Children's Long Term Support (CLTS) Program Employee Paperwork

Employee Forms Examples

- Participant Specific Training Certification
- Relationship Disclosure
- Choosing a Fiscal Agent: Statement of Understanding
- CLTS Worker Interest & Availability Form
- W-4: Employee Withholding Allowance Certificate (2026)
- WT-4: Employee's WI Withholding Exemption Certificate
- Form I-9
- F-03344: Wisconsin Medicaid Children's Long-Term Support (CLTS) Waiver Program Provider Agreement and Acknowledgment of Terms of Participation for Sole Proprietor or Individual Waiver Service Providers
- F-82064: Background Information Disclosure (BID) for Entity Employees and Contractors
- Fiscal Agent Employer/Client and Employee Agreement
- Fiscal Agent Employee Direct Deposit Authorization

iLIFE
Choice. With Confidence.

Updated: 10/2026

INSTRUCTIONS

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

Name of Child Receiving Services: The name of the child (Employer/Client) receiving services.

Knowledge/skill level required: Check the boxes that coordinate to each skill that is required if the skill level required is met.

Parent/Employer Signature: The Employer, Parent or Legal Representative signature.

Employee Signature: The Employee's signature.

Date: The date the form was signed and completed in mm/dd/yyyy format

EXAMPLE:
Participant Specific Training Certification

Participant Specific Training Certification

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

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

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

Name of Child Receiving Services: First and Last Name of Child Receiving Services

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

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

Employer/Client, Parent, or Legal Representative Signature	Employee Signature	mm/dd/yyyy
Parent/Employer Signature	Employee Signature	Date

INSTRUCTIONS

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

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

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

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

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

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

Employee Signature: The Employee's signature.

Date Signed: The date the Employee signed this form.

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

Date Signed: The date the Employer/Client, Parent, or Legal Representative signed this form.

EXAMPLE:
Relationship Disclosure Form

Relationship Disclosure Form

Employee Name: **Employee's First and Last Name**

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

Employer/Client Name: **Employer/Client First and Last Name**

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

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

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

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

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

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

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

± Due to your relationship with the Employer/Client and current legislation, you are exempt from payroll taxes for Social Security and Medicare (FICA). By not paying into Social Security and Medicare (FICA), it means you are not earning Social Security work credits. Any applicable exemptions cannot be waived.

‡ Per Wis. Statute 770.05, Domestic Partnership means you and your same sex partner have filed for Domestic Partnership, and have a certified copy of your Declaration of Domestic Partnership.

Residency Disclosure

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

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

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

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

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

INSTRUCTIONS

Read each statement carefully. When finished reading, check the box coordinating with each statement, indicating you understand the statement.

Choosing a Fiscal Agent: Statement of Understanding

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

- ☑ Recruiting, interviewing, and hiring the employee
- ☑ Providing initial and ongoing training regarding the care needs of the child and their job-related responsibilities
- ☑ Providing training regarding confidentiality concerns and expectations
- ☑ Setting the employee's wage (within the limits of what the waiver will reimburse for the particular service the employee performs and with the approval of iLIFE and the CLTS Waiver Agency),realizing that **wages will be withheld** if employee and parent/employer representative are not compliant with iLIFE and CLTS guidelines and timelines
- ☑ Supervising employee performance, providing feedback as appropriate
- ☑ Setting and enforcing expectations with regard to professionalism in the home, scheduling changes or conflicts, types of acceptable communication, amount of notice requested for vacating the position, etc.
- ☑ Preparing a back-up plan in the event that the scheduled employee is not able to meet the needs of the child/family
- ☑ **Ensuring that the employee does NOT work over 40 hours/week** (unless employee is authorized)
- ☑ Disciplining and terminating the employee, if parent/employer feels that to be appropriate and necessary
- ☑ Considering insurance coverage/implications in the event that the employee is injured while providing care. Employees will be eligible for Worker's Compensation under iLIFE.
- ☑ Ensuring that all paperwork (both employer's and employee's) is submitted to iLIFE and approved by iLIFE prior to the employee's first date of service to the child
  **No services provided prior to iLIFE's approval date will be paid.

