Lori Knapp CHOICE™
Part of the AssuranceSD Family

FISCAL CONDUIT TRANSPORTATION / MILEAGE VENDOR CHECKLIST

DOCUMENT NAME	REQUIRED / OPTIONAL
Vendor Information and Attestation	Required
Form W-9: Request for Taxpayer Identification	Required
Payroll Authorization / Direct Deposit	Required
F-82064: Background Information Disclosure (BID)	Required
F-00180C: Wisconsin Medicaid Program Provider Agreement	Required
Driver Information Form	Required
Mileage Log	Optional
Vendor Invoice Template	Optional

NOTE:

Please ensure all **REQUIRED** documents are filled out accurately before submitting them for processing

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VENDOR INFORMATION AND ATTESTATION

This form is used to capture details about vendors (agencies) providing goods or services to individuals of a self-directed program.

Lori Knapp Choice™ (LKC™) is the Fiscal Employer Agent on behalf of _____ (Payer Name). LKC™ will process payments for goods and services provided on behalf of _____.

VENDOR DETAILS

Name of Entity / Individual: _____

Business Name (if different): _____

Physical Address: _____

City: _____ State: _____ Zip: _____

County: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

CRIMINAL BACKGROUND CHECK

☐ The Vendor attests that all Employees who provide services for the named Participant have successfully completed and passed all applicable background record checks and exclusionary checks.

☐ The Vendor understands that they are solely responsible for maintaining all applicable background checks and exclusionary checks in compliance with the Wisconsin Caregiver Background Check statute.

AGREEMENT AND SIGNATURE

I confirm:

- I have read the form and agree to comply with all details as outlined.
- The details provided are accurate and complete.
- This form is not a contract between the Vendor, Lori Knapp Choice™, or the state.
- The vendor will send this completed form and the W-9 by fax or email. See the “Contact Us” section below.
- Any other required documentation / paperwork will be provided (ie. Driver Information Form).
- Vendor payment will not occur until the details on the completed W-9 are reviewed.

Vendor Representative Name: _____

Vendor Representative Signature: _____ Date: _____

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

6 City, state, and ZIP code

Requester's name and address (optional)

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

Employer identification number

__ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** **Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

must obtain your correct taxpayer identification number (TIN), which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid).
- Form 1099-DIV (dividends, including those from stocks or mutual funds).
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds).
- Form 1099-NEC (nonemployee compensation).
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers).
- Form 1099-S (proceeds from real estate transactions).
- Form 1099-K (merchant card and third-party network transactions).
- Form 1098 (home mortgage interest), 1098-E (student loan interest), and 1098-T (tuition).
- Form 1099-C (canceled debt).
- Form 1099-A (acquisition or abandonment of secured property).

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

Caution: If you don't return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding*, later.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued);

2. Certify that you are not subject to backup withholding; or

3. Claim exemption from backup withholding if you are a U.S. exempt payee; and

4. Certify to your non-foreign status for purposes of withholding under chapter 3 or 4 of the Code (if applicable); and

5. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting is correct. See *What Is FATCA Reporting*, later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding. Payments made to foreign persons, including certain distributions, allocations of income, or transfers of sales proceeds, may be subject to withholding under chapter 3 or chapter 4 of the Code (sections 1441–1474). Under those rules, if a Form W-9 or other certification of non-foreign status has not been received, a withholding agent, transferee, or partnership (payor) generally applies presumption rules that may require the payor to withhold applicable tax from the recipient, owner, transferor, or partner (payee). See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

The following persons must provide Form W-9 to the payor for purposes of establishing its non-foreign status.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the disregarded entity.
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the grantor trust.
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust and not the beneficiaries of the trust.

See Pub. 515 for more information on providing a Form W-9 or a certification of non-foreign status to avoid withholding.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person (under Regulations section 1.1441-1(b)(2)(iv) or other applicable section for chapter 3 or 4 purposes), do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515). If you are a qualified foreign pension fund under Regulations section 1.897(l)-1(d), or a partnership that is wholly owned by qualified foreign pension funds, that is treated as a non-foreign person for purposes of section 1445 withholding, do not use Form W-9. Instead, use Form W-8EXP (or other certification of non-foreign status).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a saving clause. Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if their stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first Protocol) and is relying on this exception to claim an exemption from tax on their scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include, but are not limited to, interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third-party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester;

2. You do not certify your TIN when required (see the instructions for Part II for details);

3. The IRS tells the requester that you furnished an incorrect TIN;

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only); or

5. You do not certify to the requester that you are not subject to backup withholding, as described in item 4 under "*By signing the filled-out form*" above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier.

What Is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all U.S. account holders that are specified U.S. persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you are no longer tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

• **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note for ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040 you filed with your application.

