

# Employee Set-Up Form

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**Instructions:** Please fill out all information below, where applicable. The employee must sign and date the bottom in order to be considered complete.

## Employee's Information

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## Member/Employer's Information *(Please do not put Guardian or POA information here - member only)*

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_



106 S. Beaumont Rd.  
Prairie du Chien WI 53821  
Fax: 844-634-7225  
Phone: 608-326-0434

## Employee and Member / Employer Agreement

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\_\_\_\_\_ has been hired by \_\_\_\_\_  
(Employee) (Member/Employer)

Employee will provide care services through the self-directed services program to the Member/Employer.

LKiChoice, a division of Lori Knapp Richland, Inc. has been chosen to assist the Member/Employer with administrative tasks, enrollment setup, and payroll services.

As the Employee, I agree to:

- Complete all documents that are required to be an Employee of a Fiscal Member (your Employer).
- Not begin working and filling out timesheets until all required paperwork from LKiChoice and a Background Check has been completed, returned, processed, and approved. This includes a Background Check that has been ran and approved by my Member/Employer's Funding Source. Then a start date will be given to me to start working for my Member/Employer.
- Aid in the correction of any errors that may occur with processing payroll.
- Work with my Member/Employer to provide them with the best cares and outcomes possible.
- Stay within the guidelines of what is authorized for hours worked and tasks required.
- Follow HIPAA and confidentiality requirements.
- Follow standard precautions and perform all work-related tasks in a safe manner.
- Accurate timesheet reporting. Failure to do this could result in fraud and/or abuse reporting.
- Follow processes and procedures of EVV (Electronic Visit Verification) if applicable to my Member/Employer. EVV will be mandatory and could affect payroll if not used appropriately.
- Report concerns of safety, health, or well-being of the person I am caring for to your Member/Employer's Care Manger.
- Report current charges or pending allegation of abuse or neglect to your Member/Employer's Care Manger or LKiChoice.
- Report any convictions that occur after your start date to your Member/Employer and LKiChoice.
- Report work-related injury, within 24 hours to LKiChoice at 1-844-534-7225.
- Notify LKiChoice, if I do not work within 60 days.
- Notify and send an updated form to LKiChoice, of changes to my mailing address.
- Notify and send an updated form to LKiChoice, of changes to my Direct Deposit information (Direct Deposit information will not be updated without a completed form on file). Changes to Direct Deposit information need to be made 5 business days before pay dates.
- Notify and send an updated form to LKiChoice, of any changes on my State or Federal deductions. (This will require an updated W4 or WT4 form completed)
- Notify and send an updated form to y LKiChoice, if my name changes.



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Lori Knapp Richland, Inc.  
[www.lkchoice.com](http://www.lkchoice.com)

## Employee and Member / Employer Agreement

I understand that my timesheet needs to be turned in according to the Time Report and Pay Schedule provided. Submission of timesheets and the use of EVV (if applicable) after the due date will delay pay. The late timesheet will be processed on the following scheduled payroll date.

I understand LKiChoice is not responsible for payment of services if I provide duties to the Member/Employer that are not approved. If I work more hours than approved by the Funding Source or if the Member/Employer is no longer eligible for services under this program.

I understand that if no person is designated on my Employer’s Member Authorization form from LKiChoice to sign off on timesheets due to my Member/Employer’s incapacitation or death, that I will need to wait to be paid until a person from their Estate is deemed legally responsible to sign my timesheets.

I understand I am the Employee of \_\_\_\_\_(Enter Member/Employer Name).

I understand my Member/Employer is responsible for all employment actions which might include orientation, training, supervising, disciplinary action, termination, management, and other Member/Employer - related functions.

I understand that LKiChoice **is not** my Employer but provides the payroll services and administrative tasks for my Member/Employer. If I have employment concerns, I need to discuss these with my Member/Employer.

