Wyoming Department of Health, Home and Community Based Services

(Community Choices Waiver (CCW), Comprehensive Waiver, and Supports Waiver)

FISCAL/EMPLOYER AGENT (F/EA)

EMPLOYER

ENROLLMENT PACKET

Mail or Fax Enrollment Packets to Program Fiscal/Employer Agent (F/EA):

ACES$ Financial Management Services
202 E. 18th Street
Cheyenne, WY 82001

Fax: 1 (877) 226-8836

To securely email your packet, please send a request to:
secureWY@mycil.org

QUESTIONS? CONTACT US!

Participant Care Hotline: 1 (844) 500-3815

EMAIL: supportWY@mycil.org

(Questions only- please do not email completed packets to this address.)

www.MyCIL.org

V12.22.23

Fiscal/Employer Agent (F/EA) Enrollment Process

QUICK TIPS:

- If you download the packet directly from the ACES$ website, we recommend you complete the Contact Information Form in the packet prior to printing. This page helps to fill other packet forms automatically and makes completing the packet less work for you!
- If you have any questions, please email or call ACES$ to speak with an Enrollment Specialist.

Participant Care Hotline: 1 (844) 500-3815
Email: supportWY@mycil.org

COMMON TERMS

Below are common terms used in this packet.

Participant – the Participant is the individual authorized to receive services under the Wyoming Department of Health (WYDH) HCBS Waiver Program.

Employer - the Employer is the person who is ultimately responsible for managing the employees and ensuring applicable employment laws are upheld. This includes hiring, firing, scheduling, training, ensuring competency, supervising and approving timesheets.

Employee - the Employee is the individual who provides the Participant with approved services under the Waiver Program.

Fiscal/Employer Agent – the F/EA performs background checks on potential Employee(s), processes payroll and performs required tax functions on behalf of the Employer. Payroll is issued to Employees for timesheets approved by the Employer that are within the Participant's Prior Authorization limits. The F/EA is ACES$ Financial Management Services. The F/EA is not the Employer of the Self-Direction Employee.

WY

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Steps to Enroll with ACES$, Your Fiscal/Employer Agent (F/EA)

STEP ONE

- **Employer Packet** is completed by the Individual serving as the Employer.
- The Checklist/Instructions found at the beginning of the packet provides a quick reference on how to complete each form.
- If you have any questions, please email or call ACES$ to speak with an Enrollment Specialist.
- Once your packet is complete, submit to ACES$ for processing. (See submission instructions on cover of packet.)

STEP TWO

- **Employee Packet** is completed by the Individual(s) serving as the Employee and the Employer.
- The Checklist/Instructions found at the beginning of the packet provides a quick reference on how to complete each form.
- If you have any questions, please email or call ACES$ to speak with an Enrollment Specialist.
- Once your packet is complete, submit to ACES$ for processing.

STEP THREE

- Once completed packets are received by ACES$, we will begin processing them.
- An ACES$ staff person will contact you if the packet is missing information which prevents processing.
- Employer is provided with background check instructions as part of the enrollment process. Once the packet processing, background checks, Employer and Employee training and certification requirements are complete the Employer will be notified.
- If the Employer would like to check on the status of the Employee enrollment, please email or call ACES$.

SAVE TIME WITH ACES$ ONLINE!

EMPLOYERS use the portal to:

- Approve or reject Employee timesheets
- Monitor and review Employee payroll history
- Monitor budget

EMPLOYEES use the portal to:

- Add and edit shifts worked for Employer review and approval
- Review timesheets, scheduled pay and paystubs
- Review payroll status and history

For instructions, view the *User Guide: ACES$ Online, How to Register for an Account* found in the Resources section on the ACES$ Wyoming page on www.mycil.org

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Don't Forget!

Before you submit the Employer Packet to ACES$ for processing, please make a copy for your records.

YOU'RE THE EMPLOYER

As the Employer, it's your responsibility to maintain all Employer related documentation. Please make a copy of the Employer and Employee Packets before you send them to ACES$ for processing.

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FINDING THE RIGHT FITJUST GOT EASIER

ACES$ Wyoming Attendant Directory

The Attendant Directory is a search engine that allows Self-Direction Employers or Case Managers to search for Employees who would like to work with self-directing Participants. The Attendant Directory can be found within the ACES$ Online Portal.

