</b>
<b>SIGNATURE – Participant Employer</b>	Date Signed
<b>Participant/Employer, POA, or Guardian Signature</b>	<b>mm/dd/yyyy</b>

**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

**SECTION A: PARTIES:**

**Name – Participant-Hired Worker:** The Participant-Hired Worker’s name in last name, first name format.

**Name – Participant Employer:** The Participant/Employer’s name in last name, first name format.

**Participant Medicaid Identification Number (MCI):** The Participant’s MCI.

**SECTION B: RELATIONSHIP:** Place a check next to the box that indicates the Participant-Hired Worker’s legal relationship to the Participant/Employer for tax purposes. (See page 2 for more details.)

**SECTION C: LIVING SITUATION:**

**Live-in Exemption from Overtime Pay:** Check either “Yes” to indicate the Participant and Participant-Hired Worker live in the same home or “No” to indicate they do not.

**Live-in Exemption to EVV Requirements:** If you answered “No” to Live-In Exemption from Overtime Pay, do you qualify to be EVV live-in as defined in Section B? If the PHW meets one of the requirements in this section, they are to enter the address in Section C.

F-01201A (03/2023)

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**IRIS PARTICIPANT-HIRED WORKER RELATIONSHIP IDENTIFICATION**

**SECTION A: PARTIES**

Name – Participant-Hired Worker (Last, First)	Name – Participant Employer (Last, First)
<b>Participant-Hired Worker Last Name, First Name</b>	<b>Participant/Employer Last Name, First Name</b>
Participant Medicaid Identification Number (MCI):	
<b>XXXXXXXXXX</b>	

**SECTION B: RELATIONSHIP**

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

I am the participant’s:

RELATIVE (BIOLOGICAL)	RELATIVE (BY MARRIAGE/PARTNERSHIP)	NON-RELATED RELATIONSHIPS
<input type="checkbox"/> Parent * ±	<input type="checkbox"/> Spouse * ±	<input type="checkbox"/> Friend
<input type="checkbox"/> Adult Child (age 21 or over) *	<input type="checkbox"/> Domestic Partner * †	<input type="checkbox"/> Neighbor
<input type="checkbox"/> Child (under age 21) * ±	<input type="checkbox"/> Step Parent *	<input type="checkbox"/> Former Spouse (divorce finalized)
<input checked="" type="checkbox"/> Adopted Child *	<input type="checkbox"/> Step Child *	<input type="checkbox"/> Worker
<input type="checkbox"/> Grandparent *	<input type="checkbox"/> Step Grandchild	
<input type="checkbox"/> Grandchild *	<input type="checkbox"/> Step Sibling	
<input type="checkbox"/> Sibling	<input type="checkbox"/> Parent-in-Law	
<input type="checkbox"/> Uncle / Aunt	<input type="checkbox"/> Child-in-Law	
<input type="checkbox"/> Nephew / Niece	<input type="checkbox"/> Sibling-in-Law	
<input type="checkbox"/> Cousin		

Notes:

* Due to your relationship with the participant and current legislation, you are exempt from payroll taxes for unemployment insurance (SUTA). If your employment with the participant is terminated, you will not receive unemployment benefits. Any applicable exemptions cannot be waived.	± Due to your relationship with the participant and current legislation, you are exempt from payroll taxes for Social Security and Medicare (FICA). By not paying into Social Security and Medicare (FICA), it means you are not earning Social Security work credits. Any applicable exemptions cannot be waived.	† Per Wis. Statute 770.05, Domestic Partnership means you and your same sex partner have filed for Domestic Partnership and have a certified copy of your Declaration of Domestic Partnership.
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**SECTION C: LIVING SITUATION** (see instructions on page 1)

**Live-In Exemption from Overtime Pay**

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

**Live-In Exemption to EVV Requirements**

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

Shared Home Address			
Street	City	State	Zip
<b>Shared Street Address</b>	<b>City</b>	<b>WI</b>	<b>ZIP Code</b>

**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

**SECTION D: ELECTRONIC VISIT VERIFICATION (EVV) LIVE-IN IDENTIFICATION:** If you answered "No" to Live-In Exemption from Overtime Pay, do you qualify to be EVV live-in as defined in Section B?, if the PHW meets one of the requirements in this section (on the previous page), they are to provide a copy of one document from Column A or two documents from Column B to identify their permanent residency. Please note that this document will be completed annually for workers who qualify for the EVV live-in definition.