• **Sole proprietor.** Enter your individual name as shown on your Form 1040 on line 1. Enter your business, trade, or "doing business as" (DBA) name on line 2.

• **Partnership, C corporation, S corporation, or LLC, other than a disregarded entity.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

• **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. Enter any business, trade, or DBA name on line 2.

• **Disregarded entity.** In general, a business entity that has a single owner, including an LLC, and is not a corporation, is disregarded as an entity separate from its owner (a disregarded entity). See Regulations section 301.7701-2(c)(2). A disregarded entity should check the appropriate box for the tax classification of its owner. Enter the owner's name on line 1. The name of the owner entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, enter it on line 2.

Line 3a

Check the appropriate box on line 3a for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3a.

IF the entity/individual on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation.
• Individual or • Sole proprietorship	Individual/sole proprietor.
• LLC classified as a partnership for U.S. federal tax purposes or • LLC that has filed Form 8832 or 2553 electing to be taxed as a corporation	Limited liability company and enter the appropriate tax classification: P = Partnership, C = C corporation, or S = S corporation.
• Partnership	Partnership.
• Trust/estate	Trust/estate.

Line 3b

Check this box if you are a partnership (including an LLC classified as a partnership for U.S. federal tax purposes), trust, or estate that has any foreign partners, owners, or beneficiaries, and you are providing this form to a partnership, trust, or estate, in which you have an ownership interest. You must check the box on line 3b if you receive a Form W-8 (or documentary evidence) from any partner, owner, or beneficiary establishing foreign status or if you receive a Form W-9 from any partner, owner, or beneficiary that has checked the box on line 3b.

Note: A partnership that provides a Form W-9 and checks box 3b may be required to complete Schedules K-2 and K-3 (Form 1065). For more information, see the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

If you are required to complete line 3b but fail to do so, you may not receive the information necessary to file a correct information return with the IRS or furnish a correct payee statement to your partners or beneficiaries. See, for example, sections 6698, 6722, and 6724 for penalties that may apply.

Line 4 Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

• Generally, individuals (including sole proprietors) are not exempt from backup withholding.

• Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.

• Corporations are not exempt from backup withholding for payments made in settlement of payment card or third-party network transactions.

• Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space on line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2).

2—The United States or any of its agencies or instrumentalities.

3—A state, the District of Columbia, a U.S. commonwealth or territory, or any of their political subdivisions or instrumentalities.

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities.

5—A corporation.

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or territory.

7—A futures commission merchant registered with the Commodity Futures Trading Commission.

8—A real estate investment trust.

9—An entity registered at all times during the tax year under the Investment Company Act of 1940.

10—A common trust fund operated by a bank under section 584(a).

11—A financial institution as defined under section 581.

12—A middleman known in the investment community as a nominee or custodian.

13—A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
• Interest and dividend payments	All exempt payees except for 7.
• Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
• Barter exchange transactions and patronage dividends	Exempt payees 1 through 4.
• Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5.[2]
• Payments made in settlement of payment card or third-party network transactions	Exempt payees 1 through 4.

[1] See Form 1099-MISC, Miscellaneous Information, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) entered on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37).

B—The United States or any of its agencies or instrumentalities.

C—A state, the District of Columbia, a U.S. commonwealth or territory, or any of their political subdivisions or instrumentalities.

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i).

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i).

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state.

G—A real estate investment trust.

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940.

I—A common trust fund as defined in section 584(a).

J—A bank as defined in section 581.

K—A broker.

L—A trust exempt from tax under section 664 or described in section 4947(a)(1).

M—A tax-exempt trust under a section 403(b) plan or section 457(g) plan.

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, enter "NEW" at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have, and are not eligible to get, an SSN, your TIN is your IRS ITIN. Enter it in the entry space for the Social security number. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/EIN*. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or Form SS-4 mailed to you within 15 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and enter "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, you will generally have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon. See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier, for when you may instead be subject to withholding under chapter 3 or 4 of the Code.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third-party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))**	The grantor*
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing Form 1041 or under the Optional Filing Method 2, requiring Form 1099 (see Regulations section 1.671-4(b)(2)(i)(B))**	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name on line 1, and enter your business or DBA name, if any, on line 2. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

* **Note:** The grantor must also provide a Form W-9 to the trustee of the trust.

** For more information on optional filing methods for grantor trusts, see the Instructions for Form 1041.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information, such as your name, SSN, or other identifying information, without your permission to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax return preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity, or a questionable credit report, contact the IRS Identity Theft Hotline at 800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 877-777-4778 or TTY/TDD 800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint*. You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Go to *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their laws. The information may also be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payors must generally withhold a percentage of taxable interest, dividends, and certain other payments to a payee who does not give a TIN to the payor. Certain penalties may also apply for providing false or fraudulent information.