Where to find and how to use the ACES$ Wyoming Attendant Directory

Employers: If you are an Employer, once registered for ACES$ Online and logged in, you can find the Attendant Directory on the left hand side or as a "Tile" on the Dashboard. Click either of these areas to bring you to the search engine. Please note, as an Employer you are not limited to using the Employees listed within this Attendant Directory.

Employees: If you are an Employee for a self-directing Participant and would like to join the Attendant Directory, once issued a hire date and registered for ACES$ Online, log into ACES$ Online. You can add yourself to the Directory by clicking "Attendant Directory" in the top right corner of the page and completing the indicated information.
Please see the ACES$ Online Manuals for further instructions as needed and feel free to contact us with any questions.

ACES$ Wyoming Participant Care: 1-844-500-3815
supportWY@mycil.org

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Electronic Visit Verification (EVV) Notice

EVV is used to capture information in order to process Payroll for time worked. EVV will capture time of service, date of service, who is providing the service, who is receiving the service, snap shot of location of service, and type of service being performed.

To get started, the Employee downloads the CareAttend EVV Mobile Application and the Employee and Participant/Employer each need to Register for an ACES$ Online account.

CareAttend is a free app published by CellTrak. It is compatible with a wide range of Apple and Android devices.

After a "Good to Go" date is issued, further details will be provided to the Employer as needed.

To Get the CareAttend App

Step 1: Open your device's app store

Step 2: Search for *CareAttend*

Step 3: Tap *Get or Install* to download the app to your mobile device

To register for ACES$ Online:

- Go to login.mycil.org
- Select Register for an Account and choose Wyoming for Organization
- Select Account Type
- Complete the information on the registration page
- **For Participant account type please use Participant information and Employer email address. Participant ID will be provided in the Welcome Packet mentioned above.
- Check the attestation box and push Register
- You will receive an email to set your password

Find instructional resources on our ACES$ Wyoming web page under EVV resources.

If unable to use the mobile application, you can also find information on Interactive Voice Response (IVR) on the EVV resources page.

If you have any questions or need additional information, please reach out. We are here and happy to assist!

Participant Care: 1 (844) 500-3815
Email: supportWY@mycil.org

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Wyoming Department of Health, Home and Community Based Services

ACES$ ENROLLMENT PACKET CHECKLIST

Participant: **Employer:**

Case Management Agency: **Case Manager:**

Packet Completed by: **Packet Submitted On:**

Contact Information Form

– Complete all Participant; Employer; Case Manager; and Employee information.

Employer Program Training Attestation (CCW Only)

- Completed and signed by Employer

Employer EVV Training Attestation

- Completed and signed by Employer

Employer Identification Number (EIN) Authorization Form

- Signed by Employer

Employer/FMS Authorization Form

- Signed by Employer

IRS Form 2678, Employer/Payer Appointment of Agent

– Page 1: Part 2, #2 and #4 completed; bottom print Employer name & phone, and sign.

– Page 2: Nothing needs to be done, just return the form.

IRS Form SS-4, Application for Employer Identification Number (EIN)

– # 1, 5a, 5b, 6, 7b, and 18 completed; if #18 is yes, EIN and EIN confirmation letter are included

– At bottom, signed by Employer, print Employer name and date.

Employer Grievance Policy

– Signed by Employer (one copy to stay with Employer)

Employer Workers' Compensation Acknowledgment

– Signed by Employer

ACES$ FMS Information Release Form

- List any person to whom ACES$ is able to release personal information - per State employee cannot be listed

WY Unemployment Tax Division Limited Power of Attorney (POA)

- EMPLOYER completes top portion of form and signs and dates bottom of form

Joint Business Registration Form

- EMPLOYER completes all 4 pages and signs and dates bottom of form

COMPLETED BY ACES$

Received Date: By Staff: Via: Email Fax Mail Handed

Reviewed Date: By Staff: Status: Complete Incomplete

Notes:

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Contact Information Form

Please provide the following contact information for ACES$ to ensure your enrollment is as efficient as possible.

PARTICIPANT INFORMATION

Participant's Name — Gender: F M

Participant's Full Address — Street

City — State — Zip

Participant's Phone Number

Participant's Date of Birth

Participant's Social Security Number

Participant's Email

Participant's Waiver

EMPLOYER INFORMATION

Please complete all Employer information, regardless if Participant is Employer

Employer's Name

Employer's Physical Address — Street

City — State — Zip

Employer's Mailing Address — Street

City — State — Zip

Employer's Social Security Number

Employer's Phone Number

Employer's Email

CASE MANAGER INFORMATION

Case Management Agency

Case Manager's Name

Case Manager's Phone Number

Case Manager's Email

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Wyoming Department of Health, Home and Community Based Services

Employer Program Training Attestation

All Participant-Direction Employers for the Community Choice Waiver (CCW) are required, per Program Guidance, to complete the Program-provided Training.