Employee signature: \_\_\_\_\_ Date \_\_\_\_\_

Member/Employer signature: \_\_\_\_\_ Date \_\_\_\_\_



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[www.lkichoice.com](http://www.lkichoice.com)

## Relationship Questionnaire

EMPLOYEE NAME: \_\_\_\_\_

MEMBER/EMPLOYER NAME: \_\_\_\_\_

**Please answer the questions below to determine appropriate tax-exempt status.**

**1. LIVE IN:** Do you permanently reside in the same residence as your Member/Employer?

- No       Yes - You are exempt from overtime.

**2.** What is your legal relationship to your Member/Employer? I am the Member/Employer's: (check only one box)

<input type="checkbox"/>	Child/Step under 21 years old (S,F,FI)	<input type="checkbox"/>	Child/Step over 21 years old (S)
<input type="checkbox"/>	Domestic Partner* (S)	<input type="checkbox"/>	Grandchild (S)
<input type="checkbox"/>	Parent (S,F,FI)	<input type="checkbox"/>	Sibling
		<input type="checkbox"/>	Grandparent (S)
		<input type="checkbox"/>	Spouse (S,F,FI)

*\*Per Wisconsin Statute 770.05, Domestic Partnership mean you and your same sex partner have filed for Domestic Partnership and have a certified copy of your Declaration of Domestic Partnership. **Please submit proof of Domestic Partnership to claim this relationship.***

**3.** Are you under the age of 18 or will turn 18 this year?

- Yes – I am under the age of 18 or will turn 18 this year. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
- No – I am not under the age of 18.

3a. If Yes:

Is this job or performing household services your principal occupation? If you are a student, check "No".

- Yes – This job or performing household services is my principal occupation and I am NOT a student.
- No – I am a student, providing household services which is not considered my principal occupation.

By signing, I acknowledge I have truthfully answered the above questions. I understand my Employer is a Household Employer according to the IRS. Payroll is processed according to IRS Publication 926, which may indicate I am exempt for certain payroll taxes. I understand according to Wisconsin Department of Workforce Development, Unemployment Insurance Division, my Member/Employer is a Sole Proprietor and Domestic Employer. I understand I may not be eligible to State Unemployment Benefits as indicated in UBC-201-P. I also understand exemptions and/or unemployment eligibility-based on my relationship with the Member/Employer is not optional.

Employee Signature

Date





# Payroll Information Form

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address (Required for EVV): \_\_\_\_\_

**Please check all that apply:**

- Receive paystub via email**
- Secure Email** - Allows you to send timesheets or other information securely.
- Web Entry** Allows you to submit payroll hours using our Web Entry Portal, both you and the Member/Employer will need to have an email at **Page 1 of 20** Web Entry.
- Direct Deposit\*** - Complete below sections. You may also include a Voided Check.
- Paper Check** – no direct deposit, mail check

*\*With direct deposit, Employees have their pay directly deposited in their account on payday rather than waiting for a check to arrive in the mail.*

Name of Bank: \_\_\_\_\_

Action to be taken:  New Deposit Authorization  Change from previous authorization

Type of Account:  Checking  Savings Amount: \_\_\_\_\_%

Account #: \_\_\_\_\_

9-Digit Routing #: \_\_\_\_\_

**\*For Multiple Accounts:**

Name of Bank: \_\_\_\_\_

Action to be taken:  New Deposit Authorization  Change from previous authorization

Type of Account:  Checking  Savings Amount: \_\_\_\_\_%

Account #: \_\_\_\_\_

9-Digit Routing #: \_\_\_\_\_

*LKiChoice, a division of Lori Knapp Richland, Inc., is authorized to directly deposit my pay to the account(s) identified in this document, which include my signature and date. Authorization will remain in effect until I modify, cancel in writing, or employment terminates.*

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

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

Refer to DQA form [F-82064A, Instructions](#), for additional information.