Lori Knapp CHOICE™
Part of the AssuranceSD Family

PAYROLL AUTHORIZATION

DIRECT CARE WORKER INFORMATION:

Direct Care Worker Full Name: _____ _____ _____
First MI Last

Phone Number: _____ County: _____

Mailing Address: _____ _____ _____ _____
Address City State Zip

Physical Address (if different): _____
Address City State Zip

Email Address (Required): _____

Note: You will receive your paystub via email.

Timesheet Submission: Please check all that apply:

☐ **Secure Email:** Allow you to send timesheets or other information securely.

☐ **Web Entry:** Online payroll entry. Both Participant and Direct Care Worker (Employee) will need an email address as well as access to the internet.

DIRECT DEPOSIT INFORMATION:

Complete section(s) below with your bank account information. Attach a voided check or bank account statement to confirm account and routing numbers for bank accounts.

Name of Bank: _____

Action to be taken: ☐ New Deposit Authorization ☐ Change from Previous Authorization

Type of Account: ☐ Checking ☐ Savings ☐ Pay Card 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 ☐ Pay Card Amount: _____%

Account #: _____ 9-Digit Routing #: _____

LKC™ 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.

Direct Care Worker Signature: _____ Date: _____

Changes to your payroll information may take up to one week to be processed and take effect on your profile.
Please call to verify that your account information is changed: **608.326.0434.**

Background Information Disclosure (BID)
Entity Employees and Contractors

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

Type

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

Describe the position for which you are applying or renewing: _____

Applicant information

Name (First): _____ Name (Middle): _____
Name (Last): _____

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

☐ Yes ☐ No If yes, list each name fully: _____

Social Security number: _____ Date of birth (MM/DD/YYYY): _____

Sex: ☐ Male ☐ Female Phone number: _____

Address – Street: _____

City: _____ State: _____ ZIP code: _____

Employer or organization verifying eligibility

Name of employer or organization that asked you to complete this form:

_____

Address – Street: _____

City: _____ State: _____ ZIP code: _____

Disclosures

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

1. Pending criminal charges

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

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

2. Convictions for crimes

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

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

3. Abuse or neglected or a child

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

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

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

4. Abuse or neglect of an adult

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

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

5. Stealing or other misappropriation

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

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

6. Restriction on credential

Do you have a government issued credential that is not current or has been revoked, suspended, or that limits you in any way from providing care to clients?

☐ Yes ☐ No

If **yes**, identify the type of credential and indicate the credentialing agency, the restriction, and the state, city, month and year it was issued.

7. Denial, revocation, or limitation on license, certification, or registration

Has a government or regulatory agency ever denied, revoked, or limited your license, certification, or registration to provide care, treatment, or educational services? ☐ Yes ☐ No

If **yes**, indicate the license, certification, or registration type and indicate the issuing agency. Include a description of the denial, revocation, or limitation, and the state, city, month and year it was issued.

8. Denial, revocation, or limitation on ability to reside on certain premises

Has a government or regulatory agency ever denied, revoked or limited your ability to live on the premises of a facility that provides care or treatment? ☐ Yes ☐ No

If **yes**, describe the denial, revocation, or limitation and identify the issuing agency, the state, city, month and year issued.

9. Rehabilitation review

Have you ever requested a rehabilitation review from the Wisconsin Department of Health Services, a county department, private child placing agency, school board, or DHS-designated tribe? ☐ Yes ☐ No

If **yes**, indicate the agency that conducted the review, the outcome, month, and year of the review.

Note: You must provide a copy of your rehabilitation review letter to your employer or organization. Your employer or organization must verify your status with the agency that issued the decision.

10. Armed forces

Have you been discharged from a branch of the US Armed Forces, including any reserve component? ☐ Yes ☐ No

If **yes**, indicate the month and year of discharge.

Note: You must provide your DD214 to your employer/agency, if you were discharged within the last three (3) years.

11. Out-of-state residence

Have you resided outside of Wisconsin in the last three (3) years? ☐ Yes ☐ No

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

12. Government employee

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

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

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

Review your responses and the following attestation carefully before signing.

Attestation

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

Signature — Person completing this form: _____

Date signed: _____

Department of Health Services
Division of Medicaid Services
F-00180C (10/2026)

State of Wisconsin
Wis. Stat. § 49.45(2)(a)9
Wis. Admin. Code § DHS 105.01
42 C.F.R. §§ 431.107 and 438.602(b)

Wisconsin Medicaid

Provider Agreement and Acknowledgement of Terms of Participation

Standard agreement/acknowledgement for
Home and community-based waiver service (adult long-term care) providers

By signature of its authorized representative below, the provider identified below agrees to and acknowledges the conditions of participation and terms of reimbursement set forth in this agreement:

Note: The provider's name used below **must** exactly match the name used on **all** other Medicaid documents.