PROGRAM TRAINING INFORMATION

Program Training can be found at the website below:

https://health.wyo.gov/healthcarefin/hcbs/hcbs-training/

Once on the website, scroll down to Participant-Directed Trainings and click the plus sign (+). Scroll down to Employers of Record (EOR). Here you will find the required training called:
Participant-Direction Employer Training

After you have finished the required Program Training indicated above, please be sure to follow the instructions and complete the EOR Evidence of Training Form. Mentioned form, and its instructions, are found at the link above. There is no need to provide the EOR Evidence of Training Form to ACES$.

Please complete the below information when you have completed the required training.

I, _________________________, confirm that I have completed the Program Training and that I understand the responsibilities outlined in the training as related to my role as Employer.

Date Program Training Completed: _______________________________________

Employer Signature: ________________________________ Date: _____________

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Employer EVV Training Attestation

All Employers are required, per program guidance, to complete EVV Training.

EVV TRAINING INFORMATION

EVV Training can be completed by completing one of the following:

- **Attending one of the monthly EVV Webinars hosted by ACES$**
- **Watching the recorded EVV Training on the ACES$ website**
- **Reviewing the EVV User Guides and Videos on the ACES$ website**

REGISTER FOR EVV TRAINING

EVV Webinar: Hosted the first Tuesday of every month from 1:00 p.m. – 2:00 p.m. MST

*** Unless this date is a recognized Federal or State holiday – please inquire if unsure*

Register for a Webinar here: https://www.research.net/r/WYEVVTraining or scan QR code:

EVV TRAINING RESOURCES

ACES$ Website: https://www.mycil.org/resources/wy-evv/

Please indicate below how and when you completed EVV Training:

Attended Webinar **Watched Recorded Training** **Reviewed EVV Materials**

Date EVV Training Completed: ______________________________

Employer Signature: ______________________ **Date:** __________

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Employer Identification Number Authorization Form

I, ,
(After this referred to as "Employer")

Would like ACES$ Financial Management Services (after this called "ACES$") to apply for and get the Employer Identification Number (EIN) for me.

I want ACES$ to apply for, and get, an EIN for me to be used in payroll services. I will get my EIN once the online process is finished.

I am signing IRS Form SS-4, called "Application for Employer Identification Number". I want ACES$ to run payroll for my employee(s) and to pay my federal tax obligations (Section 3504 of the IRS Code).

The date this agreement is signed, by both ACES$ and me, is the effective date. ACES$, or I, can end this agreement if we give the other ten (10) days of notice in writing.

By signing below, I agree to the above statements.

Employer Signature: Date:

ACES$ Signature: Date:

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Employer/FMS Authorization Form

This agreement gives a general overview of the expectations for individuals participating in waiver self-direction. Any federal, state, or local rules for the Wyoming Community Choices, Comprehensive and Supports Waivers Services, under the Self-directed program, are included by reference in this agreement.

A. Participant/Employer

1. I have decided to participate in this Self-directed program after meeting with my Case Manager.
2. I understand it is my job, as the Employer, to adhere to Program Guidance. The Case Manager has gone over the guidance with me. I agree to follow Program Guidance so I can stay a Participant in this Self directed program.
3. I understand that I am acting as the Employer of Record for services provided. The Employer is not the State of Wyoming or ACES$ Financial Management Services (ACES$).
4. I understand it is my job to hire and train only Employees qualified to provide services. They must be qualified according to the State of Wyoming Waiver Program Guidance.
5. I understand that my Employees must have current CPR and First Aid, along with any other trainings as specified in the Program Guidance. If these training certifications expire, I understand that the Employee will not be able to work for me until they are certified again. I understand it is my responsibility to ensure their certifications remain current.
6. I understand ACES$ will provide enrollment paperwork and is available to provide enrollment support. Every form must be complete and correct before services can be provided by my Employee.
7. I understand that Employee(s) may not work until ACES$ confirms the Employee(s)' set up is complete and the Waiver program has confirmed Participant eligibility.
8. I understand that ACES$ only processes payments for the Self-directed program and will only process payments according to the rules of the Waiver and Individual Budget/Prior Authorization. This includes payroll processing being limited to the current or two previous pay periods, per EVV Program Guidance.
9. I understand it is my responsibility to manage my budget and ensure my Employee's hours do not exceed the approved Prior Authorization. ACES$ will not pay more than the authorized amount identified within the Prior Authorization.
10. I understand that if my Employee's hours exceed the approved Prior Authorization amount, then I am responsible to pay those expenses out-of-pocket.
11. I understand it is my responsibility to review and approve all time worked as factual before submission to ACES$.
12. I understand it is my responsibility to notify ACES$ and my Case Manager immediately of any major changes that could impact my approved budget or safety.