**Check the box that applies to you.**

- |   |  |
|---|--|
| <input type="checkbox"/> Applicant / Employee | <input type="checkbox"/> Student / Volunteer |
| <input type="checkbox"/> Contractor           | <input type="checkbox"/> Other – Specify:    |

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

Full Legal Name – <i>First</i>	<i>Middle</i>	<i>Last</i>
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Other Names (including prior to marriage)

Position Title ( applied for or existing) <b>Caregiver</b>	Birth Date (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Home Address	City	State	Zip Code
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Business Name and Address – Employer (Entity)

**Answering “NO” to all questions does not guarantee employment, a contract, or service agreement.**

If more space is required, attach additional documentation to this form and indicate “see attached” in your answer.

**SECTION A – DISCLOSURES**

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?  
 If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.  
 You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

Yes    No  
   

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?  
 If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.  
 You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.

Yes    No  
   

3. Please note that Wis. Stat. § 48.981, *Abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.  
 Has any government or regulatory agency (other than the police) ever found that you committed **child** abuse or neglect?  
 Provide an explanation below, including when and where the incident(s) occurred.

Yes    No  
   

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected **any person or client**?  
 If **Yes**, explain, including when and where it happened.

Yes    No

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?  
 If **Yes**, explain, including when and where it happened.

Yes No

6. Has any government or regulatory agency (other than the police) ever found that you abused an **elderly person**?  
 If **Yes**, explain, including when and where it happened.

Yes No

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?  
 If **Yes**, explain, including credential name, limitations or restrictions, and time period.

Yes No

**SECTION B – OTHER REQUIRED INFORMATION**

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services?  
 If **Yes**, explain, including when and where it happened.

Yes No

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility?  
 If **Yes**, explain, including when and where it happened and the reason.

Yes No

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component?  
 If **Yes**, indicate the year of discharge:  
 Attach a copy of your DD214, if you were discharged within the last three (3) years.

Yes No

4. Have you resided outside of Wisconsin in the last three (3) years?  
 If **Yes**, list each state and the dates you resided there.

Yes No

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years?  
 If **Yes**, list each state and the dates you resided there.

Yes No

6. Have you had a caregiver background check done within the last four (4) years?  
 If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

Yes No

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe?  
 If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Yes No

**Read and initial the following statement.**

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

<b>NAME – Person Completing This Form</b>	<b>Date Submitted</b>
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### Employee's Withholding Certificate

OMB No. 1545-0074

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

**2023**

<b>Step 1:</b> <b>Enter Personal Information</b>	<b>(a)</b> First name and middle initial	Last name	<b>(b)</b> Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	<b>(c)</b> <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

**Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5.** See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

**Step 2: Multiple Jobs or Spouse Works**

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

Do **only one** of the following.

**(a)** Reserved for future use.

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

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

**TIP:** If you have self-employment income, see page 2.

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

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 . . . . . \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . .	<b>3</b>	\$
<b>Step 4 (optional): Other Adjustments</b>	<b>(a) Other income (not from jobs).</b> If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . .	<b>4(a)</b>	\$
	<b>(b) Deductions.</b> If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . .	<b>4(b)</b>	\$
	<b>(c) Extra withholding.</b> Enter any additional tax you want withheld each <b>pay period</b> . .	<b>4(c)</b>	\$

<b>Step 5:</b> <b>Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	<b>Employee's signature</b> (This form is not valid unless you sign it.)	<b>Date</b>	

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)
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## General Instructions

Section references are to the Internal Revenue Code.

### Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

### Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

**Exemption from withholding.** You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

**Your privacy.** If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

**Self-employment.** Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

**Nonresident alien.** If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

## Specific Instructions

**Step 1(c).** Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

**Step 2.** Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



**Multiple jobs.** Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

**Step 3.** This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

### Step 4 (optional).

**Step 4(a).** Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

**Step 4(b).** Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

**Step 4(c).** Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b) – Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables.

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3
2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a
b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b
c Add the amounts from lines 2a and 2b and enter the result on line 2c
3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.
4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld)

Step 4(b) – Deductions Worksheet (Keep for your records.)