The provider's participation in Wisconsin Medicaid is subject to the following terms and conditions:

1. **Federal compliance:** Under 42 C.F.R. § 431.107 of the federal Medicaid regulations, the provider agrees to:
   a. Keep any records necessary to disclose the extent of services provided to waiver participants for a period of **ten (10) years** and to retain the records and documents according to the terms provided by Wis. Admin. Code chs. DHS 101–108, except for the retention period specified in Wis. Admin. Code § DHS 106.02(9)(e)2.
   b. On request, provide to the Wisconsin Department of Health Services (DHS), the Secretary of the U.S. Department of Health and Human Services (HHS), or the State Medicaid Fraud Control unit any information maintained under paragraph a. of this section and any information regarding payments claimed by the provider for furnishing services under Wisconsin Medicaid, including home and community-based waiver services.
   c. If the provider is a hospital, nursing facility, provider of home health care, personal care services, or hospice, comply with the advance directives requirements specified in 42 C.F.R. Part 489, Subpart I and 42 C.F.R. § 417.436(d).
   d. Provide DHS, the managed care organization (MCO), or the IRIS (Include, Respect, I Self-Direct) program with its National Provider Identifier (NPI), if eligible for an NPI.
   e. Include its NPI (if eligible for an NPI) on all claims submitted under Wisconsin Medicaid, including home and community-based waiver services.
   f. Comply with the disclosure requirements in 42 C.F.R. Part 455, Subpart B, which includes all disclosure requirements from 455.100 through 455.106.
      i. For the purposes of this agreement, the person with an ownership or control interest means a person or corporation that:
         a. Has an ownership interest totaling 5% or more in a disclosing entity.
         b. Has an indirect ownership interest equal to 5% or more in a disclosing entity.
         c. Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity.
         d. Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the provider if that interest equals at least 5% of the value of the property or assets of the disclosing entity.
         e. Is an officer or director of a disclosing entity that is organized as a corporation.

F-00180C

f. Is a partner in a disclosing entity that is organized as a partnership.

ii. The provider, any fiscal agent, or affiliated managed care entity shall furnish to DHS:

a. The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include, as applicable, the primary business address, every business location, and any P.O. Box address.

b. Date of birth and Social Security number (SSN) (in the case of an individual).

c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest.

d. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

e. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

f. The name, address, date of birth, and SSN of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

g. A provider must submit, within 35 days of the date on a request by the HHS or DHS, full and complete information about:

1. The ownership of any subcontractor with whom the provider has had any business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

2. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

h. The provider must disclose to DHS the entity of any person who:

1. Has ownership or controlling interest in the provider or is an agent or managing employee of the provider.

2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

iii. Disclosure, as required in this agreement, from any provider or disclosing entity is due at any of the following times:

a. Upon the provider or disclosing entity submitting the provider application.

b. Upon the provider or disclosing entity executing this agreement.

c. Upon request of DHS during the revalidation of enrollment process under 42 C.F.R. § 455.414.

d. Within 35 days after any change in ownership of the disclosing entity.

2. **Wisconsin Medicaid:** The provider's participation in Wisconsin Medicaid, including home and community-based waiver services, is subject to the following terms and conditions:

   a. **Laws, rules, regulations, and policies.** The provider agrees to comply with federal and state laws, rules, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program. This includes, but is not limited to, the caregiver background checks, a waiver participant's rights granted under federal and state law, including the right to refuse medication and treatment, and policy communications published by DHS.

   b. **Provider handbooks.** The provider agrees to comply with the applicable terms, conditions, and restrictions that are set forth in the internet-based Family Care, Family Care Partnership, Program of All-Inclusive Care for the Elderly (PACE), or IRIS service areas of the ForwardHealth Online Handbook, bulletins, Adult Long-Term Care Updates, and other communications regarding changes in state or federal law, policy, reimbursement rates and formulas, departmental interpretation, procedural directives such as billing and prior authorization procedures, and specific reimbursement changes, which are issued by DHS under Wis. Admin. Code § DHS 108.02(2) and (4). The Online Handbook, bulletins, and Adult Long-Term Care Updates are available to the provider through the ForwardHealth Portal (forwardhealth.wi.gov). The omission of any applicable term, condition, or restriction from this section does not excuse the provider from complying with that term, condition, or restriction.