Employer initial after reviewing page:

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Employer/FMS Authorization Form (Continued)

13. I understand it is my responsibility to ensure services provided by my Employee(s) align with my approved Plan of Care. I understand if I allow my Employee(s) to provide services outside of the Plan of Care, I will be responsible to pay these hours out-of-pocket.
14. I understand that, per Program Guidelines, my Employee cannot be paid for more than 40 hours per work week (Sunday through Saturday) per Employer of Record, and if I request they work more than 40 hours in the work week, I will be responsible to pay them out-of-pocket for those additional hours. The work week runs from Sunday through Saturday each week.
15. I understand that payments are made from Federal and State funds and I could be held legally accountable if I, in any way, intentionally misrepresent information. I may be required to pay back any funds received based on misinformation. Additionally, I could be removed from the Waiver Program or personally required to pay legal costs.
16. I understand all time worked must be entered by the Employee using Electronic Visit Verification (EVV), a mandate of the 21st Century Cures Act. Time worked must be approved by the Employer of Record and Employee. The Employer of Record may approve time worked through EVV or through the ACES$ portal, ACES$ Online, which is password-protected.
17. I understand as an Employer, I am required, per Program Guidance, to complete EVV Training.
18. I understand that edits to time worked within the ACES$ Online portal will not be compliant with EVV requirements, and considered an exception to the 21st Century Cures Act mandates.
19. I understand that all EVV entries will be monitored for compliance with the 21st Century Cures Act mandates.
20. I understand that ACES$ will not process payroll without Employer AND Employee signatures/approvals.
21. I understand that I cannot approve time worked before my Employee(s) performs the work.
22. I understand that time worked must be submitted on time, using EVV, and according to the ACES$ payroll calendar. I understand that late approvals may hold up my Employee's paycheck.
23. It is my responsibility to arrange for back-up care in case an Employee cannot work. I understand that any Employee must be enrolled through ACES$, prior to providing services, in order to be paid for their hours through the waiver program.
24. Before providing services, Employees must have appropriate background checks completed and passed, according to Program Guidance.
25. I understand that when an Employee resigns or is terminated, I must complete and provide ACES$ with the ACES$ Separation of Employment Form.

Employer initial after reviewing page:

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Employer/FMS Authorization Form (Continued)

26. I must notify ACES$ immediately of contact changes via ACES$ Contact Update Form or email on file.
27. I understand that an individual who has been decertified as a traditional provider (through a sanction or other corrective action by an Agency/the Department) cannot receive payment through Medicaid or ACES$ for services provided through the waiver self-directed program.
28. I understand that ACES$ follows HIPAA Privacy and HIPAA Security Rule as it applies to any potential risk associated with the use of Personal Health Information (PHI). ACES$ adheres to the regulatory requirements of HIPAA to safeguard access to our Participant's PHI. ACES$ protects sensitive PHI shared with them. Should I wish to allow another individual access to my information, I must complete and submit an Information Release Form to ACES$.

B. ACES$ Financial Management Services / Fiscal/Employer Agent

1. ACES$ provides:
   - Enrollment Support
   - Payroll and Fiscal Administration
   - Maintain Employer/Employee related information
2. ACES$ agrees to provide current and accurate payroll and fiscal administration in a way that protects my information confidentially.
3. ACES$ agrees to maintain accurate records and provide relevant information to maintain Employer status.
4. ACES$ follows HIPAA Privacy and HIPAA Security Rule as it applies to any potential risk associated with the use of Personal Health Information (PHI). ACES$ adheres to the regulatory requirements of HIPAA to safeguard access to our Participant's PHI. ACES$ protects the sensitive PHI our clients share with us.

C. Acknowledgement

The Employer understands that failure to abide by this agreement may result in the Participant's removal from the Self-Directed Option.

