

DOCUMENT NAME	REQUIRED / OPTIONAL
Enrollment Information	Required
Employer and Employee Agreement	Required
Relationship Attestation	Required
Payroll Authorization	Required
F-82064: Background Information Disclosure	Required
W-4	Required
WT-4	Required
I-9: Employment Eligibility Verification	Required
F-00180C: Wisconsin Medicaid Program Provider Agreement and Acknowledgement of Terms of Participation	Required
CLTS Waiver: Kenosha County Waiver Agency Standards of Training Verification for Parent/Guardian Hired Providers	Required
Kenosha County Waiver Agency Policies and Expectations for Providers paid by a Financial Management Service	Required
Request for Child Protective Services ACCESS Employee Search Request	Required
Request for Child Protective Services ACCESS Employee Search	Required

NOTE:

Please ensure all **REQUIRED** documents are filled out accurately before submitting them for processing. The following pages must be completed.

For questions, please call 608.326.0434 and ask for _____.

DIRECT CARE WORKER ENROLLMENT INFORMATION

PARTICIPANT INFORMATION

Participant Full Name: _____
First MI Last

Legal or Authorized Representative Name (if applicable): _____

Participant Program: _____ Pronouns: _____

DIRECT CARE WORKER INFORMATION

Direct Care Worker Full Name: _____
First MI Last

Mailing Address: _____
Address City State Zip

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

Home Phone #: _____ Mobile Phone #: _____

Email Address: _____ Date of Birth: _____

Preferred Language: _____

If providing mileage:

Driver's License Number: _____

Driver's License Expiration Date: _____

By signing below, you certify that the information on this form is accurate and that you have all supporting documentation that may be needed to verify your information.

Direct Care Worker Signature: _____ Date: _____

PARTICIPANT AND DIRECT CARE WORKER AGREEMENT FORM

_____ has been hired by _____.
Direct Care Worker (Employee)* Participant (Employer)*

*Please use the name exactly as it appears on the Social Security card.

The Direct Care Professional (Employee) will provide care services through the self-directed services program to the Participant (Employer). Lori Knapp Choice™ (LKC™) has been chosen to assist the Participant (Employer) with administrative tasks, enrollment setup, and payroll services.

As the Direct Care Worker, I agree to:

- Complete all documents that are required to be an employee of a fiscal member, my employer.
- Not start working until all required paperwork from LKC™ has been completed, returned, processed, and approved. Once approved, I will be contacted with a start date from LKC™ or the care managed organization.
- Aid in the correction of any errors that may occur with processing payroll.
- Work with the Participant I am supporting to provide the best care and outcome possible.
- Stay within the guidelines of what is authorized for hours worked and tasks required.
- Follow HIPAA and confidentiality requirements.
- Follow standard precautions and perform all work-related tasks in a safe manner.
- Accurate timesheet reporting. Failure to do this could result in fraud and/or abuse reporting.
- Follow processes and procedures of EVV (Electronic Visit Verification) if applicable to the Participant (Employer) I am supporting.
- Report concerns of safety, health, or well-being of the person I am caring for to the Participant's Care Manager.
- Report current charges or pending allegation of abuse or neglect to the Participant's Care Manager or LKC™.
- Report any convictions that occur after my start date to the Participant and LKC™.
- Report work-related injury within 24 hours to LKC™ at 844.534.7225.
- Notify LKC™ if I do not work within 60 days.
- Notify and send an updated form to LKC™ of changes to my mailing address.
- Notify and send an updated form to LKC™ of changes to my direct deposit information (direct deposit information will **not** be updated without a completed form on file). Changes to direct deposit information need to be made five business days before the payment dates.
- Notify and send an updated form to LKC™ of any changes to my state or federal deductions. This will require an updated W4 or WT4 form completed.
- Notify and send an updated form to LKC™ if my name changes.



PARTICIPANT AND
DIRECT CARE WORKER
AGREEMENT FORM

I understand I am the employee of _____.
Participant Name (Employer)

I understand that my timesheet needs to be turned in according to the Time Report and Pay Schedule provided. Submission of late timesheets and non-use of the Electronic Visit Verification (EVV) system properly (if it's relevant to your job), could delay pay until the next pay period. Non-compliance with EVV (if applicable) could lead to disenrollment in SDS FEA.

I understand Lori Knapp Choice™ is not responsible for payment of services if I provide duties to the Participant that are not approved, work more hours than approved by the funding source, or if the Participant is no longer eligible for services under this program.

EXAMPLE: A member is hospitalized or admitted to a facility for a period of time.

I understand that if no person is designated on the Participant's authorization form from LKC™ to sign off on timesheets due to the Participant's incapacitation or death, I will need to wait to be paid until a person from their estate is deemed legally responsible to sign the timesheets.

I understand the Participant is responsible for all employment actions which might include orientation, training, supervising, disciplinary action, termination, management, and other Participant (employer) – related functions.

I understand that Lori Knapp Choice™ (LKC™) **is not** my employer but provides the payroll services and administrative tasks for the Participant. If I have employment concerns, I need to discuss these with the Participant.

Direct Care Worker (Employee) Signature

Date

Participant (Employer) Signature

Date

Direct Care Worker Full Name: _____
First MI Last

Participant Full Name: _____
First MI Last

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

1. Live In: Do you permanently reside in the same residence as the Participant (Employer)?
No Yes: You are exempt from overtime

2. What is your legal relationship to the Participant (Employer)?

I am the Participant's: (check only one box)

Child/Step under 21 years old (S, F, FI)	Child/Step over 21 years old (S)	
Domestic Partner* (S)	Grandchild (S)	Grandparent (S)
Parent/Step (S, F, FI)	Sibling	Spouse (S, F, FI)
Other _____		

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

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

Yes: I am under the age of 18 or will turn 18 this year. Date of Birth: _____

No: I am not under the age of 18.