   c. **Actual knowledge not required.** The provider agrees to comply with all applicable terms, conditions, and restrictions governing the provider's participation in Wisconsin Medicaid, including the home and community-based waiver programs, regardless of whether the provider has actual knowledge of those terms, conditions, and restrictions.

   d. **Claim submission.** The provider agrees to comply with all claim submission requirements as defined by the program that authorized the service, and from which the provider is seeking reimbursement. This includes, but is not limited to: DHS, the MCO, or IRIS fiscal employer agent (FEA), including electronic and web-based submission methodologies that require the input of secure and discrete access codes but not written provider signatures. The provider has the sole responsibility for maintaining the privacy and security of any access code used to submit information to DHS, the MCO, or IRIS FEA. Any person who submits information to DHS, the MCO, or IRIS FEA, using the provider's access code does so on behalf of the provider, regardless of whether the provider gave permission to use the access code, otherwise revealed the access code to the person, or had knowledge that the person knew the access code or used it to submit information to DHS, the MCO, or IRIS FEA.

   e. **Confidentiality.** The provider is subject to applicable federal and state laws regarding confidentiality and disclosure of medical records or other health information, including the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for all services, information, transactions (including electronic transactions), privacy, and security regulations.

   f. **Repayment.** The provider is responsible for repayment to DHS, the MCO, or IRIS program of any overpayment based on any information submitted by the provider or by any third party in the provider's name or NPI or using the provider's access code, with or without the provider's knowledge or consent, regardless of the manner in which the information was submitted.

   g. **Sanctions.** The provider is subject to sanctions that may be imposed by DHS under Wis. Stat. § 49.45(2)(a)13 and Wis. Admin. Code § DHS 106.08 based on information submitted by the provider or by any third party in the provider's name or NPI or using the provider's access code, with or without the provider's knowledge or consent, regardless of the manner in which the information was submitted.

3. **Written policies for employees:** An entity that receives or makes payments under a state Medicaid plan or any waiver of such plan totaling at least $5,000,000 annually shall establish written policies for all employees and contractors according to 42 U.S.C. § 1396a(68).

4. **Civil rights compliance:** The provider agrees to all of the following:

    a. In accordance with the provisions of Section 1557 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C. § 18116), Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 701 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.), and regulations implementing these Acts, found at 45 C.F.R. Parts 80, 84, 91, and 92, the provider shall not exclude, deny benefits to, or otherwise discriminate against any person on the basis of sex, race, color, national origin, disability, or age in admission to, participation in, in aid of, or in receipt of services and benefits under any of its programs and activities, and in staff and employee assignments to patients, whether carried out by the provider directly or through a sub-contractor or any other entity with which the provider arranges to carry out its programs and activities.

    b. The provider will comply with all assurance, notice, grievance procedures, and other requirements in the aforementioned federal regulations found at 45 C.F.R. Parts 80, 84, 91, and 92.

    c. The provider will ensure meaningful access to individuals with limited English proficiency (LEP) at no cost to the LEP individuals, in compliance with 42 U.S.C. § 2000d, et seq., and 42 U.S.C. § 18116, and 45 C.F.R. Parts 80 and 92.

    d. The provider will ensure that its communications with individuals with disabilities are as effective as its communications with others in its health programs and activities, including its electronic and information technology communications, and it provides appropriate auxiliary aids and services, in compliance with Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and 42 U.S.C. § 18116, and their respective implementing regulations found in 28 C.F.R. Part 35 and 45 C.F.R. Part 92.

    e. The provider agrees to cooperate with DHS, the MCO, or IRIS program, in any complaint investigations, monitoring, or enforcement related to civil rights compliance of the provider or its subcontractors.

5. **Terms of reimbursement:** Reimbursement of the provider for services and items properly provided under Wisconsin Medicaid, including the home and community-based waiver programs, is governed by this agreement and the terms of reimbursement as are now in effect in the Online Handbook and Adult Long-Term Care Updates, or as may later be amended. All claims are subject to post-payment audit and recoupment if the claim or the underlying transaction fails to comply with the applicable laws, regulations Online Handbook, Adult Long-Term Care Updates, or program guidance. Terms of reimbursement include, but are not limited to:

    a. The provider agrees to provide only the items or services authorized by the MCO or IRIS program.
    b. The provider agrees to accept the payment issued by the MCO or IRIS FEA as payment in full for provided items or services.
    c. The provider agrees to make no additional claims or charges for provided items or services.

6. **On-site inspections:** The provider must permit the Centers for Medicare & Medicaid Services, HHS, DHS, or their agents or designated contractors to conduct unannounced on-site inspections of any and all provider locations per 42 C.F.R. § 455.432.