Employer Signature: Date:

ACES$ Signature: Date:

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Form **2678** **Employer/Payer Appointment of Agent**

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

OMB No. 1545-0748

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

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

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

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

For IRS use:

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

(Check one)

☐ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

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

1 Employer identification number (EIN) ☐☐ – ☐☐☐☐☐☐☐

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

3 Trade name (if any)

4 Address

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

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

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☐	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☐	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	☐	☐

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

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

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

✗ **Sign your name here**

Date / /

Print your name here

Print your title here Employer

Best daytime phone

Now give this form to the agent to complete. ➡

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

6 Agent's employer identification number (EIN) 2 3 2 6 6 1 1 6 5

7 Agent's name (not trade name) NEPA Center for Independent Living

8 Trade name (if any) ACES$

9 Address 1142 Sanderson Ave, Suite 2

Number Street Suite or room number

Scranton PA 18509

City State ZIP code

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

Sign your name here

Print your name here Duane Seidel

Print your title here Director of FMS Tax Operations

Date / /

Best daytime phone 570-344-7211

Form **2678** (Rev. 8-2014)

Form SS-4 Application for Employer Identification Number

Form **SS-4** (Rev. December 2023)
Department of the Treasury
Internal Revenue Service

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)
See separate instructions for each line. Keep a copy for your records.
Go to *www.irs.gov/FormSS4* for instructions and the latest information.

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)
1142 SANDERSON AVE, STE 2

5a Street address (if different) (Don't enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)
SCRANTON PA 18509-2624

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? ☐ Yes ☑ No

8b If 8a is "Yes," enter the number of LLC members

8c If 8a is "Yes," was the LLC organized in the United States? ☐ Yes ☐ No

9a **Type of entity** (check only one box). **Caution:** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN)
- ☐ Partnership
- ☐ Corporation (enter form number to be filed)
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify)
- ☑ Other (specify) HHCSR
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ Military/National Guard
- ☐ State/local government
- ☐ Farmers' cooperative
- ☐ Federal government
- ☐ REMIC
- ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any

9b If a corporation, name the state or foreign country (if applicable) where incorporated — State — Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type)
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) HHCSR
- ☐ Banking purpose (specify purpose)
- ☐ Changed type of organization (specify new type)
- ☐ Purchased going business
- ☐ Created a trust (specify type)
- ☐ Created a pension plan (specify type)

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year 12-31

14 Reserved for future use

13 Highest number of employees expected in the next 12 months (enter -0- if none).

Agricultural	Household	Other

15 First date wages or annuities were paid (month, day, year). **Note:** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year)

16 Check **one** box that best describes the principal activity of your business.

- ☐ Construction
- ☐ Rental & leasing
- ☐ Transportation & warehousing
- ☐ Health care & social assistance
- ☐ Wholesale-agent/broker
- ☐ Real estate
- ☐ Manufacturing
- ☐ Finance & insurance
- ☐ Accommodation & food service
- ☐ Wholesale-other
- ☐ Retail
- ☑ Other (specify) HHCSR

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☐ No
If "Yes," write previous EIN here

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name: DUANE SEIDEL, NEPACIL DBA ACESS
Designee's telephone number (include area code): 800 344 7211
Address and ZIP code: 1142 SANDERSON AVE, STE 2, SCRANTON PA 18509-2624
Designee's fax number (include area code): 570 558 5571

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

Name and title (type or print clearly)

Applicant's telephone number (include area code)

Applicant's fax number (include area code)

Signature

Date

Grievance Policy

All Participants/Employers have the right to file a formal complaint. A complaint is also called a grievance. If you are having a problem with the services provided by ACES$, you can make a complaint. We have what is called, a Formal Grievance Procedure Policy.

Before you make a written complaint (also called filing a grievance), be sure to work with ACES$ Participant Care (1-844-500-3815) and the Director of Wyoming Programs, Paige Crawford (570-344-7211, ext. 24101 or pcrawford@mycil.org) to help resolve the problem. If that does not address the issue, the next step would be to file a formal complaint.

If you make a written complaint, you will not have any problems from ACES$ because of that complaint. We ask that all complaints/grievances are in writing to the ACES$ SVP of Administration and Operations.

When the ACES$ SVP of Administration and Operations gets the complaint, they will write to you within two (2) working days, and let you know they have the complaint.

Then the ACES$ SVP of Administration and Operations will let you know the action taken or decision within five (5) working days after getting the complaint.

If you are not happy with the response from the ACES$ SVP of Administration and Operations, say so and keep the complaint in action.

