

NC Independent Living Consumer Packet

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**Please refer to the Consumer Sample Forms Packet to complete forms correctly.
If you need help, call iLIFE at 1-888-851-2420.**

Consumer Forms Checklist

Unless otherwise noted, each of the following forms must be submitted to iLIFE to complete your application:

| ✓ | Consumer Forms | When Required |
|---|---|---|
| | Consumer Information Form | New Consumer |
| | Form 2678 | New Consumer |
| | Form SS-4 | New Consumer |
| | Form 8821 | New Consumer |
| | Form Power of Attorney and Declaration of Representative | New Consumer |
| | Form NCUI 604 Employer Status Report | New Consumer |
| | Form GEN-58 | New Consumer |
| | iLIFE and Consumer Agreement | New Consumer |
| | iLIFE Consent for the Release of Confidential Information | Optional: Consumer wants to allow someone access to his/her NC Independent Living information |
| | Guardianship or Power of Attorney Documents | Consumer has a guardian or Power of Attorney |
| | Consumer Status Change Form | When Consumer's personal information changes or an Attendant is terminated |

Please keep the forms in this list for your reference.

| ✓ | Payment Forms and Information | How to Use |
|---|---|--|
| | Payment Schedule | Lists when timesheets are due and paid |
| | Timesheet | To be filled out and sent for each Attendant for each pay period he or she works |
| | Consumer Employer Handbook: How to be an Employer | Lists tips to be a successful employer |
| | OSHA Standard Precautions | Explains OSHA Precautions |
| | Standard Precautions for Blood Borne Transmission | Explains Blood Borne Transmission Precautions |

If you need help, call iLIFE at 1-888-851-2420.

● Print Consumer Name: _____

● Consumer Signature: _____ Date: _____

Print iLIFE Staff Name: _____

iLIFE Staff Signature: _____ Date: _____

(10/2025)



Consumer Information Form

Consumer Name: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Mailing Address (if different): _____

City: _____ State: _____ ZIP: _____

Primary Phone Number: (____) - ____ - ____ Cell Home Work

Alternate Phone Number: (____) - ____ - ____ Cell Home Work

Birth Date: ____/____/____ Social Security Number: ____-____-____

Email: _____ Opt in for iLIFE email.

Male Female

Preferred Language: English Spanish Hmong Other: _____

Local Office: _____

Case Manager Name: _____

Case Manager Email: _____

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

Consumer Signature: _____ Date: _____

Form 2678 Employer/Payer Appointment of Agent

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

For IRS use:

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

Part 1: Why you are filing this form...

(Check one)

- You want to **appoint** an agent for tax reporting, depositing, and paying.
- You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN)

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

2 Employer's or payer's name
(not your trade name)

3 Trade name (if any)

4 Address

Number Street Suite or room number

| | | |
|--|--|--|
| | | |
|--|--|--|

City State ZIP code

| | | |
|--|--|--|
| | | |
|--|--|--|

Foreign country name Foreign province/county Foreign postal code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (Check all that apply.)

| | For ALL employees/ payees/payments | For SOME employees/ payees/payments |
|--|---------------------------------------|--|
|--|---------------------------------------|--|

| | | |
|--|-------------------------------------|--------------------------|
| Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)* | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return) | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees) | <input type="checkbox"/> | <input type="checkbox"/> |
| Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return) | <input type="checkbox"/> | <input type="checkbox"/> |
| Form 945 (Annual Return of Withheld Federal Income Tax) | <input type="checkbox"/> | <input type="checkbox"/> |
| Form CT-1 (Employer's Annual Railroad Retirement Tax Return) | <input type="checkbox"/> | <input type="checkbox"/> |
| Form CT-2 (Employee Representative's Quarterly Railroad Tax Return) | <input type="checkbox"/> | <input type="checkbox"/> |

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

- Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

X Sign your name here

Print your name here

Print your title here

Date

Best daytime phone

Now give this form to the agent to complete. ➡

Part 3: Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.

6 Agent's employer identification number (EIN)

3 9 - 1 6 1 7 9 7 7

7 Agent's name (not trade name)

ILIFE LLC FISCAL AGENT

8 Trade name (if any)

9 Address

2020 W WELLS ST

Number

Street

Suite or room number

MILWAUKEE

WI

53233

City

State

ZIP code

Foreign country name

Foreign province/county

Foreign postal code

- Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

X Sign your name here

Print your name here

Print your title here

Date

 / /

Best daytime phone

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

See separate instructions for each line. Keep a copy for your records.
Go to www.irs.gov/FormSS4 for instructions and the latest information.

EIN

| | | | | | | | | |
|---|---|---|--|--|-------|--|--|--|
| 1 Legal name of entity (or individual) for whom the EIN is being requested | | | HCSR | | | | | |
| Type or print clearly. | 2 Trade name of business (if different from name on line 1) | | 3 Executor, administrator, trustee, "care of" name | | | | | |
| | 4a Mailing address (room, apt., suite no. and street, or P.O. box) 2020 W WELLS ST | | 5a Street address (if different) (Don't enter a P.O. box.) | | | | | |
| | 4b City, state, and ZIP code (if foreign, see instructions) MILWAUKEE, WI 53233 | | 5b City, state, and ZIP code (if foreign, see instructions) | | | | | |
| | 6 County and state where principal business is located MILWAUKEE COUNTY WI | | | | | | | |
| 7a Name of responsible party | | | 7b SSN, ITIN, or EIN | | | | | |
| 8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 8b If 8a is "Yes," enter the number of LLC members | | | | | |
| 8c If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 9a Type of entity (check only one box). Caution: If 8a is "Yes," see the instructions for the correct box to check. | | | | | | | | |
| <input type="checkbox"/> Sole proprietor (SSN) _____ | | <input type="checkbox"/> Partnership | | <input type="checkbox"/> Estate (SSN of decedent) _____ | | | | |
| <input type="checkbox"/> Corporation (enter form number to be filed) _____ | | <input type="checkbox"/> Personal service corporation | | <input type="checkbox"/> Plan administrator (TIN) _____ | | | | |
| <input type="checkbox"/> Church or church-controlled organization | | <input type="checkbox"/> Other nonprofit organization (specify) _____ | | <input type="checkbox"/> Trust (TIN of grantor) _____ | | | | |
| <input checked="" type="checkbox"/> Other (specify) HCSR | | <input type="checkbox"/> Other (specify) _____ | | <input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government | | | | |
| | | | | <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government | | | | |
| | | | | <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises | | | | |
| Group Exemption Number (GEN) if any | | | | | | | | |
| 9b If a corporation, name the state or foreign country (if applicable) where incorporated | | State | | Foreign country | | | | |
| 10 Reason for applying (check only one box) | | | | | | | | |
| <input type="checkbox"/> Started new business (specify type) _____ | | <input type="checkbox"/> Banking purpose (specify purpose) _____ | | <input type="checkbox"/> Changed type of organization (specify new type) _____ | | | | |
| <input type="checkbox"/> Hired employees (Check the box and see line 13.) | | <input type="checkbox"/> Purchased going business | | <input type="checkbox"/> Created a trust (specify type) _____ | | | | |
| <input type="checkbox"/> Compliance with IRS withholding regulations | | <input type="checkbox"/> Created a pension plan (specify type) _____ | | | | | | |
| <input checked="" type="checkbox"/> Other (specify) HCSR | | | | | | | | |
| 11 Date business started or acquired (month, day, year). See instructions. | | | 12 Closing month of accounting year DECEMBER | | | | | |
| 13 Highest number of employees expected in the next 12 months (enter -0- if none). | | | 14 Reserved for future use | | | | | |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">Agricultural</td> <td style="width: 33%; text-align: center;">Household</td> <td style="width: 33%; text-align: center;">Other</td> </tr> </table> | | | Agricultural | Household | Other | | | |
| Agricultural | Household | Other | | | | | | |
| 15 First date wages or annuities were paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) N/A | | | | | | | | |
| 16 Check one box that best describes the principal activity of your business. | | | | | | | | |
| <input type="checkbox"/> Construction | | <input type="checkbox"/> Rental & leasing | | <input type="checkbox"/> Health care & social assistance | | | | |
| <input type="checkbox"/> Real estate | | <input type="checkbox"/> Manufacturing | | <input type="checkbox"/> Accommodation & food service | | | | |
| <input type="checkbox"/> Finance & insurance | | <input checked="" type="checkbox"/> Other (specify) HCSR | | <input type="checkbox"/> Wholesale-agent/broker | | | | |
| 17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. HCSR | | | | | | | | |
| 18 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| If "Yes," write previous EIN here | | | | | | | | |
| Third Party Designee | Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form. | | | | | | | |
| | Designee's name ILIFE LLC FISCAL AGENT C/O MEGAN KEINTZ | | | Designee's telephone number (include area code) 715-298-9823 | | | | |
| | Address and ZIP code 2020 W WELLS ST MILWAUKEE WI 53233 | | | Designee's fax number (include area code) 414-937-2034 | | | | |
| Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete. | | | | | | | | |
| Name and title (type or print clearly) | | | Title: HCSR | | | | | |
| Signature | | | Date | | | | | |
| Applicant's telephone number (include area code) | | | | | | | | |
| Applicant's fax number (include area code) | | | | | | | | |

Do I Need an EIN?

File Form SS-4 if the applicant entity doesn't already have an EIN but is required to show an EIN on any return, statement, or other document.¹ See also the separate instructions for each line on Form SS-4.

| IF the applicant... | AND... | THEN... |
|--|--|--|
| started a new business | doesn't currently have (nor expect to have) employees | complete lines 1, 2, 4a-8a, 8b-c (if applicable), 9a, 9b (if applicable), 10-13, and 16-18. |
| hired (or will hire) employees, including household employees | doesn't already have an EIN | complete lines 1, 2, 4a-6, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), and 10-18. |
| opened a bank account | needs an EIN for banking purposes only | complete lines 1-5b, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18. |
| changed type of organization | either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership) ² | complete lines 1-18 (as applicable). |
| purchased a going business ³ | doesn't already have an EIN | complete lines 1-18 (as applicable). |
| created a trust | the trust is other than a grantor trust or an IRA trust ⁴ | complete lines 1-18 (as applicable). |
| created a pension plan as a plan administrator ⁵ | needs an EIN for reporting purposes | complete lines 1, 3, 4a-5b, 7a-b, 9a, 10, and 18. |
| is a foreign person needing an EIN to comply with IRS withholding regulations | needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits ⁶ | complete lines 1-5b, 7a-b (SSN or ITIN as applicable), 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18. |
| is administering an estate | needs an EIN to report estate income on Form 1041 | complete lines 1-7b, 9a, 10-12, 13-17 (if applicable), and 18. |
| is a withholding agent for taxes on nonwage income paid to an alien (that is, individual, corporation, or partnership, etc.) | is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons | complete lines 1, 2, 3 (if applicable), 4a-5b, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18. |
| is a state or local agency | serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581 ⁷ | complete lines 1, 2, 4a-5b, 7a-b, 9a, 10, and 18. |
| is a single-member LLC (or similar single-member entity) | needs an EIN to file Form 8832, Entity Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes ⁸ , or is a foreign-owned U.S. disregarded entity and needs an EIN to file Form 5472, Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business | complete lines 1-18 (as applicable). |
| is an S corporation | needs an EIN to file Form 2553, Election by a Small Business Corporation ⁹ | complete lines 1-18 (as applicable). |

¹ For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity doesn't have employees.

² However, don't apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

³ Don't use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

⁴ However, grantor trusts that don't file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

⁵ A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

⁶ Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

⁷ See also *Household employer agent* in the instructions. **Note:** State or local agencies may need an EIN for other reasons, for example, hired employees.

⁸ See *Disregarded entities* in the instructions for details on completing Form SS-4 for an LLC.

⁹ An existing corporation that is electing or revoking S corporation status should use its previously assigned EIN.

Tax Information Authorization

▶ Go to www.irs.gov/Form8821 for instructions and the latest information.
 ▶ Don't sign this form unless all applicable lines have been completed.
 ▶ Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you. See instructions.

OMB No. 1545-1165
For IRS Use Only
 Received by: _____
 Name _____
 Telephone _____
 Function _____
 Date _____

1 Taxpayer information. Taxpayer must sign and date this form on line 6.

| | |
|---------------------------|-----------------------------------|
| Taxpayer name and address | Taxpayer identification number(s) |
| Daytime telephone number | Plan number (if applicable) |

2 Designee(s). If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached** ▶

| | |
|---|---|
| Name and address SHAWN ROSSMANN ILIFE LLC FISCAL AGENT 2020 WEST WELLS ST, MILWAUKEE, WI 53233 Check if to be sent copies of notices and communications <input checked="" type="checkbox"/> | CAF No. _____ PTIN _____ Telephone No. 414-937-2035 Fax No. 414-937-2034 Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/> |
| Name and address BRANDON AUSTIN ILIFE LLC FISCAL AGENT 2020 W WELLS ST, MILWAUKEE, WI, 53233 Check if to be sent copies of notices and communications <input type="checkbox"/> | CAF No. _____ PTIN _____ Telephone No. 414-937-2142 Fax No. 414-937-2034 Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/> |

3 Tax information. Each designee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

| (a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.) | (b) Tax Form Number (1040, 941, 720, etc.) | (c) Year(s) or Period(s) | (d) Specific Tax Matters |
|--|---|-----------------------------|-----------------------------|
| INCOME TAX WITHHOLDING | 940, 940R, 941, 941B, 941R, 941-X | 2023-2026 | NOT APPLICABLE |
| EMPLOYMENT TAXES | W-2, W-2C, W-3, SS-4, 2678, 147C | 2023-2026 | NOT APPLICABLE |

4 Specific use not recorded on the Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip line 5 ▶

5 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain ▶
 To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 5 instructions.

6 Taxpayer signature. If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ IF NOT COMPLETED, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.

▶ DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

| | |
|------------|-----------------------|
| Signature | Date |
| Print Name | Title (if applicable) |

POWER OF ATTORNEY AND DECLARATION OF REPRESENTATIVE

Part 1. Employer's Information. Must sign and date this form on page 2

| | |
|---|---|
| <p>EMPLOYER'S NAME AND ADDRESS <i>(Exactly as shown on the Division of Employment Security Records)</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>EMPLOYER DES IDENTIFICATION NUMBER</p> <p>_____</p> |
| | <p>EMPLOYER FEDERAL IDENTIFICATION NUMBER</p> <p>_____</p> |

Part 2. Agent

| | |
|--|---|
| <p>AGENT NAME iLIFE LLC FISCAL AGENT</p> <p>ADDRESS 2020 W WELLS STREET MILWAUKEE, WI 53233</p> | <p>AGENT DES IDENTIFICATON NUMBER 15853</p> <p>AGENT FEDERAL IDENTIFICATION NUMBER 39 1617977</p> |
| <p>EMAIL ADDRESS payrolltaxdept@ilife.org</p> | <p>PHONE NUMBER (888) 851-2420</p> <p>FAX NUMBER (optional) (888) 339-2554</p> |

The above agent is appointed to represent the above-referenced employer in any of the matters pertaining to contributions (tax) and/or benefits (claims) as listed below. The agent appointed pursuant to this Power of Attorney and Declaration is authorized to:

MAINTENANCE:

- Authorize maintenance of and changes to an employer's DES online account, including, but not limited to, contact details, ownership information, address (physical and mailing), FEIN, name change, reporting successorship, request change in reporting method and/or request seasonal designation, and inactivate/reactivate account.

TAX:

- Complete and submit documents for filing employer's tax and wage report;
- Complete and submit documents regarding an employer's tax rate, contributions and direct reimbursements; and/or
- Accept and receive correspondence sent by DES on an employer's tax contributions.

CLAIMS:

- Accept and receive correspondence sent by DES regarding claims for benefits, or respond to benefit claim documents, including responding to requests for information about a claimant's separation status.

The undersigned employer acknowledges that the agent appointed pursuant to this Power of Attorney and Declaration of Representative is not authorized to: (a) Represent the employer in hearings or (b) Enter appeals except as authorized by N.C. Gen. Stat. 96-17(b) and 04 N.C. Admin. Code 24A .0110(a) and (b). The undersigned employer further acknowledges that its mailing address for tax matters will remain unchanged, unless the employer submits a change of address in accordance with 04 N.C. Admin. Code 24A .0102.

Part 3. Declaration of Representative

This Power of Attorney and Declaration of Representative shall become effective on _____ and shall remain in effect until terminated by the employer, the representative, or the Division of Employment Security. Authorizing any of the above-listed roles also authorizes the agent to engage in discussion with a representative of the Division of Employment Security regarding the selected role(s). On the effective date, this Power of Attorney and Declaration of Representative revokes any earlier power of attorney on file with the Division of Employment Security on the roles selected above.

AUTHORIZED SIGNATURE

DATE SIGNED

INDIVIDUAL

TYPED OR PRINTED NAME

TITLE

The document must be signed by (a) the individual, if the employer is an individual; (b) the president, vice president, or other principal officer, if the employer is a corporation; (c) a partner, if the employer is a partnership or limited liability partnership; (d) a member, if the employer is a limited liability company or professional limited liability company; (e) a responsible and duly authorized member or officer having knowledge of its affairs, if the employer is a government entity, or other unincorporated organization; (f) the fiduciary, if the employer is a trust or an estate, or (g) a person appointed by the employer pursuant to a power of attorney under Chapter 32C of the N.C. General Statutes.

THIS REPORT IS REQUIRED OF EVERY EMPLOYING UNIT AND WILL BE USED TO DETERMINE LIABILITY UNDER THE NORTH CAROLINA EMPLOYMENT SECURITY LAW, GENERAL STATUTE 96 AND DIVISION REGULATIONS.

Employer Status Report

Please Read Instructions!

NC Dept. of Commerce
Division of Employment Security
Post Office Box 26504
Raleigh, N.C. 27611-6504

Please Type or Print in Black Ink
or File Online www.ncesc.com
Return Within 10 Days

| | | | | | | | | |
|----------------------|---------|------------|-------------|------|-------|-----------|-------------|--------|
| For Agency Use Only: | | | Account No. | | | | Liab Y N | A/C/AS |
| Root | OW/OF | S Add | ET AL | S/PR | BR | Liab Date | | |
| Del After | | | Law Sec | | M/W | County | ERA | Own |
| Curr | P1 | P2 | P3 | P4 | P5 | Next | | |
| Orig | Ind Ctr | React Date | | | L Let | St Adj | TA | |
| PC Let | | | | | | | | |

1. Federal ID number: _____ 2. N.C. Dept. of Revenue withholding ID number: _____

3. Enter any previously assigned North Carolina unemployment tax numbers: _____

4. **Employer name:** _____
Enter exact name of legal entity – for further details see instructions)

5. Trade name: _____

6. **Mailing address:** _____
Street or P.O. Box City State Zip Code

7. **Phone number:** (____) _____ 8. **FAX number:** (____) _____

9. Contact person: Andrea Hoettels Title Director - Payroll Operations

Phone number: (414) 459-3068 E-mail Address: andrea.hoettels@cfihope.org

10. N.C. business location: _____ *Street (Do not use a post office box)* **Number of Employees expected in the next 12 months:** _____

N.C.

City _____ **Zip Code** _____ **County** _____

(Attach a list of ALL NC locations, if there is no NC business location, enter the primary employee's home address)

11. Check type of ownership:
- | | | |
|--|--|--|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Sub-Chapter S Corporation | <input type="checkbox"/> LLC taxed as Individual |
| <input type="checkbox"/> General Partnership | <input type="checkbox"/> 501(c)(3) - Attach a copy | <input type="checkbox"/> LLC taxed as Partnership |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Governmental | <input type="checkbox"/> LLC taxed as Corporation |
| <input type="checkbox"/> Limited Partnership - Attach a list of ALL General Partners | | <input type="checkbox"/> Indian Tribal Governments/Enterprises |
| | | <input type="checkbox"/> Disregarded Entity |
| | | <input type="checkbox"/> Other: _____ |

12. Enter the principal activity or services performed in your North Carolina operation: _____

13. If you are part of a larger organization and are primarily engaged in providing support services to that organization, check one of the following:
- | | |
|---|--|
| <input type="checkbox"/> Control, Administrative (Headquarters, etc.) | <input type="checkbox"/> Storage/Warehouse |
| <input type="checkbox"/> Research, Development or Testing | <input type="checkbox"/> Other _____ |

14. Enter date you first employed one or more workers in North Carolina: 08 / 23 / 2014
MM DD YYYY

For Items 15 through 20, check only the ONE item that applies

15. **GENERAL EMPLOYERS:**
a. Have you or will you have a quarterly payroll of \$1,500 or more? Yes No _____ / _____ / _____
If yes, enter the date this occurred or will occur. MM DD YYYY

b. Have you or will you employ at least one worker in 20 different calendar weeks during a calendar year? Yes No _____ / _____ / _____
If yes, enter the date this first occurred or will occur. MM DD YYYY

16. Are you an EMPLOYEE LEASING company? Yes No

17. **AGRICULTURAL EMPLOYERS:**
a. Have you or will you have a quarterly payroll of \$20,000 or more? Yes No _____ / _____ / _____
If yes, enter the date this occurred or will occur. MM DD YYYY

b. Have you or will you employ at least 10 workers in 20 different calendar weeks during a calendar year? Yes No _____ / _____ / _____
If yes, enter the date this first occurred or will occur. MM DD YYYY

18. DOMESTIC EMPLOYERS:

Have you or will you pay \$1,000 or more in a calendar quarter for domestic service in a private home, college club, fraternity or sorority? If yes, enter the date this occurred or will occur.

Yes No 12 / 31 / 2014
MM DD YYYY

19. NON-PROFIT ORGANIZATIONS: (Attach a copy of Federal Letter of Exemption under Section 501(c)(3) of the Internal Revenue Code.)

Have you or will you employ four or more workers in 20 different calendar weeks during a calendar year? If yes, enter the date this occurred or will occur.

Yes No MM / DD / YYYY

20. GOVERNMENTAL ENTITY: (check one type below)

Federal State Local Other: _____

21. If you are not otherwise subject to the unemployment tax law under one of the preceding criteria (Items 15-20), do you wish to voluntarily cover your employees for unemployment insurance?

Yes No

22. Have you ever paid Federal Unemployment Tax (FUTA)? If yes, for what year(s)? _____

Yes No

23. If you have acquired, transferred assets or merged with another business, or made any other changes in the ownership of the business, including changes, such as from a sole proprietorship to a corporation or a partnership, complete the following:

- a. Name of Former Owner: _____ (Full Organizational Name, including Trade Name)
b. Former Owner's N.C. UI Tax Number: _____
c. Former Owner's Address: _____ Street or P.O. Box City State Zip Code
d. On what date did you acquire or change the business? MM / DD / YYYY
e. Did you acquire all or a portion of the former owner's North Carolina business? All Portion (Specify) % _____
f. Was the business in operation at the time you acquired it? Yes No Date Closed MM / DD / YYYY
g. Was the business in bankruptcy at the time you acquired it? Yes No
h. Does the former owner continue to have employees in North Carolina? Yes No

24. Do you have workers who perform services for your business whom you consider to be self-employed or independent contractors? If yes, see instructions for list to be attached.

Yes No

25. List owners (parent corporation, sole proprietor, ALL general partners, principal corporate officers, or members.) Attach a list of those for which there is no space below.

Table with 6 columns: First Name, Middle Name, Last Name, Title, SSN or FEIN, Phone. Includes rows for Street or P.O. Box, City, State, Zip Code.

Be Sure That All Applicable Items Are Completed Before Signing

I certify that the information entered on this form is true and accurate, and that I am authorized by the named employing unit to complete this report for determining unemployment tax liability.

Signature Title MM / DD / YYYY

GEN-58 Power of Attorney and Declaration of Representative

North Carolina Department of Revenue, P. O. Box 25000, Raleigh, NC 27640-0005
Fax: 919-715-1786

Part 1. Power of Attorney (Please type or print.)

1 Taxpayer Information (Taxpayer(s) must sign and date this form on page 2, line 7.)

| | | |
|------------------------------|---------------------------|------------------------|
| Taxpayer name(s) and address | Social security number(s) | Fed Employer ID Number |
| | Daytime telephone number | |

hereby appoint(s) the following representative(s) as attorney(s)-in-fact:

2 Representative(s) (Representative(s) must sign and date this form on page 2, Part 2.)

| | |
|---|------------------------------|
| Name and address ILIFE LLC FISCAL AGENT 2020 W WELLS ST MILWAUKEE WI 53233 | Telephone No. (888) 851-2420 |
| | Fax No. (800) 441-1569 |
| Name and address | Telephone No. |
| | Fax No. |
| Name and address | Telephone No. |
| | Fax No. |

to represent the taxpayer(s) before the North Carolina Department of Revenue for the following matters:

3 Tax Matters You may list any tax years or periods that have already ended as of the date you sign the power of attorney. You may include future tax years or periods that end no later than 3 years after the date the power of attorney is received by the Department of Revenue.

| Type of Tax (Individual, Corporate, Sales, etc.) | Year(s) or Period(s) |
|--|----------------------|
| WITHHOLDING TAX | 2022-2025 |
| | |
| | |

4 Acts Authorized. - The representatives are authorized to receive and inspect confidential tax information, which may include federal tax information, and to perform any and all acts that I (we) can perform with respect to the tax matters described on line 3, for example, the authority to sign any agreements, consents, or other documents. For purposes of this section, federal tax information is defined as federal tax returns and return information received from the Internal Revenue Service.

List any specific additions or deletions to the acts otherwise authorized in this power of attorney:

5 e-Business Center Account - Your tax representative can create an e-Business Center account with the Department of Revenue to perform online services on behalf of your business. The online services offered through the e-Business Center include filing a return and paying tax for certain business tax types, viewing online tax history, and managing tax payment information. Please visit the Department's website at www.ncdor.gov for a list of the online services for businesses that require login to the e-Business Center.

PLEASE CHECK THIS BOX IF YOUR REPRESENTATIVE WILL CREATE AN e-BUSINESS CENTER ACCOUNT TO PERFORM ONLINE SERVICES ON YOUR BEHALF

6 Retention/Revocation of Prior Power(s) of Attorney. - The filing of this power of attorney automatically revokes all earlier power(s) of attorney on file with the Department of Revenue for the same tax matters and years or periods covered by this document. If you do not want to revoke a prior power of attorney, check here.....

YOU MUST ATTACH A COPY OF ANY POWER OF ATTORNEY YOU WANT TO REMAIN IN EFFECT.

7 Signature of Taxpayer(s). - If a tax matter concerns a joint return, both spouses must sign if joint representation is requested. If signed by a corporate officer, partner, guardian, tax matters partner/person, executor, representative, receiver, administrator, or trustee on behalf of the taxpayer, I certify that I have the authority to execute this form on behalf of the taxpayer.

▶ IF NOT SIGNED AND DATED, THIS POWER OF ATTORNEY WILL BE RETURNED.

| | | |
|------------|------|-----------------------|
| Signature | Date | Title (if applicable) |
| Print Name | | |
| Signature | Date | Title (if applicable) |
| Print Name | | |

Part 2. Declaration of Representative

Under penalties of perjury, I declare that:

- I am authorized to represent the taxpayer(s) identified in Part 1 for the tax matter(s) specified there; and
- I am one of the following:
 - a Attorney - a member in good standing of the bar of the highest court of the jurisdiction shown below.
 - b Certified Public Accountant - duly qualified to practice as a certified public accountant in the jurisdiction shown below.
 - c Enrolled Agent - Enrolled as an agent under the requirements of Treasury Department Circular No. 230.
 - d Officer - a bona fide officer of the taxpayer's organization.
 - e Full-Time Employee - a full-time employee of the taxpayer.
 - f Family Member - a member of the taxpayer's immediate family (i.e., spouse, parent, child, brother, or sister).
 - g Other (explain) -

▶ IF THIS DECLARATION OF REPRESENTATIVE IS NOT SIGNED AND DATED, THE POWER OF ATTORNEY WILL BE RETURNED.

| Designation - Insert above letter (a-g) | Jurisdiction (state) or Enrollment Card No. | Signature | Date |
|---|---|-----------|---|
| | <input style="width: 100%; height: 20px;" type="text"/> | | <input style="width: 100%; height: 20px;" type="text"/> |
| | <input style="width: 100%; height: 20px;" type="text"/> | | <input style="width: 100%; height: 20px;" type="text"/> |
| | <input style="width: 100%; height: 20px;" type="text"/> | | <input style="width: 100%; height: 20px;" type="text"/> |



iLIFE and NC Independent Living Consumer Agreement

Agreement between Consumer (print Consumer's name) _____
and iLIFE

The Consumer and iLIFE agree that:

1. The Consumer shall:
 - a. Fill out required Consumer documents to establish employer of record status
 - b. Act as the employer for the Attendants by:
 - i. Conducting interviews
 - ii. Hiring
 - iii. Training
 - iv. Supervising
 - v. Evaluating
 - vi. Giving feedback
 - c. Ensure each Attendant completes all required documents before performing any work for the Consumer
 - d. Communicate to iLIFE to notify of potential Attendant
 - e. Arrange for timesheet submission by the timesheet due dates listed on the iLIFE Payment Schedule
 - f. Submit the Status Change Form to change any of the Consumer's or Attendant's personal information, such as name, address, phone number and email address
2. iLIFE shall:
 - a. Process required Consumer documents, communicating any errors with the Consumer
 - b. Process required Attendant documents, communicating any errors with the Consumer
 - c. Conduct criminal background checks for each prospective Attendant, notifying the Consumer of any serious convictions on the Attendant's record
 - d. Process the Consumer's payroll, withholding required taxes
 - e. Submit payment to the Consumer's Attendants by direct deposit or check
 - f. Garnish the Attendant wages as determined by the garnishing authority
 - g. Deposit payroll taxes to appropriate authorities
 - h. Issue Form W-2 annually to each of the Consumer's Attendants
 - i. Purchase Workers Compensation Insurance
3. This agreement shall be effective when it has been signed by both the Consumer and iLIFE.
4. This agreement shall terminate when the Consumer ceases to receive Consumer-directed services from NC Independent Living.

By signing below, we have read and agree to the roles and responsibilities listed above.

Consumer Signature: _____ Date: _____

iLIFE Staff Signature: _____ Date: _____

iLIFE Staff Member Name Printed: _____

iLIFE Consent for the Release of Confidential Information

Consumer Name: _____

Name of person to which disclosure is authorized: _____

Full address of recipient of disclosure: _____

Phone number of recipient of disclosure: _____

Phrase or four-digit code to be supplied for disclosure: _____

Information authorized for disclosure (check all that apply):

- The Attendants' pay rates, hours and payment amounts
- The Consumer's budget details, including pay rates and services
- All details regarding relevant Consumer-directed services from NC Independent Living
- Other (please explain the information to be released in detail): _____

The Consumer acknowledges that he or she may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

- Upon termination from receiving Consumer-directed services from NC Independent Living
- Upon termination of the relationship with the person to which the disclosure is to be made
- Other (please explain the action in detail with applicable dates): _____

Consumer Signature: _____ Date: _____

Signature of person signing form if not Consumer: _____

Describe authority to sign on behalf of Consumer: _____ Date: _____



Choice. With Confidence.

Consumer Status Change Form

Consumer Name: _____ Local Office: _____

| Fill out only the sections you need changed. | |
|--|---|
| <input type="checkbox"/> | New Name: _____ Please attach a copy of your updated, signed Social Security card. |
| <input type="checkbox"/> | New Address: _____ City: _____ State: _____ ZIP: _____ |
| <input type="checkbox"/> | New Phone Number: (_____) _____ - _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work |
| <input type="checkbox"/> | New Email Address: _____ |
| <input type="checkbox"/> | On Hold Starting This Date: _____ Off Hold Starting This Date: _____ On Hold Reason: _____ |
| <input type="checkbox"/> | No longer receiving services. Reason: _____ Last Day of Service: _____ |
| <input type="checkbox"/> | Consumer Deductible Amount: \$ _____ . _____ Deducted <input type="checkbox"/> Monthly or <input type="checkbox"/> Per Pay Period |
| <input type="checkbox"/> | Other: _____ |

| Fill out only the sections your Attendant needs changed. | |
|--|--|
| Attendant Name: _____ | |
| <input type="checkbox"/> | Send check or check stub to Attendant instead of Consumer. |
| <input type="checkbox"/> | Employment Termination Date: _____ <small>Write the last day the Attendant worked.</small> Reason for Termination: _____ |

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

Consumer or Local Office Representative Signature: _____

Date: _____

2026 NC Independent Living Payroll Payment Schedule

| Pay Period | Pay Period Start Date Sunday at 12:00 AM | Pay Period End Date Saturday at 11:59 PM | Due Date (Wednesday) | Pay Date (Tuesday) |
|------------|---|---|-------------------------|-----------------------|
| P1 | 12/14/2025 | 12/27/2025 | 12/31/2025 | 1/13/2026 |
| P2 | 12/28/2025 | 1/10/2026 | 1/14/2026 | 1/27/2026 |
| P3 | 1/11/2026 | 1/24/2026 | 1/28/2026 | 2/10/2026 |
| P4 | 1/25/2026 | 2/7/2026 | 2/11/2026 | 2/24/2026 |
| P5 | 2/8/2026 | 2/21/2026 | 2/25/2026 | 3/10/2026 |
| P6 | 2/22/2026 | 3/7/2026 | 3/11/2026 | 3/24/2026 |
| P7 | 3/8/2026 | 3/21/2026 | 3/25/2026 | 4/7/2026 |
| P8 | 3/22/2026 | 4/4/2026 | 4/8/2026 | 4/21/2026 |
| P9 | 4/5/2026 | 4/18/2026 | 4/22/2026 | 5/5/2026 |
| P10 | 4/19/2026 | 5/2/2026 | 5/6/2026 | 5/19/2026 |
| P11 | 5/3/2026 | 5/16/2026 | 5/20/2026 | 6/2/2026 |
| P12 | 5/17/2026 | 5/30/2026 | 6/3/2026 | 6/16/2026 |
| P13 | 5/31/2026 | 6/13/2026 | 6/17/2026 | 6/30/2026 |
| P14 | 6/14/2026 | 6/27/2026 | 7/1/2026 | 7/14/2026 |
| P15 | 6/28/2026 | 7/11/2026 | 7/15/2026 | 7/28/2026 |
| P16 | 7/12/2026 | 7/25/2026 | 7/29/2026 | 8/11/2026 |
| P17 | 7/26/2026 | 8/8/2026 | 8/12/2026 | 8/25/2026 |
| P18 | 8/9/2026 | 8/22/2026 | 8/26/2026 | 9/8/2026 |
| P19 | 8/23/2026 | 9/5/2026 | 9/9/2026 | 9/22/2026 |
| P20 | 9/6/2026 | 9/19/2026 | 9/23/2026 | 10/6/2026 |
| P21 | 9/20/2026 | 10/3/2026 | 10/7/2026 | 10/20/2026 |
| P22 | 10/4/2026 | 10/17/2026 | 10/21/2026 | 11/3/2026 |
| P23 | 10/18/2026 | 10/31/2026 | 11/4/2026 | 11/17/2026 |
| P24 | 11/1/2026 | 11/14/2026 | 11/18/2026 | 12/1/2026 |
| P25 | 11/15/2026 | 11/28/2026 | 12/2/2026 | 12/15/2026 |
| P26 | 11/29/2026 | 12/12/2026 | 12/16/2026 | 12/29/2026 |

- Dates change from pay period to pay period. Please double check your timesheet due date in advance.
- Please make sure the timesheet is complete and correct before submitting to iLIFE. If it is not on time or correct this will cause a delay in payment for the following scheduled pay run.

Submit Timesheets via:

Email: NCIL@iLIFE.org
Fax: 800-411-1569 and 888-339-2554
Mail: PO Box 80455, Milwaukee, WI 53208
Questions: 888-851-2420

(10/2025)



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Submit timesheets by: • Fax 1-800-441-1569 and 1-888-339-2554
• Email: NCIL@iLIFE.org
• Mail: iLIFE, 2020 West Wells Street, Milwaukee, WI 53233

Attendant Timesheet

Attendant Number: _____

Period Begins: _____ Consumer Name: _____

Period Ends: _____ Attendant Name: _____

Table with 7 columns: Day of Week, Date mo/day, Start time hh:mm am/pm, Stop time hh:mm am/pm, Start time hh:mm am/pm, Stop time hh:mm am/pm, Total Hours hh:mm. Rows for SUNDAY through SATURDAY.

Total hours for week 1: _____

Table with 7 columns: Day of Week, Date mo/day, Start time hh:mm am/pm, Stop time hh:mm am/pm, Start time hh:mm am/pm, Stop time hh:mm am/pm, Total Hours hh:mm. Rows for SUNDAY through SATURDAY.

Total hours for week 2: _____

Total hours for both weeks: _____

I certify that I worked the hours shown on this timesheet on the days indicated, and that this timesheet has been signed by the person receiving the services or his or her legal representative.
Attendant Signature: _____ Date: _____

As the person receiving the services, I certify that the Attendant's hours shown on this timesheet are correct and that the work was performed satisfactorily.
Consumer Signature: _____ Date: _____

Consumer Employer Handbook: How to be an Employer

Empower yourself to be a successful employer. Consider the following when hiring and supervising your Attendants:

Determine your support needs

1. What needs to be done?
 - a. What is the job?
 - b. How does it need to be done?
 - c. How often does it need to be done?
2. What are the hours?
 - a. When do you need support?
 - b. Are the hours flexible?
 - i. Cleaning and laundry can be done anytime, but bathing and dressing may require scheduling
 - c. Create a weekly schedule
3. Who will supervise?
 - a. How do you define quality work?
 - b. Who will approve the time sheets?
 - c. How will you share your expectations with Attendants?

Find an Attendant

1. Create a job posting – Use every opportunity to post your job.
 - a. Newspaper – Costs may occur
 - b. County – Your county may have a job bulletin board you can use
 - c. College campuses
2. Applications – How do you prefer the person to apply: over the phone or in person?
3. Interviewing – This is a necessary step to find the best Attendant
4. Background checks – iLIFE conducts these on your behalf
5. Make a job offer – Clearly communicate your expectations by providing new hires with a statement of the job, rate of pay, job duties and a schedule of hours

Create a job application

1. Request the following information from job applicants:
 - a. Name, address and phone number
 - b. Training or education
 - c. Skills and work experience



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- d. References
 - e. Authorization to check references
 - f. Signature
2. Topics to avoid:
- a. Height/weight/sex
 - b. Age
 - c. Race
 - d. Marital status
 - e. Religion
 - f. Has children or plans to have children

Interview the Attendant

- 1. An applicant should be treated the way you want to be treated
- 2. Thoroughly describe the position and responsibilities
- 3. Ask open-ended questions to encourage more than a yes or no answer
- 4. Allow the person to ask questions
- 5. Thank the person for his or her time

Good interview questions

- 1. What kind of experience do you have?
- 2. What skills do you have that would help you complete this job?
- 3. What are you looking for in a job?
- 4. What motivates you to do your job well?

Prohibited interview questions

- 1. Are you married?
- 2. Do you have children? Are you planning to?
- 3. Are you dating anyone?
- 4. Have your wages ever been garnished?
- 5. Do you have a disability?
- 6. How often do you drink?
- 7. What is your religion?

Hire the Attendant

- 1. Come to an agreement about hours and rate of pay
- 2. Provide required forms to be filled out



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Create a positive professional relationship

1. Communication is key
2. Be clear, honest and fair
3. State your expectations

Evaluate the Attendant

1. Be constructive
2. Give specific examples of how to improve

Eliminate misconduct (when needed)

1. Examples of misconduct include:
 - a. Your Attendant is late or absent
 - b. Your Attendant fails to follow rules or complete work
2. If misconduct occurs, provide a progressive discipline schedule such as:
 - a. First occurrence: a verbal notice and expectations of improvement
 - b. Second occurrence: a written notice and expectations of improvement
 - c. Third occurrence: a 30-day notice
 - d. Fourth occurrence: termination
3. If the Attendant commits a crime, such as theft or fraud, the Attendant may need to be terminated immediately
 - a. Contact your Counselor to discuss the Attendant's actions and possible legal actions to be taken

Terminate the Attendant (when needed)

1. Termination may be necessary for many reasons, including:
 - a. The Attendant found another job
 - b. The Attendant failed to meet the job requirements
 - c. The Attendant showed up late or was absent too often
2. If your Attendant is terminated from your employment, send notification to the Counselor and iLIFE of the following:
 - a. Reason for termination
 - b. Date of termination

OSHA Standard Precautions for Your Attendant

What are Standard Precautions?

Standard Precautions are basic infection control guidelines for your Attendants to follow as they perform their daily work. These guidelines help prevent the spread of blood borne diseases and infections.

Why should I worry about this?

As an employer, you must adhere to OSHA (Occupational Safety and Health Administration) guidelines to protect your Attendants. Also, you want to keep yourself and your Attendants free from communicable disease.



What do I need to do?

- Let your Attendants know you expect them to follow these guidelines.
- Remind them to wash their hands, supplying soap and clean towels or paper towels.
- Supply and require them to wear gloves when they are in contact with body fluids (i.e. feces, urine, mucous membranes, blood, saliva, etc.)
- If your physician requires that your Attendants wear gowns and masks, you must supply these items.
- Supply sharps containers for needle disposal if your Attendants assist you with injections.
- Review this information with your Attendants upon hire, annually and when needed.

Where can I get more information?

Get more information on OSHA guidelines and disease prevention from the following websites or your local County Health Department:

- www.osha.gov
- www.cdc.gov

Standard Precautions for Blood-borne Transmission



What is blood-borne transmission?

Blood-borne transmission means that a disease is spread when the blood of an infected person reaches the bloodstream of another person.

What are the Standard Precautions for blood-borne transmission?

Standard Precautions are what you should do to practice basic infection control against blood-borne diseases. Remember Standard Precautions apply to all your patients no matter what their diagnosis – even if they do not seem sick.

Standard Precautions include:

- Wash your hands after touching body fluids or contaminated items – even if you were wearing gloves
- Wash your hands whenever you remove a pair of gloves
- Wash your hands between patients
- Wear gloves whenever you touch blood, body fluids or contaminated items
- Put on clean gloves before you touch a patient's broken skin or mucous membranes
- Change gloves between tasks and patients
- Wear a gown to protect your skin and clothing from body fluids
- Remove a dirty gown as soon as possible and then wash your hands
- Wear a mask and eye protection to protect your mucous membranes from body fluids
- Keep your work environment as clean as possible by cleaning up spills and patient care areas promptly