7. **Submission of claims:** The provider understands and agrees that every time the provider signs and submits a claim, whether done electronically or otherwise, the provider certifies that:

    a. The claim complies with all federal and state Medicaid laws and regulations including, but not limited to, the Online Handbook, all Adult Long-Term Care Updates, and other program guidance.

    b. The claim is truthful, accurate, and complete and contains services and items that have been furnished or caused to be furnished in accordance with applicable federal and state Medicaid laws.

    c. The provider has not offered, paid, or received any illegal remuneration or any other thing of value in return for referring an individual to a person for the furnishing of any service or item, or for arranging for the furnishing of any service or item for which payment may be made in whole or in part under

Medical Assistance in violation of 42 U.S.C. § 1320a-7b, Wis. Stat. § 946.91(3), or any other federal or state anti-kickback statutes.

d. The provider has not engaged in or committed fraud or abuse. "Fraud" includes any act that constitutes fraud under applicable federal or state law.

e. The payment of claims will be from federal and state funds, or both; that compliance with the above requirements is a condition precedent to payment and conditioned upon compliance with all state and federal Medicaid laws, regulations, the Online Handbook, Adult Long-Term Care Updates, and all other program guidance, and therefore, no payment shall be made for services in violation of said requirements; any claim submitted or caused to be submitted or any statement made or used in violation of the above requirements constitutes a false or fraudulent claim for purposes of liability under 31 U.S.C. § 3729 and/or Wis. Stat. §§ 49.485 and 49.49; and that any false claim or statement of concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law.

8. **False claims:** Any acts or omissions by the provider's staff or any entity acting on the provider's behalf shall be deemed those of the provider, including any acts and/or omissions in violation of federal or state criminal and civil false claims statutes.

9. **Extrapolation to determine overpayment:** Extrapolation under Wis. Admin. Code § DHS 105.01(3)(f) may be used as a method to calculate the amount owed by the provider to Wisconsin Medicaid when it has been determined, as a result of an investigation or audit conducted by DHS, the Department of Justice (DOJ) Medicaid fraud control unit, HHS, the Federal Bureau of Investigation, or an authorized agent of any of these entities, based on a sample of claims, that the provider was overpaid.

10. **Inactive status:** Failure by the provider to submit claims for payment for more than a 12 consecutive month period may result in the provider being placed on inactive status. A provider is not eligible for reimbursement for services provided while on inactive status. A provider placed on inactive status must reapply to Wisconsin Medicaid to reactivate their status.

11. **Licensure:** The provider certifies that the provider and each person employed by it for the purpose of providing services hold all licenses or similar entitlements and meet other requirements specified in federal or state statute, regulation, rule, or program authority for the provision of the service.

12. **Voluntary termination:** The provider may terminate its certification to participate in Wisconsin Medicaid as provided under Wis. Admin. Code § DHS 106.05.

13. **Involuntary termination:** DHS may terminate or suspend the provider's certification under this agreement as provided in Wis. Admin. Code § DHS 106.06.

14. **Duration:** This agreement will remain in full force and effect as long as the provider is certified to participate in Wisconsin Medicaid under Wis. Admin. Code ch. DHS 105 and/or in the Medicaid home and community-based services waiver programs under the IRIS Waiver or Family Care Waiver.

15. **Statement of material fact:** The provider acknowledges that any statement made in this agreement or in the provider application process constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made by the provider for a benefit or payment, or for use in determining rights to such benefit or payment. Under Wis. Stat. §§ 49.49(1d) and (4m), if any such statements or representations are false, the provider may be subjected to criminal or other penalties.

16. **Attestations:** The provider acknowledges and attests compliance to all statements below.

    a. Provider has written policies regarding testing for communicable diseases, as well as protocols in place for positive results, for all staff.

    b. Provider has documentation to support all attestations made within this application and agrees to provide DHS such documentation upon request.

    c. Provider has written policies and procedures in place to address staff shortages.

    d. Provider has a continuity of operations plan, specifically related to emergency or disaster preparedness.

e. If a member or participant experiences a medical emergency while in the presence of the provider, provider will call 911 to access emergency services and wait with the member or participant until the first responders are on-site, have assessed the situation, and have taken the member or participant into their care if needed.

f. Provider has policies and procedures in place for hiring that include review of Wisconsin DOJ results and the Background Information Disclosure (BID) form, F-82064 (dhs.wisconsin.gov/library/collection/f-82064). Provider's policies and procedures include action the provider will take based on results of the background check, in compliance with Wis. Stat. §§ 50.065(2)(bb), (br), and (2m) and Wis. Admin. Code §§ DHS 12.06 and 12.115.

g. Provider completes Wisconsin DOJ criminal and caregiver background checks at its own expense for all persons who will provide care to members and participants, whether an employee or contractor of an entity or a sole proprietor, prior to the person(s) providing direct services to a member or participant and at a minimum every four (4) years thereafter or any time the organization or agency has a reason to believe a new check should be performed.