At that point the written complaint is sent to the Chief Executive Officer (CEO) within five (5) working days. The CEO will respond within five (5) working days. The CEO's decision or actions taken will be the final decision of ACES$.

Submit Complaints or Grievances to:
ACES$ – SVP of Administration and Operations
1142 Sanderson Avenue
Scranton, PA 18509-2623

ACES$ – Chief Executive Officer
1142 Sanderson Avenue
Scranton, PA 18509-2623

Employer Signature: **Date:**

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Grievance Policy

EMPLOYER COPY

All Participants/Employers have the right to file a formal complaint. A complaint is also called a grievance. If you are having a problem with the services provided by ACES$, you can make a complaint. We have what is called, a Formal Grievance Procedure Policy.

Before you make a written complaint (also called filing a grievance), be sure to work with ACES$ Participant Care (1-844-500-3815) and the Director of Wyoming Programs, Paige Crawford (570-344-7211, ext. 24101 or pcrawford@mycil.org) to help resolve the problem. If that does not address the issue, the next step would be to file a formal complaint.

If you make a written complaint, you will not have any problems from ACES$ because of that complaint. We ask that all complaints/grievances are in writing to the ACES$ SVP of Administration and Operations.

When the ACES$ SVP of Administration and Operations gets the complaint, they will write to you within two (2) working days, and let you know they have the complaint.

Then the ACES$ SVP of Administration and Operations will let you know the action taken or decision within five (5) working days after getting the complaint.

If you are not happy with the response from the ACES$ SVP of Administration and Operations, say so and keep the complaint in action.

At that point the written complaint is sent to the Chief Executive Officer (CEO) within five (5) working days. The CEO will respond within five (5) working days. The CEO's decision or actions taken will be the final decision of ACES$.

Submit Complaints or Grievances to:
ACES$ – SVP of Administration and Operations
1142 Sanderson Avenue
Scranton, PA 18509-2623

ACES$ – Chief Executive Officer
1142 Sanderson Avenue
Scranton, PA 18509-2623

Employer Signature: *Employer Copy Signature Not Needed*
Please Retain for Your Records **Date:**

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Workers' Compensation Form

As the Employer:

I know that ACES$ is not the business who hires my Employee(s).

I know that ACES$ is the payroll service in the Self-directed waiver program I am in (Section 3504 of the IRS Procedure 2013-39).

I know that I am legally the Employer of my Employee(s). Because of this I will not blame ACES$, or anyone who works for them or with them, for any and all costs, expenses, losses, claims, damages, liabilities, settlements, and judgments, including lawyers' fees to defend ACES$ about claims brought by Employee(s) if they are hurt while they are working for me.

In this statement, Employee(s) are any people who are hired, trained, directed, and supervised by the Employer under the waiver program.

Employer Signature: Date:

ACES$ Signature: Date:

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Wyoming Department of Health, Home and Community Based Services

Information Release Form

I, ______________________________ , *(after this referred to as "Employer")*
allow ACES$ to give out information about the payroll services for (Name of Participant) to the people listed below, for as long as _______________________ has an account with ACES$.

I know the information that is given out could be their personal identification information (for example: date of birth, social security number), bank account information, hours available, and pay rate of workers. ACES$ could give out more information if it is needed. I know that ACES$ does not have to tell me when this happens. I free ACES$, and anyone working for them or with them, from any claims for damages or losses that come from giving out information to the people listed below and how they use the information. I understand that I can change this agreement any time by telling ACES$ in writing.

NAME	RELATIONSHIP TO PARTICIPANT

By signing below, I confirm that I have read and understood the legal significance of this Authorization. I understand that I am not obligated to allow the persons identified above access to the information, but I am voluntarily consenting to the release of the information by ACES$. In choosing to sign this document, I have not relied upon any representations of ACES$, it agents, or employees.

Employer Signature: **Date:**

REVOCATION of Financial Management Services (FMS) Information Release Authorization

I, **, hereby revoke this Authorization.**
("Employer")

Employer Signature: ____ **Date:**

Email: SupportWY@mycil.org
Fax: 1-877-226-8836

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DFC041

Wyoming Unemployment Tax Division

LIMITED POWER OF ATTORNEY

UNEMPLOYMENT INSURANCE ACCOUNT #: ________________

WORKERS' COMPENSATION EMPLOYER #: ________________

EMPLOYER NAME: ____

EMPLOYER ADDRESS: ____

____

TO WHOM IT MAY CONCERN:

I/We have appointed Northeast PA Center for Independent Living / ACES$ as our agent to represent our company in Unemployment Insurance and/or Workers' Safety and Compensation matters until further notice.
Authorized agent's telephone number: 570-344-7211

This representation includes:

1. The presenting of completed forms, including claims for refund or adjustment of account, employer's protest of benefit claims, and information relative thereto.