- 1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income
2 Enter: { \$27,700 if you're married filing jointly or a qualifying surviving spouse; \$20,800 if you're head of household; \$13,850 if you're single or married filing separately }
3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

**Married Filing Jointly or Qualifying Surviving Spouse**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
\$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
\$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
\$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

**Single or Married Filing Separately**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
\$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
\$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
\$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

**Head of Household**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
\$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
\$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
\$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
\$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600



# Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

**WT-4**

**Employee's Section** (Print clearly)

Employee's legal name ( <i>first name, middle initial, last name</i> )			Social security number		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note:</b> If married, but legally separated, check the Single box.
Employee's address ( <i>number and street</i> )			Date of birth		
City	State	Zip code	Date of hire		

**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 \_\_\_\_\_ Date Signed \_\_\_\_\_

**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's payroll address ( <i>number and street</i> ) 106 South Beaumont Road			City Prairie du Chien	State WI
Completed by Natalie Freymiller			Title Fiscal Agent	Zip code 53821
Phone number (608) 326-0434		Email		

**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/](http://dwd.wi.gov/uinh/) for more information.





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

**USCIS**  
**Form I-9**

OMB No. 1615-0047  
 Expires 10/31/2022

► **START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

**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	Other Last Names Used (if any)		
Address (Street Number and Name)			Apt. Number	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's E-mail Address		Employee's Telephone Number		
	□ □ □ □ - □ □ □ □						

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States		
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>		
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____		
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	QR Code - Section 1 Do Not Write In This Space	
<i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:          An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i>		
1. Alien Registration Number/USCIS Number: _____		
2. Form I-94 Admission Number: _____		
3. Foreign Passport Number: _____		
Country of Issuance: _____		

Signature of Employee	Today's Date (mm/dd/yyyy)
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**Preparer and/or Translator Certification (check one):**

I did not use a preparer or translator.  A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
*(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)*

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		Today's Date (mm/dd/yyyy)		
Last Name (Family Name)		First Name (Given Name)		
Address (Street Number and Name)		City or Town	State	ZIP Code



*Employer Completes Next Page*





EXAMPLE ONLY

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Form with columns for Employee Info from Section 1, List A, List B, and List C. Includes fields for Document Title, Issuing Authority, Document Number, and Expiration Date. A large red watermark 'EXAMPLE ONLY' is overlaid on the bottom half.

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment (mm/dd/yyyy): (See instructions for exemptions)

Signature and contact information section. Includes fields for Signature of Employer or Authorized Representative, Today's Date, Title of Employer or Authorized Representative, Last Name, First Name, Employer's Business or Organization Name, Address, City or Town, State, and ZIP Code.

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

Section 3 sub-sections A and B. A: New Name (if applicable) with fields for Last Name, First Name, Middle Initial. B: Date of Rehire (if applicable) with field for Date.

Section 3 sub-section C: If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below. Fields for Document Title, Document Number, Expiration Date.

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 document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Final signature section with fields for Signature of Employer or Authorized Representative, Today's Date, and Name of Employer or Authorized Representative.

## LISTS OF ACCEPTABLE DOCUMENTS

### All documents must be UNEXPIRED

Employees may present one selection from List A  
or a combination of one selection from List B and one selection from List C.

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	OR	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	AND	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <b>a.</b> Foreign passport; and <b>b.</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 alien's nonimmigrant status 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
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
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		<b>For persons under age 18 who are unable to present a document listed above:</b>		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
	12. Day-care or nursery school record			

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

**Refer to the instructions for more information about acceptable receipts.**



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

**USCIS**  
**Form I-9**  
 OMB No. 1615-0047  
 Expires 10/31/2022

**Section 2. Employer or Authorized Representative Review and Verification**

*(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")*

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

**Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.**

**The employee's first day of employment (mm/dd/yyyy):** \_\_\_\_\_ *(See instructions for exemptions)*

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Employer's Business or Organization Address (Street Number and Name)	City or Town	State      ZIP Code

**Section 3. Reverification and Rehires** *(To be completed and signed by employer or authorized representative.)*

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

**C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.**

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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DEPARTMENT OF HEALTH SERVICES  
 Division of Long Term Care  
 F-00180A (11/2009)

STATE OF WISCONSIN  
 42 CFR 431.107

**WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND  
 ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION**

**FOR INDIVIDUAL OR NON-SPECIFIED WAIVER SERVICE PROVIDERS<sup>1</sup>**

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

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Telephone Number	
Address – Street	City	State	Zip Code

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

1. To provide only the items or services authorized by the local waiver administrative agency.
2. To accept the payment issued by the local waiver administrative agency as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the local waiver administrative agency.
5. To keep records of the items or services provided.
6. To provide, upon request by the local waiver administrative agency or Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations and policies relating to providing home and community-based waiver services under Wisconsin’s Medicaid program.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant’s status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant’s right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants **for a period of seven (7) years** and to furnish upon request to the Department, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. (For state policy related to record retention see DHS 106.02, Wis. Administrative Code or the DLTC numbered memo addressing record retention available at [http://dhs.wisconsin.gov/dsl\\_info/NumberedMemos/DSL/CY\\_2001/NMemo2001-07.htm](http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DSL/CY_2001/NMemo2001-07.htm) .)
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the waiver agency and upon request, to the Department in writing:

<sup>1</sup> Note: This agreement is intended to be used for providers who are individuals, unaffiliated with an agency or service. It is also to be used by a company or organization that provides waiver funded services and who are not typically Medicaid program providers and who may not be specifically listed in the Medicaid Waivers Manual (e.g., carpenters and other skilled trades providing home modifications or those doing specialty work such as vehicle modifications, etc.)

- a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;
- b) The names and addresses of all persons who have a controlling interest in the provider;
- c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;
- d) The names and addresses of any subcontractors who have had business transactions with the provider;
- e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

Pursuant to 42 CFR § 447.10(e), I hereby voluntarily reassign my right to direct payment from the State to each local waiver administrative agency that has authorized me to provide waiver services to an individual waiver participant.

If you check yes, it means that you will receive payment from the local waiver administrative agency that is responsible for the participants to whom you are authorized to provide waiver services rather than directly from the State Medicaid Agency.

Yes       No

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

Name – Provider (Typed or Printed)

SIGNATURE – Provider

Date Signed

SIGNATURE – Waiver Agency Representative

Date Signed

*Beth Culp*

Print Name – Waiver Agency Representative

*Beth Culp*



# CONSUMER & NEW PRIVATE PROVIDER TO COMPLETE TOGETHER

**\*Please keep a copy for you records\***

## WINNEBAGO COUNTY DHS SUPPORTIVE HOME CARE / RESPITE AGREEMENT

CONSUMER/REPRESENTATIVE

EMPLOYEE/PRIVATE PROVIDER

NAME

NAME

ADDRESS

ADDRESS

CITY

ZIP CODE

CITY

ZIP CODE

TELEPHONE

TELEPHONE

- We, the above named persons, agree to the following Supportive Home Care/Respite services:  
 Service Beginning Date: \_\_\_\_\_ Service Ending Date: \_\_\_\_\_ (leave blank if ongoing)

Personal Care Activities: \_\_\_\_\_

Household Care Activities: \_\_\_\_\_

Other Activities: \_\_\_\_\_

- Provider's Work Schedule: \_\_\_\_\_

- Rate of reimbursement based on actual services rendered, exclusive of any deductions:  
 (check one)  Hourly \$\_\_\_\_\_ and # of hours/day/week/month \_\_\_\_\_  
 Other: (specify rate, # of units/day/week/month) \_\_\_\_\_

- Provider will come to work reliably and on time per the schedule noted above.
- Provider will perform his/her assigned duties in a thorough and competent manner. Provider is responsible for assignments noted above but not for additional assignments and errands.
- Provider is employed to provide care and services for the agreed upon needs of the individual. This agreement does not include providing care or services for other household individuals.
- Provider will not be under the influence of alcohol or other drugs during scheduled work hours.
- Provider will give the employer/representative at least a two-week notice prior to service termination.



Consumer/Representative



Private Provider

Date

Date

## Documentation of Training for: Supportive Home Care (SHC), Respite, Specialized Child Care, and Daily Living Skills (DLTS) in County Funded Self-Direction FEA

-----  
***Before filling out this form please make sure to read the portion on Exemptions. This form is not optional, a start date of employment will not be given until the form is completed and returned.***

Name of Employee:
Name of Employer:

**Exemption:** If you are currently: Certified Nursing Assistant (C.N.A.), Licensed Practical Nurse (LPN), Registered Nurse (RN), and Personal Care Worker (PCW) then you may be exempted from training on #5-7 below. This is **only** if a copy of proof of licensure, certification or credentialing is sent with this form.

SHC and/or Respite Services – Required Training 1. Orientation to policies & Employer’s cares 2. Safe Provision of Services 3. Recognizing & Responding to Emergencies 4. Employer Specific Information 5. General Target group information 6. Working Effectively with Employer 7. Homemaking/Household Services	<input type="checkbox"/> Required Training Completed by Employer/Member or Representative <b>with</b> Employee
DLTS and/or Specialized Child Care – Required Training 1. Orientation to policies & Employer’s cares 2. Safe Provision of Services 3. Recognizing & Responding to Emergencies 4. Employer Specific Information 5. General Target Group Information 6. Working Effectively with Employer 7. Homemaking/Household Services	<input type="checkbox"/> Required Training Completed by Employer/Member or Representative <b>with</b> Employee

Details on each of the 7 areas above are below to train on.

Policies, procedures, and expectations of Employer and Employee duties, including training on Member and Employee rights and responsibilities; time sheet keeping and reporting, and other information deemed necessary and appropriate.

Understand of all confidentiality and privacy laws and rules.

Understanding of procedures for handling complaints.



106 S. Beaumont Rd.  
 Prairie du Chien WI 53821  
 Fax: 844-634-7225  
 Phone: 608-326-0434



## Documentation of Training for: Supportive Home Care (SHC), Respite, Specialized Child Care, and Daily Living Skills (DLTS) in County Funded Self-Direction FEA

Information specific to disabilities, abilities, needs, functional deficits, and strengths of the Member served. This training should be Member specific.

Recognizing and appropriately responding to all conditions that might adversely affect the Members health and safety, including how to respond to emergencies and critical incidents specifically for your Employer/Member.

Developing interpersonal and communications skills that are appropriate and effective for working with your specific Member. These skills should include understanding the principles of person-centered services; consumer rights; respect for age; cultural, linguistic, and ethnic differences; active listening, responding with emotional support and empathy; ethics in dealing with you Member, including family and other providers of the Member; conflict-resolution skills; ability to deal with death and dying and other topics relevant to the specific Member you are working for.

Understanding of your Members' support needs, including personal hygiene needs, preferences, and techniques for assisting with activities of daily living (ADL's), including were 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 Member you are working for, including nutrition, dietary needs, exercise needs, and weight monitoring and control.

LKiChoice has trainings online for the Employer/Member to use for training on these topics. The website is

<https://lkichoice.com/trainings>

***By signing below, I attest that I meet the training requirements listed in order to provide services to my Employer/Member.***

***As the Employer/Member, I attest the above Employee of mine has been trained on all trainings listed on the form. We both understand that this training needs to be completed, the form sent in, and processed before a start date can be given for services to be paid. No shifts worked before the start date will be paid.***

Employee:	Date of signature:	
Employer/Member:	Date of signature:	
SSC:	Date of signature	Start date:



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