h. Pursuant to Wis. Admin. Code chs. DHS 12 and 13, prior to providing services that result in direct contact with members or participants, provider verifies all persons who will provide care to members or participants, whether an employee or contractor of an entity or a sole proprietor do not appear on the list of excluded individuals on the DHS Wisconsin Misconduct Registry. The provider will remove any employee found on the Misconduct Registry (wi.tmutest.com/search) from any work related to any state or federal health care program.

i. Provider understands that the U.S. DOJ may impose civil monetary penalties on anyone who hires an excluded individual or entity. Provider agrees to check the HHS Office of Inspector General (OIG) online List of Excluded Individuals/Entities database (Exclusions Database) for all new hires and at least quarterly for existing employees to ensure that no excluded employees work in any capacity related to any state or federal health care program. The provider will remove any employee found in the OIG Exclusions Database (exclusions.oig.hhs.gov/) from any work related to any state or federal health care program.

j. As applicable, provider shall have written policy and train its staff to immediately report all allegations of misconduct, including abuse and neglect of a member or participant or misappropriation of a member's or participant's property.

k. Provider will require, via written policy and procedures, that persons, whether an employee or contractor of an entity or a sole proprietor, report criminal convictions or investigations to their immediate supervisor as soon as possible, but no later than the next working day per Wis. Admin. Code § DHS 12.07(1).

l. In compliance with Wis. Admin. Code § DHS 12.10, provider shall retain in its personnel files the following documents related to all persons providing direct care to members and participants: pertinent BID form, F-82064, and search results from the Wisconsin DOJ, DHS, and the Wisconsin Department of Safety and Professional Services, as well as out-of-state records, tribal court proceedings, and military records, in accordance with searches required in Wis. Stat. § 50.065(2) and Wis. Admin. Code § DHS 12.08. Provider shall make these documents available to DHS upon request.

m. Provider ensures staff is able to perform skills as required in their position description prior to initial performance.

n. Provider ensures and documents qualifications of each staff member, including academic preparation and relevant experience, verification of current license, certifications, and/or registrations to practice in Wisconsin that are applicable to, or required by, the staff member's duties. Upon request, the provider will supply any applicable documentation to DHS.

o. Provider ensures staff working with frail elders or disabled populations have documented experience with the population that the staff will work with or provider has plans to ensure staff is adequately trained.

p. Provider maintains a training plan for each staff member who provides or will provide direct care to members or participants and has a mechanism for ensuring that all necessary training has been completed prior to performing work and that completion of all training is documented.

q. Provider will maintain documentation that staff is trained annually on compliance, fraud, waste, and abuse.

r. Provider ensures staff is trained on DHS recording and reporting requirements for documentation, critical incident reporting, and other information and procedures necessary for the staff to ensure the health and safety of members and participants receiving supports. The applicable requirements are documented in the Family Care Contract, Family Care Partnership, and PACE: Managed Care Organization Contracts (dhs.wisconsin.gov/familycare/mcos/contract.htm) and the IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards, P-03071 (PDF) (dhs.wisconsin.gov/publications/p03071.pdf).

s. Provider ensures staff is trained on the needs of the target group they are serving.

t. Provider ensures staff is trained on the provision of the services being provided.

u. As applicable, provider ensures staff has been trained or will be trained on the needs, strengths, and preferences of the individual(s) being served, prior to providing direct care.

v. Provider ensures all staff are trained on rights and privacy provisions applicable to providers, members, and participants in Wisconsin, including rights and privacy provisions guaranteed under HIPAA, Wis. Stat. ch. 146, and the Family Care Contract, Family Care Partnership, and PACE: Managed Care Organization Contracts and the IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards.

w. Provider will refrain from influencing an individual to either not enroll in or to disenroll from another MCO or the IRIS program.

By signature, the provider or authorized representative swears or affirms under penalty of perjury that the information given in this agreement is true and accurate. By signature, the provider certifies that they have read the LTC Waiver Provider Online Handbook and all regulations.

Name – Provider: _____

NPI: _____ Medicaid-assigned provider ID: _____

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

Street address line 1: _____

Street address line 2: _____

City: _____ State: _____ ZIP+4 code: _____

Signature – Provider or authorized representative: _____

Date signed: _____

Title: _____

For DMS use only (Do not write below this line.)

Signature – Department of Health Services	Date
	2/21/2026

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

Lori Knapp CHOICE™
Part of the AssuranceSD Family

VENDOR DRIVER INFORMATION FORM

Welcome to the Lori Knapp Choice™ Fiscal Agent Program. Lori Knapp Choice™ has a referral that you will be providing transportation services to a Participant. Lori Knapp Choice™ will need the following information to confirm a valid Driver's License and proof of insurance at the time of the referral for the mileage reimbursement to you.