2. All matters affecting merit rating, contributions and/or direct reimbursements.

3. The personal discussion of any or all of the foregoing with proper officials of the State of Wyoming Unemployment Tax Division, Unemployment Insurance Division, and the Workers' Safety and Compensation Division.

4. This appointment supersedes and replaces any prior authorization which our company may have filed with your agency.

Authorized by:

Title: ________________________

Phone #:

Date: ________________________

RETURN TO: DEPT OF EMPLOYMENT
Unemployment Tax Division
Employer Services
P O Box 2760
Casper WY 82602-2760
FAX: 307-235-3278

POA 7-25-05

WYOMING DEPARTMENT OF EMPLOYMENT

JOINT BUSINESS REGISTRATION FORM

INTERNET

Return Completed Form to: Employer Services
PO Box 2760
Casper WY 82602-2760

For information call Unemployment Insurance (307) 235-3217 or Workers' Compensation (307) 777-6763

1. Legal Business Name: (Name of the sole owner, partnership, corporation, limited liability company, governmental entity or other.)

2. Doing Business As: (d.b.a. - the name you present to the public, if different than #1.)

3. Addresses	Street or P. O. Box	City	State	Zip
Mailing address Tax Forms:				
Primary Office address:				
For Unemployment Claims:				
For Workers' Comp Claims:				

4. Work Locations/Physical Locations in Wyoming.
Physical location of all business operations in Wyoming (i.e., office street address; location of a job site; address of employee working out of his home; sales representative location). List principal business location first and attach additional sheets if necessary.

Street Address (NO P.O. BOXES)	In Wyoming		Zip	Phone Number and Location Type (i.e., office; home; job site)
	City	County		
a.				Loc Type: Phone:
b.				Loc Type: Phone:

Do your Wyoming based employees also work in other states? ☐ Yes ☐ No

If yes, list those states:

5. Contact Person and Business Telephone Number:
(Individual(s) authorized to provide and receive information about your account.)

	Contact Name	Phone Number	Fax Number (optional)
For Unemployment Insurance:			
For Workers' Compensation:			

6. Type of Ownership: (Check only one.)

- ☐ Sole Owner
- ☐ Corporation
  State where incorporated:
- ☐ Non Profit Corporation
- ☐ Government
- ☐ Partnership
- ☐ Limited Liability Company
  Do you wish to have Unemployment coverage for your LLC members?
  ☐ Yes ☐ No
- ☐ Other (describe):

7a. Reason for applying:

- ☐ New Business (Continue with question 8.)
- ☐ We have an existing Unemployment account and are now requesting Workers Compensation coverage. Provide your Unemployment account number: ____________________ (Continue with question 8.)
- ☐ Change of Entity - example: change from sole owner to corporation (Continue with question 7b.)
- ☐ Reorganization (Continue with question 7b.)
- ☐ Acquired/Purchased an existing business (Continue with question 7b, and complete page 5)
- ☐ Merger (Continue with question 7b. and complete page 5)
- ☐ Other (describe):

7b. Information about the previous business:

Business Name:

Owner's Name:

Federal Employer Identification Number (FEIN):

Unemployment Account #: Workers Compensation Employer #:

What percentage of the business did you acquire?

Did you own an interest in the previous business?

Date of acquisition:

8a. Date you first hired or expect to hire employees in Wyoming: (Required)
(Excluding Corporate Officers and LLC Members)

8b. Date you first paid wages to employees performing service in Wyoming:
(Excluding Corporate Officers and LLC Members)

8c. Will corporate officers receive compensation or salary? ☐ Yes ☐ No
If yes, beginning on what date:

Will you be using an Employee Leasing or Professional Employer Organization? ☐ Yes ☐ No
If Yes, What is their business name and UI account number ?

9. Estimated Total Monthly Payroll (Wyoming wages only): $

10. Identify all owners, partners, corporate officers, trustees, or members:

Name	Title	Social Security Number	% of ownership	State of Residency	Date Residency Established
	Owner		100%		

11. Federal Employer Identification Number (FEIN) as assigned by IRS: ____________________
(If you do not have an FEIN at this time, leave this space blank and submit your FEIN to the Division once you receive it.)