INSTRUCTIONS

Parent/Employer Signature: The Employer's, Parent's, or Legal Representative's Signature.

Employee Signature: The Employee's Signature.

Date: The date in mm/dd/yyyy format of when the document was signed.

Name of child receiving services: First and last name of the child receiving services (Employer/Client),

Choosing a Fiscal Agent: Statement of Understanding

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

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

Employer, Parent, or Legal Representative Signature

Parent/Employer Signature

Employee Signature

Employee Signature

mm/dd/yyyy

Date

First and Last Name of Child Receiving Services (Employer)

Name of child receiving services

INSTRUCTIONS

EMPLOYEE'S SECTION

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

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

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

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

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

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

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

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

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

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

Signature: The Employee's signature.

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

EMPLOYER'S SECTION

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

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

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

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

Title: "HHCSR" if being completed by the Employer/Client or "Parent" or "Legal Representative" if being completed by their representative.

EXAMPLE:
Employee WI Withholding Exemption Certificate

Save | Print | Clear

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

Employee's legal name (first name, middle initial, last name)	Social security number	
Employee Last Name, First Name and Middle Initial	###-##-####	☑ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, check the Single box.
Employee's address (number and street)	Date of birth	
Employee's Street Address	mm/dd/yyyy	
City / State / Zip code	Date of hire	
City / State ZIP Code	mm/dd/yyyy	

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

1. (a) Exemption for yourself – enter 1 . . . . . #
   (b) Exemption for your spouse – enter 1 . . . . . #
   (c) Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent . . . . .
   (d) Total – add lines (a) through (c) . . . . . #
2. Additional amount per pay period you want deducted (if your employer agrees) . . . . .
3. I claim complete exemption from withholding (see instructions). Enter "Exempt" . . . . .

I CERTIFY that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming complete exemption from withholding, I certify that I incurred no liability for Wisconsin income tax for last year and that I anticipate that I will incur no liability for Wisconsin income tax for this year.

Signature Employee Signature Date Signed Month Day , Year

EMPLOYEE INSTRUCTIONS:

- **WHO MUST COMPLETE:**
  Effective on or after January 1, 2020, every newly-hired employee is required to provide a completed Form WT-4 to each of their employers. Form WT-4 will be used by your employer to determine the amount of Wisconsin income tax to be withheld from your paychecks. If you have more than one employer, you should claim a smaller number or no exemptions on each Form WT-4 provided to employers other than your principal employer so that the total amount withheld will be closer to your actual income tax liability.

  You must complete and provide your employer a new Form WT-4 within 10 days if the number of exemptions previously claimed DECREASES.

  You may complete and provide to your employer a new Form WT-4 at any time if the number of your exemptions INCREASES.

  Your employer may also require you to complete this form to report your hiring to the Department of Workforce Development.

- **UNDER WITHHOLDING:**
  If sufficient tax is not withheld from your wages, you may incur additional interest charges under the tax laws. In general, 90% of the net tax shown on your income tax return should be withheld.

- **OVER WITHHOLDING:**
  If you are using Form WT-4 to claim the maximum number of exemptions to which you are entitled and your withholding exceeds your expected income tax liability, you may use Form WT-4A to minimize the over withholding.

WT-4 Instructions – Provide your information in the employee section.

- **LINE 1:**
  (a)-(c) Number of exemptions – Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1(a)-(c) or you may enter into an agreement with your employer to have additional amounts withheld (see instruction for line 2).

  (c) Dependents – Those persons who qualify as your dependents for federal income tax purposes may also be claimed as dependents for Wisconsin purposes. The term "dependents" does not include you or your spouse. Indicate the number of dependents that you are claiming in the space provided.

- **LINE 2:**
  Additional withholding – If you have claimed "zero" exemptions on line 1, but still expect to have a balance due on your tax return for the year, you may wish to request your employer to withhold an additional amount of tax for each pay period. If your employer agrees to this additional withholding, enter the additional amount you want deducted from each of your paychecks on line 2.

- **LINE 3:**
  Exemption from withholding – You may claim exemption from withholding of Wisconsin income tax if you had no liability for income tax for last year, and you expect to incur no liability for income tax for this year. You may not claim exemption if your return shows tax liability before the allowance of any credit for income tax withheld. If you are exempt, your employer will not withhold Wisconsin income tax from your wages.