Participant Name: _____

Vendor or Vendor Representative Name: _____

Mailing Address on File: _____ _____ _____ _____
Address City State Zip

Date of Birth: _____ Social Security #: _____ Driver's License #: _____

Vehicle Insurance Carrier: _____

Vehicle Insurance Policy #: _____ Vehicle Insurance Date of Expiration: _____

Vendors or Vendor Representatives (Employees/Drivers) are required to have a current Driver's License always issued by the Department of Transportation and current insurance. Vehicles used to provide transportation must be insured and in good repair, with all operating and safety systems functioning.

By signing this form, I agree that I am meeting all of these requirements. If there is a change in any of the information provided, I will update this agency.

My signature below verifies that my information above is accurate, and I am the owner of the vehicle.

Signature: _____ Date: _____

Lori Knapp CHOICE™
Part of the AssuranceSD Family

MILEAGE LOG

Vendor or Vendor Representative (Driver): _____ Participant Driving For: _____

Pay Period Beginning (MM/DD/YYYY): _____ Pay Period Ending (MM/DD/YYYY): _____

ATTENTION: Mileage logs received after the payroll schedule due date will be paid with the following payroll. NO EXCEPTIONS. Lori Knapp Choice™ is not responsible for reimbursement that exceeds the authorization. Falsification of this mileage log is considered Medicaid fraud and may result in dismissal from the program and/or criminal prosecution.

Do not use white-out to make corrections.

REMINDER: To be eligible for mileage reimbursement, you must be the owner of the insured vehicle.

Date (MM/DD)	To	From	Medical OR Non-Medical	Total Miles/Trip

Page: _____ of _____ **Total miles / trips for this page:** 0

MEMBER / POA / GUARDIAN

"I, the Participant, certify that the above Direct Care Worker drove the hours listed, the services were provided in accordance with the care plan, and the Participant was NOT in a hospital, nursing home, or institution.

DIRECT CARE WORKER

"I, the Direct Care Worker of this Participant, certify that the miles/trips driven and listed were provided in accordance with the care plan, and the Participant was NOT in a hospital, nursing home, or institution.

Signature must be dated on or after the last day worked. This is a legal document.
A wet signature from both parties is required.

Signature _____ Date _____

Signature _____ Date _____

Email _____ Phone _____

PLEASE CHOOSE YOUR FUNDING SOURCE: [SELECT ONE]

If completing a printed check request, write in your correct Funding Source / County Name.

Submit Mileage Log to Lori Knapp Choice™

It is your responsibility to verify that your completed and accurate mileage log has been received by Lori Knapp Choice™ once submitted via mail, fax, or email. Please allow 48 hours before verification contact.

Mail
106 S Beaumont Rd
Prairie du Chien, WI 53821

Email
payroll@LoriKnappChoice.com

Fax
844.634.7225

For any questions or concerns, please contact our office at 608.326.0434.

OFFICE USE ONLY

Lori Knapp CHOICE™
Part of the AssuranceSD Family

VENDOR INVOICE TEMPLATE

Participant Name: _____ Participant Phone Number: _____

Pay to:
Vendor Name: _____ Vendor Phone Number: _____

Vendor Address: _____ _____ _____ _____
Address City State Zip

Services and supplies may only be paid up to the authorized amount.

Description of Purchases or Services: _____

Dates of Service or Purchases (If applicable, please send receipts for purchases):

_____ $_____ Date Amount	_____ $_____ Date Amount
_____ $_____ Date Amount	_____ $_____ Date Amount
_____ $_____ Date Amount	_____ $_____ Date Amount
_____ $_____ Date Amount	_____ $_____ Date Amount
_____ $_____ Date Amount	_____ $_____ Date Amount
_____ $_____ Date Amount	_____ $_____ Date Amount

# of Units: _____ Unit Rate: $_____ Total: $_____

Approved: _____ Date: _____
Participant Signature

Approved: _____ Date: _____
Vendor Signature

PLEASE CHECK YOUR FUNDING SOURCE: [SELECT ONE]

It is your responsibility to verify that your completed and accurate check request has been received by Lori Knapp Choice™ once you submit via mail, fax, or email. Please call us to verify your timesheet(s) has been received. For any questions or concerns, please contact our office at: 844.534.7225.

Submit Invoice to Lori Knapp Choice™

Mail	Email	Fax
106 S Beaumont Rd Prairie du Chien, WI 53821	payroll@LoriKnappChoice.com	844.634.7225