12. Are you covered by the Federal Unemployment Tax Act (FUTA)? ☐ Yes ☐ No
(Information on whether you are liable for FUTA can be obtained by contacting the IRS.)

13a. Provide detailed information about the primary nature of your business in the description area below, including your business activities, goods, products, or services in Wyoming, as though you were telling a prospective employee what you do. Then give us the approximate percentage of sales or revenues resulting from each item. Percentages should total 100%. If you are a third party agent for the business, such as a payroll service or accountant, please review this item with your client. Examples follow:

Goods or Products: What are they, and what do you do with them? Do you design, manufacture, sell directly to consumers, distribute to wholesalers, install, repair, or do something else with them? What are these goods or products made of?

Example 1: *Major appliances: Sell to public 40%; Sell to retailers 30%; Repair 30%*
Example 2: *Install fiber optic cable 100%.*
Example 3: *Merchant Wholesaler: Industrial Supplies 100%*
Example 4: *Manufacturer Representative: Pharmaceuticals 100%*

Manufacturer: What are your main products? What are your most important materials? What are the main production methods?

Example 1: *Weaving cotton broad-woven fabrics 80%; Spinning cotton threads 20%*
Example 2: *Ready- mix concrete manufacturing 40%; Precast concrete pipe manufacturing 60%*

Services: Describe in detail the services you provide. To whom do you provide those services? If you offer consulting, brokerage, management, or similar services, what are your major activities?

Example 1: *Hair cutting & styling 65%; Manicure 25%; Facials 10%*
Example 2: *Long distance trucking, general freight, less than truckload 100%*
Example 3: *Marketing consulting: Planning marketing strategy 60%, Sales forecasting 40%*
Example 4: *Employee leasing company 100% (Include information on your clients nature of business.)*
Example 5: *Lawn care 60%; Snow removal 40%*
Example 6: *Full-service restaurant 100%*

Construction or Building Trade: Is the work mostly residential or nonresidential? Single or multifamily? New or remodeling?

Example 1: *Electrical contractor: Wiring new homes 51%; Electrical refurbishing of office buildings 49%*
Example 2: *Fencing grazing land 20%; digging ditches for utility lines 10%; residential driveway construction (poured concrete) 70%*

This information is critical to determine your tax rate.

Description____
____
____
____

13b. Provide information for a contact person who has knowledge about the nature of this business.

Name:	Title:
Phone #	E-mail address (if available):
Company website if available:	

Domestic Employers, Agricultural Employers, Non-Profit organizations, and Political Subdivisions answer Questions 14, 15, 16, or 17.

All other employers skip to the *Signature is Required* area

14. For Employers of Domestic (household) help only:

Have you or will you have a total payroll of $1,000 or more during any calendar quarter?

- ☐ Yes If yes, what calendar quarter and year?
- ☐ No

15. For Agricultural operations only:

15a. Have you paid or will you pay $20,000 or more in wages during any calendar quarter?

- ☐ Yes If yes, what calendar quarter and year?
- ☐ No

15b. Have you had or will you have 10 or more workers for 20 weeks or more in any calendar year?

- ☐ Yes If yes, what calendar quarter and year?
- ☐ No

16. For 501(c)(3) Non-Profit Organizations only:

(You must provide a copy of your 501(c)(3) exemption letter from the IRS)

Did your **entire** organization employ four (4) or more persons in twenty (20) weeks during any calendar year including full and part time employees?

- ☐ Yes If yes, what date?
  For Unemployment Insurance, do you wish to elect: (check only one)
  ☐ Liability on a tax basis ☐ Reimbursement of benefits paid to former employees
- ☐ No If no, do you wish to have optional Unemployment Insurance Coverage? ☐ Yes ☐ No

17. For Political Subdivisions only:

☐ City	☐ State	☐ Board of Education
☐ Town	☐ School District	☐ Other:
☐ County	☐ College or University	

For Unemployment Insurance, do you wish to elect: (check only one)

☐ Liability on a tax basis ☐ Reimbursement of benefits paid to former employees

Signature is Required

If You Are:	Who Must Sign:
A Corporation	An Officer Authorized to sign on behalf of the corporation
A Partnership	One Partner
A Limited Liability Company	The Managing Member
A Sole Ownership	The Owner

I certify this application has been examined by me and to the best of my knowledge and belief is true, correct, and complete.

Signature:

Name:

Title: Date: