Updated: 2/12/2024

Choice. With Confidence.

IRIS Participant-Hired Worker Paperwork

Participant-Hired Worker Forms Examples

- F-01201: IRIS Participant-Hired Worker Set-up
- F-01201A: IRIS Participant-Hired Worker Relationship Identification
- W-4: Employee Withholding Allowance Certificate (2024)
- 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
- F-82064: Background Information Disclosure (BID) for Entity Employees and Contractors
- F-01246: Background Information Disclosure Addendum
- F-01201C: IRIS Participant Employer/ Participant-Hired Worker Agreement
- iLIFE Participant-Hired Worker Payment Election Form
- 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**)
PHW Last Name, First Name and Middle Initial		☐ Male ☑ Female	**mm/dd/yyyy**
Mailing Address	City	Phone Number	
PHW Address	**City**	**(###) ### - ####**	
State	Zip	Email Address (**Required**)	
State	**ZIP Code**	**Participant-Hired Worker's Email Address**	

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

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

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

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

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.

IRIS PARTICIPANT-HIRED WORKER RELATIONSHIP IDENTIFICATION

SECTION A: PARTIES

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

Participant Medicaid Identification Number (MCI):
XXXXXXXXXX

SECTION B: RELATIONSHIP

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

I am the participant's:

RELATIVE (BIOLOGICAL)	RELATIVE (BY MARRIAGE/PARTNERSHIP)	NON-RELATED RELATIONSHIPS
☐ Parent * ±	☐ Spouse * ±	☐ Friend
☐ Adult Child (age 21 or over) *	☐ Domestic Partner * ∓	☐ Neighbor
☐ Child (under age 21) * ±	☐ Step Parent *	☐ Former Spouse (divorce finalized)
☑ Adopted Child *	☐ Step Child *	☐ Worker
☐ Grandparent *	☐ Step Grandchild	
☐ Grandchild *	☐ Step Sibling	Notes:
☐ Sibling	☐ Parent-in-Law	
☐ Uncle / Aunt	☐ Child-in-Law	
☐ Nephew / Niece	☐ Sibling-in-Law	
☐ Cousin		

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

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

Live-In Exemption from Overtime Pay

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

Live-In Exemption to EVV Requirements

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

Shared Home Address

Street	City	State	Zip
Shared Street Address	**City**	WI	**ZIP Code**

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.

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

EXAMPLE: W-4
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.

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.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
PHW First Name and Initial	PHW Last Name	XXX-XX-XXXX

Address: **Participant-Hired Worker 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.

Participant-Hired Worker 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 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.

EXAMPLE: WT-4
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)	Social security number	
PHW 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	
Participant-Hired Worker'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 **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).

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

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 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.

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. 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: "IRIS Participant"

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)
PPT Last Name PPT First Name	Signature	mm/dd/yyyy

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

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 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)*: Preparer or Translator Last Name		First Name *(Given Name)*: Preparer or Translator First Name		Middle Initial *(if any)*: Middle Initial
Address *(Street Number and Name)*: Preparer or Translator Street Number and Name	City or Town: City/Town		State: State	ZIP Code: 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

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 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.

INSTRUCTIONS

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.

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

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

Continued on Page 2

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

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

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

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

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Phone Number	
Participant-Hired Worker's Name		**(###) ### - ####**	
Address – Street	City	State	Zip Code
Participant-Hired Worker's Street Address	**City**	**State**	**ZIP Code**

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

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

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

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

Name – Provider: The Participant-Hired Worker name.

Signature – Provider: The Participant-Hired Worker signature.

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

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

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

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

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

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

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

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

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

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

Name – Provider (Typed or Printed)

Participant-Hired Worker's Full Printed Name

SIGNATURE – Provider	Date Signed
Participant-Hired Worker's Signature	**mm/dd/yyyy**

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)

SIGNATURE – Department of Health Services	Date Signed
	8/14/17

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 and Middle): The Participant-Hired Worker's legal first and middle names.

Legal Name – (Last): The Participant-Hired Worker's legal last name.

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

Position Title: Enter "Employee."

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 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*
PHW's First Name	**PHW's Middle Name**	**PHW's Last Name**

Other Names (including prior to marriage)
Any other names the Participant-Hired Worker 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
Participant-Hired Worker's Street Address	**City**	**State**	**ZIP Code**

Business Name and Address – Employer (Entity)
Participant/Employer'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 Participant-Hired Worker's initials.

Name – The Person Completing This Form: The Participant-Hired Worker's name.

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

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
Participant-Hired Worker's Name	**mm/dd/yyyy**

EXAMPLE: F-01246
Background Information Disclosure Addendum

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 (01/2024)

STATE OF WISCONSIN
Wisconsin Statutes
§ 48.685 and 50.065
Administrative Rule
DHS 12.05(4)

BACKGROUND INFORMATION DISCLOSURE ADDENDUM—IRIS

INSTRUCTIONS: Completion of this form is required under the provisions of Chapters 48.685 and 50.065 Wis. Stats. Failure to comply may result in a denial or termination of your employment.

Personally identifiable information on this form is collected to verify your identity and that the form is complete.

SECTION I – APPLICANT INFORMATION

Name – (Last, First, MI)	Date of Birth
PHW's Last Name, First Name, Middle Initial	**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 lived there.

Address – (Address, City, State, Zip Code)	Years at Residence	Any Other Names By Which You Have Been Known (Including Maiden Name)
Participant-Hired Worker's Street Address, City, State, and ZIP Code	**#**	**Any other names the Participant-Hired Worker has used.**

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
PHW's Current Address	**City**	**State**	**ZIP Code**	**County**
Previous Address	City	State	Zip Code	County
PHW's Previous Address	**City**	**State**	**ZIP Code**	**County**
Previous Address	City	State	Zip Code	County
Previous Address	City	State	Zip Code	County

Mother's Maiden Name	Mother's Current Name – (Last, First, MI)
Participant-Hired Worker's Mother's Maiden Name	**Participant-Hired Worker's Mother's Current Name in 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

SECTION III – ACKNOWLEDGEMENTS AND SIGNATURE

Applicant must check all boxes, sign, and date.

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

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

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

SIGNATURE – Applicant	Date Signed
Participant-Hired Worker Signature	**mm/dd/yyyy**

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 — **STATE OF WISCONSIN**
Division of Medicaid Services
F-01201C (02/2017)

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)	☐	☑	☐	☑	☐	☑	☐
Self-Directed Personal Care (SDPC)	☐	☐	☐	☐	☐	☐	☐
Respite Care (R)	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
Mileage	☐	☑	☐	☑	☐	☑	☐

If "Other", please explain:

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

Service	Pay Rate	Unit Type (per hour, per day, etc.)	Units/Week
Supportive Home Care (SHC)	**$$.$$**	**"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.

SIGNATURE – Participant-Hired Worker	Date Signed
Participant-Hired Worker Signature	**mm/dd/yyyy**
SIGNATURE – Participant Employer	Date Signed
Participant/Employer (or Representative) Signature	**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.

iLIFE
Choice. With Confidence.

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

☐ **Checking Account**	☐ **Savings Account**
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.	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.

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**

P.O. Box 80439 | Milwaukee, WI 53208 | Phone: 1-888-800-5599 | Fax: 1-414-918-4463
Email: IRIS.Employment@iLIFE.org | Website: iLIFE.org

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

SECTION II – SUPPORTIVE HOME CARE REQUIRED TRAINING

	Required training completed on:
☑ Employee is oriented to participant's place of care. ☑ Employee safely performs cares and duties. ☑ Employee knows what to do in an emergency situation*. ☐ Employee works effectively with participants and respects their choices. ☐ Employee is familiar with homemaking/household services. ☑ Employee uses gloves as appropriate while assisting with participant's cares. ☐ Employee understands participant's disability, diagnosis and related needs. ☐ Employee is familiar with participant's daily schedule, needs, and duties. ☐ Employee is aware of the participant's back-up plan.	***Example: "Reviewed exits, showed where supplies are kept. Reviewed MyCares plan."***

SECTION III – SELF-DIRECTED PERSONAL CARE REQUIRED TRAINING

	Required training completed on:
☐ Employee is oriented to participant's place of care. ☑ Employee safely performs cares and duties. ☐ Employee knows what to do in an emergency situation*. ☐ Employee works effectively with participants and respects their choices. ☑ Employee uses gloves as appropriate while assisting with participant's cares. ☐ Employee understands participant's disability, diagnosis and related needs. ☐ Employee is familiar with participant's daily schedule, needs, and duties. ☐ Employee is aware of the participant's back-up plan.	***Example: "Reviewed MyCares."***

SECTION IV – RESPITE CARE REQUIRED TRAINING

	Required training completed on:
☐ Employee is oriented to participant's place of care. ☐ Employee safely performs cares and duties. ☐ Employee knows what to do in an emergency situation*. ☐ Employee works effectively with participants and respects their choices. ☐ Employee uses gloves as appropriate while assisting with participant's cares. ☐ Employee understands participant's disability, diagnosis and related needs. ☐ Employee is familiar with participant's daily schedule, needs, and duties. ☐ Employee is aware of the participant's back-up plan.	***Example: "I do not have a Respite Care Worker."***

***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.

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.

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