**SECTION E: ATTESTATIONS:**  
**Participant-Hired Worker:** The worker is responsible for notifying the FEA of any change in live-in status within seven (7) days.

**Participant-Employer (Check if applicable):** Check the appropriate check box based on the residency documents supplied by the PHW.

**SIGNATURE – Participant-Hired Worker:** The Participant-Hired Worker’s signature.

**Date Signed:** The date the Participant-Hired Worker signed this form.

**SIGNATURE – Participant Employer:** The Participant/ Employer's signature.

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

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

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

Column A (Choose **One**)

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

Column B (Choose **Two**)

- Current or past three month’s gas, electric, or phone service statement
- Current or past month’s bank statement
- Current or past month’s paycheck or paystub

**SECTION E: ATTESTATIONS**

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

**Participant-Employer (Check if applicable):**

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

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

SIGNATURE – Participant-Hired Worker

**Participant-Hired Worker Signature**

Date Signed

**mm/dd/yyyy**

SIGNATURE – Participant Employer

**Participant/Employer, POA, or Guardian Signature**

Date Signed

**mm/dd/yyyy**

Employee Withholding Allowance Certificate

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

**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 PHWs may separate the form here to keep the worksheet (page 3, not included here) for their records.

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

**Step 1b:** The PHW's Social Security number. If the PHW'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](http://www.ssa.gov).

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

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

**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 Participant-Hired Worker and the date the form was signed.

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Certificate</b> 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 <b>2026</b>
<b>Step 1:</b> Enter Personal Information	(a) First name and middle initial <b>PHW First Name and Initial</b>		Last name <b>PHW Last Name</b>	
	Address <b>Participant-Hired Worker Street Address</b>			
	City or town, state, and ZIP code <b>City, State and ZIP Code</b>			
(c) <input checked="" type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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.)				
<b>Caution:</b> 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.				
<b>TIP:</b> Consider using the estimator at <a href="http://www.irs.gov/W4App">www.irs.gov/W4App</a> 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.				
<b>Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5.</b> See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at <a href="http://www.irs.gov/W4App">www.irs.gov/W4App</a> .				
<b>Step 2: Multiple Jobs or Spouse Works</b> 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 <b>only one</b> of the following. (a) Use the estimator at <a href="http://www.irs.gov/W4App">www.irs.gov/W4App</a> for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; <b>or</b> (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; <b>or</b> (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. <input type="checkbox"/>				
<b>Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs.</b> 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.)				
<b>Step 3: Claim Dependent and Other Credits</b> 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 . . . . . <b>3(a) \$ XXXX</b> (b) Multiply the number of other dependents by \$500 . . . . . <b>3(b) \$ XXXX</b> Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . <b>3 \$ XXXX</b>				
<b>Step 4: Other Adjustments</b> (a) <b>Other income (not from jobs).</b> 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 . . . . . <b>4(a) \$ XXXX</b> (b) <b>Deductions.</b> 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 . . . . . <b>4(b) \$ XXXX</b> (c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . . <b>4(c) \$ XX</b>				
Exempt from withholding I claim exemption from withholding for 2026, and I certify that I meet <b>both</b> of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 . . . . . <input type="checkbox"/>				
<b>Step 5: Sign Here</b> Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.				
<b>Participant-Hired Worker Signature</b> Employee's signature (This form is not valid unless you sign it.)		<b>Date</b> mm/dd/yyyy		
<b>Employers Only</b> Employer's name and address		First date of employment	Employer identification number (EIN)	
For Privacy Act and Paperwork Reduction Act Notice, see page 4. <span style="float: right;">Cat. No. 10220Q <b>Form W-4</b> (2026) Created 12/8/25</span>				

**Special Instructions for Claiming "Exempt"**

*If the PHW 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 Participant-Hired Worker wishes to remain at "Exempt" status from year to year.*

Employee's WI Withholding Exemption Certificate

INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

EMPLOYEE'S SECTION

**Employee's Legal Name:** The Participant-Hired Worker's legal name in last name, first name and middle initial format.

**Social Security Number:** The Participant-Hired Worker's Social Security Number.

**Check Boxes:** Check the box that best describes the Participant-Hired Worker's marital status.

**Employee's Address, City, State, and Zip Code:** The Participant-Hired Worker's street address, city, state, and ZIP code.

**Date of Birth:** The Participant-Hired Worker's birthdate in mm/dd/yyyy format.

**Date of Hire:** If the Participant-Hired Worker'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 Participant-Hired Worker's signature.

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

EMPLOYER'S SECTION

**Employer's Name:** The IRIS Participant's full legal, printed name.

**Federal Employer ID Number:** This is the Employer Identification Number issued by the IRS after the Participant/Employer 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 Participant/Employer's street address, city, state, and ZIP code.

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

**Title:** "HHCSR" if being completed by the Participant/Employer 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) <b>PHW Last Name, First Name and Middle Initial</b>		Social security number ###-##-####	<input checked="" type="checkbox"/> Single <input type="checkbox"/> Married
Employee's address (number and street) <b>Participant-Hired Worker's Street Address</b>		Date of birth mm/dd/yyyy	<input type="checkbox"/> Married, but withheld at higher Single rate. Note: If married, but legally separated, check the Single box.
City	State ZIP code	Date of hire 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 Participant-Hired Worker 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).
  - 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 <b>Participant/Employer's Name</b>	Federal Employer ID Number #####
Employer's payroll address (number and street) <b>Participant/Employer's Address</b>	City <b>City</b>
Completed by <b>Participant/Employer or Representative Name</b>	State ZIP code <b>State ZIP Code</b>
Title <b>HHCSR, POA, or Guardian</b>	Phone number <b>(###) ###-####</b>
	Email <b>Participant/Employer Email Address</b>

- 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/uhnh/> 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/uhnh/](http://dwd.wi.gov/uhnh/) for more information.

**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

**SECTION 1**

\*\*Completed by the Participant-Hired Worker.\*\*

**Last Name, First Name, Middle Initial:** Participant-Hired Worker's full, legal name in last name, first name, middle initial format.

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

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

**Date of Birth:** Participant-Hired Worker's date of birth in mm/dd/yyyy format.

**U.S. Social Security Number:** Participant-Hired Worker's Social Security Number.

**E-mail Address:** Participant-Hired Worker's email address.

**Telephone Number:** Participant-Hired Worker's telephone number with Area Code.

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

**Signature of Employee:** The PHW's signature.

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

**Preparer and/or Translator Certification:** This section is only completed if the PHW 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 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) PHW Last Name		First Name (Given Name) PHW First Name		Middle Initial (if any)	Other Last Names Used (if any) PHW Other Last Names	
Address (Street Number and Name) PHW Street Number and Street #		Apt. Number (if any)	City or Town PHW City/Town		State PHW State	ZIP Code PHW Zip
Date of Birth (mm/dd/yyyy) mm/dd/yyyy	U.S. Social Security Number ### ## ###	Employee's Email Address PHW Email Address		Employee's Telephone Number PHW 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.): <input checked="" type="checkbox"/> 1. A citizen of the United States <input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.) <input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.) <input type="checkbox"/> 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 PHW Signature				Today's Date (mm/dd/yyyy) mm/dd/yyyy		

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

**SECTION 2**

\*\*Completed by the Participant/Employer 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 PHW provides an identifying document from List A, it is the only identification needed for this form.
- If the PHW 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.

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:** The IRIS Participant's first and last name.

**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
Additional Information					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)		<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
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): <b>Leave Blank</b>
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
<b>PPT Last Name PPT First Name</b>			<b>PPT Signature</b>		<b>mm/dd/yyyy</b>
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		
<b>PPT Last Name PPT First Name</b>			<b>Business Street Number and Street Name, City, State, Zip Code</b>		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li>For persons under age 18 who are unable to present a document listed above:</li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security                 For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="http://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.                 The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.             </li> </ol>
<p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List B document.</li> </ul>	AND	<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List C document.</li> </ul>

\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.