  You must revoke this exemption (1) within 10 days from the time you expect to incur income tax liability for the year or (2) on or before December 1 if you expect to incur Wisconsin income tax liabilities for the next year. If you want to stop or are required to revoke this exemption, you must complete and provide a new Form WT-4 to your employer showing the number of withholding exemptions you are entitled to claim. This certificate for exemption from withholding will expire on April 30 of next year unless a new Form WT-4 is completed and provided to your employer before that date.

Employer's Section

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

EMPLOYER INSTRUCTIONS for Department of Revenue:

- If you do not have a Federal Employer Identification Number (FEIN), contact the Internal Revenue Service to obtain a FEIN.
- If the employee has claimed more than 10 exemptions OR has claimed complete exemption from withholding and earns more than $200.00 a week or is believed to have claimed more exemptions than they are entitled to, mail a copy of this certificate to: Wisconsin Department of Revenue, Audit Bureau, PO Box 8906, Madison WI 53708 or fax (608) 267-0834.
- Keep a copy of this certificate with your records. If you have questions about the Department of Revenue requirements, call (608) 266-2772 or (608) 266-2776.

EMPLOYER INSTRUCTIONS for New Hire Reporting:

- This report contains the required information for reporting a New Hire to Wisconsin. If you are reporting new hires electronically, you do not need to forward a copy of this report to the Department of Workforce Development. Visit https://dwd.wi.gov/uinh/ to report new hires.
- If you do not report new hires electronically, mail the original form to the Department of Workforce Development, New Hire Reporting, PO Box 14431, Madison WI 53708-0431 or fax toll free to 1-800-277-8075.
- If you have questions about New Hire requirements, call toll free (888) 300-HIRE (888-300-4473). Visit dwd.wi.gov/uinh/ for more information.

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

INSTRUCTIONS

SECTION 1
Completed by the Employee.

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

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

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

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

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

E-mail Address: Employee's email address.

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

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

Signature of Employee: The Employee's signature.

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

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

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

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

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

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

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

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
Employee 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	# # # - # # - # # # #	Employee'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. An alien authorized to work until (exp. date, if any)

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

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

Signature of Employee	Today's Date (mm/dd/yyyy)
Employee 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.

EXAMPLE: I-9
Page 1 continued

SECTION 2
Completed by the Employer/ Client or his/her Representative.

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

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

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

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

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

Last Name, First Name, and Title of Employer, Parent, or Legal 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 their Parent or Legal Representative if they are completing this form on the Participant/Employer's behalf.

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

Employer's Business or Organization Name: "HCSR"

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

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1			Wisconsin Driver's License		Social Security Card
Issuing Authority			WI Department of Transportation		Social Security Administration
Document Number (if any)			###-####-####-##		###-##-####
Expiration Date (if any)			mm/dd/yyyy		N/A
Document Title 2 (if any)			Additional Information		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

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

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

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

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

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

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

Form I-9 Edition 01/20/25 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, sex, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on I-9 Central for more information.

INSTRUCTIONS

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

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

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

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

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

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

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

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

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

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

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

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

Signature of Preparer or Translator	Date *(mm/dd/yyyy)*
Preparer or Translator Signature	mm/dd/yyyy

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

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

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

Signature of Preparer or Translator	Date *(mm/dd/yyyy)*

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

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

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

Signature of Preparer or Translator	Date *(mm/dd/yyyy)*

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

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

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

Signature of Preparer or Translator	Date *(mm/dd/yyyy)*

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

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

INSTRUCTIONS

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

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

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

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

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

Expiration Date: The date that the document expires.

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

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

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

Additional Information: Any additional information that may be needed.

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

Supplement B, Reverification and Rehire (formerly Section 3)

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

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

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

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

NPI (if applicable): The NPI number if applicable.

Medicaid Assigned Provider ID (When assigned): If assigned, write down the Medicaid Provider ID.

Address, City, State, and Zip Code: Write down the Provider's physical practical street address, city, state, and zip code.

Signature and Date: The Provider's signature and date the document was signed.

Title: Title of Provider if applicable.

F-03344

Name – Provider (Legal name listed on W-9): **Provider's Legal First and Last Name**

NPI (if applicable): _____

Medicaid-Assigned Provider ID (When assigned): _____

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

Street Address Line 1: **Street Address where Provider is in Practice**

Street Address Line 2: _____

City: **City** State: _____ ZIP+4 Code: _____

Signature – Provider or Authorized Representative	Date Signed
Provider or Authorized Representative's Signature	**mm/dd/yyyy**
Title	

For DMS Use Only (Do not write below this line.)

Signature	Date
	2/10/25

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

EXAMPLE: F-82064
Background Information Disclosure (BID) for Entity Employees and Contractors

INSTRUCTIONS

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

Describe the position for which you are applying or renewing: Enter "Employee"

Full Legal Name – (First, Middle, and Last): The Employee's legal first, middle, and last name.

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

Social Security Number (SSN): The Employee's SSN.

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

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

Phone Number: The Employee's phone number.

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

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

Continued on Page 2

Department of Health Services
F-82064 (07/2026)

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

Background Information Disclosure (BID)
Entity Employees and Contractors

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

Type

- [x] Applicant/employee
- [ ] Contractor – Name of company: _____
- [ ] Student – Name of school: _____
- [ ] Volunteer – Name of organization: _____
- [ ] Household member
- [ ] Other - specify: _____

Describe the position for which you are applying or renewing: **Position Description**

Applicant information

Name (First): **Employee's First Name** Name (Middle): **Employee's Middle Name**
Name (Last): **Employee's Last Name**

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

- [x] Yes
- [ ] No

If yes, list each name fully: **Any other names the Employee has used**

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

Sex: [ ] Male [x] Female Phone number: **Employee's Phone Number**

Address – Street: **Employee's Street Address**

City: **City** State: **State** ZIP code: **ZIP**

Employer or organization verifying eligibility

Name of employer or organization that asked you to complete this form:
Name of Employer/Client or Organization that asked you to complete this form

Address – Street: **Street Address of Employer or Organization**

City: **City** State: **State** ZIP code: **ZIP**

INSTRUCTIONS

Disclosures: For each question, check either "Yes" or "No".

Note: Some questions require additional information. Please read carefully.

Disclosures

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

1. Pending criminal charges

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

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

2. Convictions for crimes

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

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

3. Abuse or neglected or a child

Please note that Wis. Stat. § 48.981, *abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.

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

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

4. Abuse or neglect of an adult

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

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

5. Stealing or other misappropriation

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

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

Attestation:

Read , Sign, and Date:: Read the attestation carefully. When finished, the Employee with sign and date when this form was completed.

F-82064 Page 4 of 4

12. Government employee

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

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

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

Review your responses and the following attestation carefully before signing.

Attestation

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

Signature — Person completing this form: Employee's Signature

Date signed: mm/dd/yyyy

INSTRUCTIONS

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

Employee Name: The Employee's name.

Employer/Client Tasks and Duties: List the tasks and duties the Employee would perform for the Employer/Client.

Employee Schedule: Check the box next to each day the Employee will work.

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

Example: Every other week.

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

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

Employee Signature and Date: The Employee's signature and date this form was signed.

Employer/Client Signature and Date: The signature of the Employer/Client and date this form was signed.

EXAMPLE:
Fiscal Agent Employer/Client and Employee Agreement

Fiscal Agent Employer/Client and Employee Agreement

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

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

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

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

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

☐ Other: _____

☑ Mileage (miles per week): **# of miles per week**

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

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

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

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

INSTRUCTIONS:

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

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

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

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

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

Employee Number: The Employee's iLIFE Employee Number.

Signature: The Employee's signature.

Date: The date the Employee signed this form.

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

EXAMPLE:
Fiscal Agent Employee Direct Deposit Authorization

Fiscal Agent Employee Direct Deposit Authorization

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

Name of Financial Institution: **Name of Financial Institution**

Routing Number: **##########**

Account Number: **##########**

Type of Account: ☑Checking ☐Savings

Required Documents

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

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

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

Employee Name (printed): **Employee Name**

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

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

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