**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

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

\*\*Completed by the Preparer or Translator\*\*

**Last Name, First Name, Middle Initial:** Participant-Hired Worker'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:** Participant-Hired Worker'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 05/31/2027

Last Name (Family Name) from Section 1. <b>PHW Last Name</b>	First Name (Given Name) from Section 1. <b>PHW First Name</b>	Middle initial (if any) from Section 1. <b>Middle Initial</b>
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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 <b>Preparer or Translator Signature</b>	Date (mm/dd/yyyy) <b>mm/dd/yyyy</b>
--	--

Last Name (Family Name) <b>Preparer or Translator Last Name</b>	First Name (Given Name) <b>Preparer or Translator First Name</b>	Middle Initial (if any) <b>Middle Initial</b>
--	---	--

Address (Street Number and Name) <b>Preparer or Translator Street Number and Name</b>	City or Town <b>City/Town</b>	State <b>State</b>	ZIP Code <b>#####</b>
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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)
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Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)
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Address (Street Number and Name)	City or Town	State	ZIP Code
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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)
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Address (Street Number and Name)	City or Town	State	ZIP Code
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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
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**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

**Supplement B, Reverification and Rehire (formerly Section 3)**

\*\*Completed by the Participant/Employer or his/her Representative.\*\*

**Last Name, First Name, Middle Initial:** Participant-Hired Worker'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 05/31/2027

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

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) Date (mm/dd/yyyy)	New Name (if applicable) Last Name (Family Name)	First Name (Given Name)	Middle Initial
<b>mm/dd/yyyy</b>	<b>Rehire Last Name</b>	<b>Rehire First Name</b>	<b>Middle Initial</b>

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)
<b>Document Title</b>	<b>Document Number</b>	<b>mm/dd/yyyy</b>

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)
<b>Name of Employer or Authorized Representative</b>	<b>Employer or Authorized Representative Worker Signature</b>	<b>mm/dd/yyyy</b>

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) Date (mm/dd/yyyy)	New Name (if applicable) Last Name (Family Name)	First Name (Given Name)	Middle Initial
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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)
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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)
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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) Date (mm/dd/yyyy)	New Name (if applicable) 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)
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Additional Information (Initial and date each notation.)

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

**INSTRUCTIONS**

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

*Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.*

This form is used for Participant-Hired Workers.

**Name of Provider:** The full, legal name of the Participant-Hired Worker.

**Address – Street, City, State, and ZIP Code:** The Participant's city, state, and ZIP code.

**Signature-Provider:** The Participant-Hired Worker Signature.

**Date Signed:** The date this form was signed by the Participant-Hired Worker.

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 trainings is documented.
- q. Provider will maintain documentation that staff is trained annually on compliance, fraud, waste, and abuse.
- r. Provider ensures staff are 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](#) and the [IRIS \(Include, Respect, I Self-Direct\) Support Services Provider Training Standards](#), P-03071.
- s. Provider ensures staff are trained on the needs of the target group they are serving.
- t. Provider ensures staff are trained on the provision of the services being provided.
- u. As applicable, provider ensures staff have 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.

<u>Name – Provider</u>	
<b>Participant-Hired Worker's Name</b>	
NPI	Medicaid-Assigned Provider ID
<u>Address (This is the provider's practice location address.)</u>	
<b>Participant's Street Address</b>	
<u>Street Address Line 1</u>	
Street Address Line 2	
<u>City</u> <b>City</b>	<u>State</u> <b>State</b>
<u>ZIP+4 Code</u> <b>Zip Code</b>	
<u>SIGNATURE – Provider or Authorized Representative</u>	<u>Date Signed</u>
<b>Participant-Hired Worker's Signature</b>	<b>mm/dd/yyyy</b>

Background Information Disclosure (BID) for Entity Employees and Contractors

**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

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

**Full Legal Name – (First, Middle, and Last):** The Participant-Hired Worker's legal first, middle, and last names.

**Social Security Number:** Enter the Participant-Hired Workers Social Security Number (SSN).

**Phone Number:** Enter the PHW's phone number.

**Other Names (including prior to marriage):** Check either "Yes" or "No". If you checked "Yes", include any names that the Participant-Hired Worker has been known by – including maiden name.

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

**Sex:** Check the box that best describes the Participant-Hired Worker's sex.

**Home Address, City, State, and Zip Code:** Enter the Participant-Hired Worker's street address, city, state, and ZIP code.

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

**Disclosures**  
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  
F-82064 (02/2026)

State of Wisconsin  
Wis. Stat. § 50.065/Wis. Admin Code § DHS 12.05(4)  
Page 1 of 3

**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): PHW's First, Middle, and Last Name

Social Security number: SSN Date of birth (MM/DD/YYYY): mm/dd/yyyy

Sex:  Male  Female Phone number: Phone number

Address – Street: Participant-Hired Worker's Street Address

City: City State: State ZIP code: Zip Code

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

Yes  No If yes, list each name fully: Any other names the Participant-Hired Worker has used

**Employer or organization verifying eligibility**

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

**Name of Employer or organization that you asked to complete this form** \_\_\_\_\_

Address – Street: Employer or organizations Street Address

City: City State: State ZIP code: Zip Code

**Disclosures**

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.

Background Information Disclosure (BID) for Entity Employees and Contractors

**Disclosures**

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

F-82064

Page 2 of 3

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 neglected or 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 abuse 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 credential

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.

**Disclosures**

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

**Attestation**

Read the Attestation carefully before signing your name and writing the date.

**Signature:**

The person completing the form will sign their name.

**Date Signed:**

Write the date the form was signed on.

F-82064

Page 3 of 3

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 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 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: Signature of person completing the form

Date signed: Date the form was signed

**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

**SECTION I**

**Name:** The Participant-Hired Worker's name in last name, first name, middle initial format.

**Date of Birth:** The Participant-Hired Worker's birthdate in mm/dd/yyyy format.

**Address, Years at Residence, and Any Other Names:** For the past 3 years, list:

- The Participant-Hired Worker's Address (street address, city, state, and ZIP code)
- The number of years at that residence
- Any other names that the PHW went by while at that location

\*\*Report for each prior address until the total years at residence listed is equal to at least 3 years.\*\*

**SECTION II**

If the PHW has lived outside of Wisconsin in the past 3 years, this section will need to be completed. If the PHW has NOT lived outside of Wisconsin for the past 3 years, skip to the Signature and Date Signed fields.

Section II includes:

- **Current Address/Previous Address, City, State, ZIP Code, and County:** For the past 3 years, list:

- The PHW's address (street address, city, state, and ZIP code)
- The number of years at that residence
- Any other names that the PHW went by while at that location
- Repeat for each prior address until the total years at residence listed is equal to at least 3 years.

- **Mother's Maiden Name:** The PHW's mother's maiden name.

- **Mother's Current Name:** The PHW's mother's current name in last name, first name, middle initial format.

- **Father's Name:** The PHW's name in last name, first name, middle initial

**SECTION III**

**Read and check the acknowledgements.**

**Signature:** The PHW's signature.

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

**Department of Health Services**  
Division of Medicaid Services  
F-01246 (07/2025)

**State of Wisconsin**  
Page 1 of 2

**Background Information Disclosure Addendum – IRIS**

**Instructions:** Completion of this form is required under the provisions of Chapters 48.685 and 50.065 Wis. Stats.

Personally identifiable information on this form is collected to verify your identity and verify that the form is complete and will be used for these purposes.

**Section I: Applicant information**

Name (Last, First, MI): PHW's Last Name, First Name, Middle Initial

Date of birth: mm/dd/yyyy

Please list all the cities and states in which you have lived in the past three years, and the name(s) by which you were known (if different from your name now). Please indicate the number of years you have lived there.

Address – (Address, city, state, ZIP code)	Years at residence	Any other names by which you have been known (including maiden name)
<b>Participant-Hired Worker's Street Address, City, State, and ZIP Code</b>	<b>#</b>	<b>Any other names the Participant-Hired Worker has used.</b>

**Section II: Additional applicant information**

Completion of this section is only required for applicants who have lived outside the state of Wisconsin in the past three years.

Current address	City	State	ZIP Code	County
<b>PHW's Current Address</b>	<b>City</b>	<b>State</b>	<b>ZIP Code</b>	<b>County</b>
Previous address	City	State	ZIP code	County
<b>PHW's Previous Address</b>	<b>City</b>	<b>State</b>	<b>ZIP Code</b>	<b>County</b>
Previous address	City	State	ZIP code	County
Previous address	City	State	ZIP code	County

**Participant-Hired Worker's Mother's Maiden Name**

Mother's maiden name: \_\_\_\_\_

**Participant-Hired Worker's Mother's Current Name in**

Mother's current name (Last, First, MI): Last Name, First Name, Middle Initial Format

Father's name (Last, First, MI): Participant-Hired Worker's Father's Name in Last Name, First Name, Middle Initial Format

**EXAMPLE: F-01201C**  
**IRIS Participant Employer/Participant-Hired Worker**  
**Agreement**

**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

**PAGE 1**

**Name – Participant-Hired Worker:**

The Participant-Hired Worker's name in last name, first name format.

**Name – Participant Employer:** The Participant/Employer's name in last name, first name format.

**Date of Birth – Participant-Hired Worker:** The Participant-Hired Worker's birthdate in mm/dd/yyyy format.

**The participant requires...** Enter the tasks the Participant-Hired Worker will provide.

**The participant employer agrees...** Enter the training the Participant/Employer will provide for the Participant-Hired Worker.

**Participant-Hired Worker Schedule:** Check the days of the week the Participant-Hired Worker will be providing services or enter an explanation of the schedule in the "Other" field.

**Participant-Hired Worker Services:** Enter the Pay Rate, Unit Type, and Units per Week for each service that the Participant-Hired Worker will be providing or an explanation in the "Other" field.

**PAGE 2**

**Signature – Participant-Hired Worker:**

The Participant-Hired Worker's signature.

**Date Signed:** The date the Participant-Hired Worker signed this form.

**Signature – Participant Employer:** The date the Participant/Employer (or their representative) signed this form.

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

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

STATE OF WISCONSIN

**IRIS PARTICIPANT EMPLOYER / PARTICIPANT- HIRED WORKER AGREEMENT**

**INSTRUCTIONS:** Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS Program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. Participant-hired worker may not begin working for participant employer until they have received a mailed start date letter.

Personally identifiable information on this form is collected to verify that the application is complete, and will be used only for this purpose.

Completed forms should be submitted to the participant's Fiscal Employer Agent.

Name – Participant-Hired Worker (Last, First) \_\_\_\_\_ Name – Participant Employer (Last, First) \_\_\_\_\_  
**Participant-Hired Worker Last Name, First Name**      **Participant/Employer Last Name, First Name**

Date of Birth – Participant-Hired Worker \_\_\_\_\_  
**mm/dd/yyyy**

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

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

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

**Example: "On first day of employment, the employee will receive a schedule of my daily living activities and they will help me get dressed and ready for the day."**

**Participant-Hired Worker Schedule – Indicate Day(s) of the Week Participant-Hired Worker Will Provide Service(s)**

Service	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Supportive Home Care (SHC)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Self-Directed Personal Care (SDPC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respite Care (R)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mileage	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If "Other", please explain:

**Participant-Hired Worker Services – Indicate Which Service(s), Pay Rate(s), Unit Type(s) and Units Per Week the Participant-Hired Worker will Provide**

Service	Pay Rate	Unit Type (per hour, per day, etc.)	Units/Week
Supportive Home Care (SHC)	\$\$.\$	"Per Hour," Per Day," etc.	#
Self-Directed Personal Care (SDPC)			
Respite Care (R)			
Other			
Mileage	Indicate the rate and the number of miles per month the participant-hired worker is authorized to provide.		#
	\$\$.\$	Per Mile	

If "Other", please explain:

F-01201C Page 2

**BY SIGNING BELOW:**

I (We) understand that the services are provided under Medicaid regulations and that I (we) may not charge in excess of the amount authorized on the participant employer's plan. After the participant-hired worker has performed the service(s) per this agreement, time reports are due to the participant's Fiscal Employer Agent.

Both signers agree to only submit time reports within the hours authorized. Without prior approval, excess hours claimed above the authorization may be rejected for payment.

<b>SIGNATURE – Participant-Hired Worker</b>	Date Signed
<b>Participant-Hired Worker Signature</b>	mm/dd/yyyy
<b>SIGNATURE – Participant Employer</b>	Date Signed
<b>Participant/Employer (or Representative) Signature</b>	mm/dd/yyyy

**INSTRUCTIONS**

Note: Participant-hired worker may be abbreviated as PHW throughout this form.

**Participant-hired Worker Name:** The PHW's name in first name, last name format.

**PHW Employee ID Number:** The PHW's worker number.

**Last four digits of Participant-hired Worker's Social Security number:** The last four digits of the PHW's Social Security number.

**Participant Employer Name:** The Participant/Employer's name in first name, middle initial, last name format.

**Payment Option:** Check one option: iLIFE Pay Card, Checking Account, or Savings Account.

**iLIFE Pay Card:** If checked, include PHW's street address, city, state and ZIP code.

**Direct Deposit:** If Checking Account or Savings Account checked, include:

- 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.

**Participant-hired Worker Signature:** The signature of the Participant-Hired Worker.

**Date:** The date the form was signed.



**IRIS Participant-hired Worker Payment Election Form**

**Instructions:** 1. Participant-hired worker completes all information and signs at the bottom.  
2. Attach required documents and return form to iLIFE.  
NOTE: This document replaces all prior Payment Election forms. If you have more than one IRIS employer, the payment method selected on this form will apply to all payments made by iLIFE.

Participant-hired Worker Name: PHW First Name, Last Name  
PHW Employee ID Number: ##### Last four digits of PHW Social Security number: ####  
Participant Employer Name: Participant Employer First Name, Last Name

**iLIFE Pay Card**  
No additional documentation required. iLIFE is not responsible for lost or stolen cards or funds. By choosing this option, you agree that you have read and accept the terms of this card, which may be found at <https://ilife.org/wp-content/uploads/terms-and-conditions-flyer.pdf>

Street Address: PHW Street Address  
City: City State: WI ZIP: ####

NOTE: iLIFE pay cards cannot be mailed to P.O. boxes. iLIFE pay cards need to be activated immediately upon receipt of mailed card or you may experience a delay in payment and/or cancellation of the card.

**OR**

**Direct Deposit**

<input type="checkbox"/> <b>Checking Account</b> Attach either a voided check or a typed letter from the bank (on bank letterhead) that has the participant-hired worker's name, the routing number, and the account number. Starter checks may not be used.	<input type="checkbox"/> <b>Savings Account</b> Attach a typed letter from the bank (on bank letterhead) that has the participant-hired worker's name, the routing number, and the account number.
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Name of Financial Institution: \_\_\_\_\_  
Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

I hereby authorize iLIFE to initiate credit entries, debit entries and adjustments to the financial institution account type or pay card option noted above.

This authorization replaces all prior direct deposit and payment election forms I may have submitted. 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. I understand that to be effective for the pay date, I must submit this form at least five business days before the pay date.

Participant-hired Worker Signature: Participant-hired Worker Signature Date: mm/dd/yyyy

**EXAMPLE: F-01201B**  
**IRIS Supportive Home Care/Self-Directed Personal Care/  
 Respite Care Training Verification**

**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

**NOTE: This form is required but does not need to be submitted with the start-up forms. Please complete after the Participant-Hired Worker's issued start date.**

**SECTION 1**

**Name – Participant-Hired Worker:**

The Participant-Hired Worker's name in last name, first name format.

**Name – Participant Employer:** The Participant/Employer's name in last name, first name format.

**Date of Birth – Participant-Hired Worker:** The Participant-Hired Worker's birthdate in mm/dd/yyyy format.

**Anticipated Start Date:** Enter the date the Participant-Hired Worker will likely start in mm/dd/yyyy format.

**SECTION II-IV**

Check the box(es) that best describe the required training that the Participant-Hired Worker will need.

**Required training completed on:** Enter the date the training was completed and any notes about what was covered in the training.  
**NOTE: This must be after the issued start date.**

**PAGE 2**

**Signature – Participant-Hired Worker:** The Participant-Hired Worker's signature.

**Date Signed:** The date the Participant-Hired Worker signed this form.

**Signature – Participant Employer:** The date the Participant/Employer (or their representative) signed this form.

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

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

**IRIS SUPPORTIVE HOME CARE / SELF-DIRECTED PERSONAL CARE / RESPITE CARE  
 TRAINING VERIFICATION**

**INSTRUCTIONS:** Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS Program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. Participant-hired worker may not begin working for participant employer until they have received a mailed start date letter.

Please fill out the appropriate section(s) based on services that will be provided.

Completed forms should be submitted to the participant's Fiscal Employer Agent.

**SECTION I – PARTICIPANT-HIRED WORKER DEMOGRAPHICS (all fields must be filled)**

Name – Participant-Hired Worker (Last, First)	Name – Participant Employer (Last, First)
<b>Participant-Hired Worker Last Name, First Name</b>	<b>Participant/Employer Last Name, First Name</b>
Date of Birth – Participant-Hired Worker mm/dd/yyyy	Anticipated Employment Start Date mm/dd/yyyy

**SECTION II – SUPPORTIVE HOME CARE REQUIRED TRAINING**

<input checked="" type="checkbox"/> Employee is oriented to participant's place of care. <input checked="" type="checkbox"/> Employee safely performs cares and duties. <input checked="" type="checkbox"/> Employee knows what to do in an emergency situation*. <input type="checkbox"/> Employee works effectively with participants and respects their choices. <input type="checkbox"/> Employee is familiar with homemaking/household services. <input checked="" type="checkbox"/> Employee uses gloves as appropriate while assisting with participant's cares. <input type="checkbox"/> Employee understands participant's disability, diagnosis and related needs. <input type="checkbox"/> Employee is familiar with participant's daily schedule, needs, and duties. <input type="checkbox"/> Employee is aware of the participant's back-up plan.	Required training completed on:  <p style="text-align: center;"><b>Example: "Reviewed exits, showed where supplies are kept. Reviewed MyCares plan."</b></p>
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**SECTION III – SELF-DIRECTED PERSONAL CARE REQUIRED TRAINING**

<input type="checkbox"/> Employee is oriented to participant's place of care. <input checked="" type="checkbox"/> Employee safely performs cares and duties. <input type="checkbox"/> Employee knows what to do in an emergency situation*. <input type="checkbox"/> Employee works effectively with participants and respects their choices. <input checked="" type="checkbox"/> Employee uses gloves as appropriate while assisting with participant's cares. <input type="checkbox"/> Employee understands participant's disability, diagnosis and related needs. <input type="checkbox"/> Employee is familiar with participant's daily schedule, needs, and duties. <input type="checkbox"/> Employee is aware of the participant's back-up plan.	Required training completed on:  <p style="text-align: center;"><b>Example: "Reviewed MyCares."</b></p>
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**SECTION IV – RESPITE CARE REQUIRED TRAINING**

<input type="checkbox"/> Employee is oriented to participant's place of care. <input type="checkbox"/> Employee safely performs cares and duties. <input type="checkbox"/> Employee knows what to do in an emergency situation*. <input type="checkbox"/> Employee works effectively with participants and respects their choices. <input type="checkbox"/> Employee uses gloves as appropriate while assisting with participant's cares. <input type="checkbox"/> Employee understands participant's disability, diagnosis and related needs. <input type="checkbox"/> Employee is familiar with participant's daily schedule, needs, and duties. <input type="checkbox"/> Employee is aware of the participant's back-up plan.	Required training completed on:  <p style="text-align: center;"><b>Example: "I do not have a Respite Care Worker."</b></p>
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\***Emergency Response:** employee knows how to evacuate the participant in an emergency, and knows how to respond to emergencies related to the participant's health and safety.

F-01201B Page 2 of 2

By signing below, you agree the information on this form is accurate. Both signers also acknowledge that no hours worked prior to a passed background check will be authorized.

<b>SIGNATURE – Employee</b>	Date Signed
<b>Participant-Hired Worker Signature</b>	mm/dd/yyyy
<b>SIGNATURE – Participant</b>	Date Signed
<b>Participant/Employer (or Representative) Signature</b>	mm/dd/yyyy