3a: If Yes:

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

Yes: This job or performing household services is my principal occupation and I am NOT a student.

No: I am a student, providing household services, which is not considered my principal occupation.

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

Direct Care Worker (Employee) Signature _____

Date _____



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) For 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 | ☐ Volunteer |
| ☐ Contractor | ☐ Household member |
| ☐ Student | ☐ Other, specify: _____ |

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

Applicant information

Name (First, Middle, Last): _____

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

Sex: ☐ Male ☐ Female Phone number: _____

Address – Street: _____

City: _____ State: _____ ZIP code: _____

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

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

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 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 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: _____

Employee's Withholding Certificate

OMB No. 1545-0074

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**Give Form W-4 to your employer.****Your withholding is subject to review by the IRS.****2026****Step 1:**
Enter
Personal
Information

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) ☐ Single or Married filing separately ☐ Married filing jointly or Qualifying surviving spouse ☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at www.irs.gov/W4App.

Step 2:
Multiple Jobs
or Spouse
Works

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate ☐

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

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

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 . . . ☐
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Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

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-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 and you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

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



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

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

Step 4.

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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

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

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

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____

- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____

- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____

- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) **4** \$ _____

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1	Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.				
a	Qualified tips. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000	1a \$ _____			
b	Qualified overtime compensation. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation	1b \$ _____			
c	Qualified passenger vehicle loan interest. If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000	1c \$ _____			
2	Add lines 1a, 1b, and 1c. Enter the result here	2 \$ _____			
3	Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):				
a	Enter \$6,000 if you are age 65 or older before the end of the year	3a \$ _____			
b	Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment	3b \$ _____			
4	Add lines 3a and 3b. Enter the result here	4 \$ _____			
5	Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information	5 \$ _____			
6	Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:				
a	Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income	6a \$ _____			
b	State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately)	6b \$ _____			
c	Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)	6c \$ _____			
d	Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income	6d \$ _____			
e	Other itemized deductions. Enter the amount for other itemized deductions	6e \$ _____			
7	Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here	7 \$ _____			
8	Limitation on itemized deductions.				
a	Enter your total income	8a \$ _____			
b	Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9	8b \$ _____			
9	Enter: <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td> • \$768,700 if you're married filing jointly or a qualifying surviving spouse • \$640,600 if you're single or head of household • \$384,350 if you're married filing separately </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>	{	• \$768,700 if you're married filing jointly or a qualifying surviving spouse • \$640,600 if you're single or head of household • \$384,350 if you're married filing separately	}	9 \$ _____
{	• \$768,700 if you're married filing jointly or a qualifying surviving spouse • \$640,600 if you're single or head of household • \$384,350 if you're married filing separately	}			
10	If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	10 \$ _____			
11	Standard deduction.				
	Enter: <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td> • \$32,200 if you're married filing jointly or a qualifying surviving spouse • \$24,150 if you're head of household • \$16,100 if you're single or married filing separately </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>	{	• \$32,200 if you're married filing jointly or a qualifying surviving spouse • \$24,150 if you're head of household • \$16,100 if you're single or married filing separately	}	11 \$ _____
{	• \$32,200 if you're married filing jointly or a qualifying surviving spouse • \$24,150 if you're head of household • \$16,100 if you're single or married filing separately	}			
12	Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)	12 \$ _____			
13	Add lines 11 and 12. Enter the result here	13 \$ _____			
14	If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12	14 \$ _____			
15	Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4	15 \$ _____			

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

Employee's legal name (first name, middle initial, last name)			Social security number	☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, check the Single box.
Employee's address (number and street)			Date of birth	
City	State	Zip code	Date of hire	

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

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

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

Signature _____ Date Signed _____

EMPLOYEE INSTRUCTIONS:

• WHO MUST COMPLETE:

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

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

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

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

• UNDER WITHHOLDING:

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

• OVER WITHHOLDING:

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

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

• LINE 1:

(a)-(c) Number of exemptions – Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will

be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1(a)-(c) or you may enter into an agreement with your employer to have additional amounts withheld (see instruction for line 2).

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

• LINE 2:

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

• LINE 3:

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

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

Employer's Section

Employer's name			Federal Employer ID Number	
Employer's payroll address (number and street)			State	Zip code
Completed by	Title	Phone number	Email	

EMPLOYER INSTRUCTIONS for Department of Revenue:

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

EMPLOYER INSTRUCTIONS for New Hire Reporting:

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

EXAMPLE TO HELP WITH COMPLETING I-9

The **IRS Form I-9** is used to verify the identity and employment authorization of new and current employees in the United States.

Need assistance? Please call **608.326.0434**.

NEEDED EMPLOYEE INFORMATION HIGHLIGHTED YELLOW.

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.			
Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.			
	List A	OR	List B AND List C
Document Title 1	Passport Information BELOW	OR	Drivers License/State ID Social Security Card
Issuing Authority			State Issued Social Security Admin.
Document Number (if any)			Drivers License or State ID Number Social Security Card Number
Expiration Date (if any)			Expiration Date n/a
Document Title 2 (if any)		Additional Information	
Issuing Authority			
Document Number (if any)			
Expiration Date (if any)			
Document Title 3 (if any)			
Issuing Authority			

PARTICIPANT OR GUARDIAN/POA WILL SIGN & DATE NEXT TO THE RED X IN HIGHLIGHTED PINK SECTION.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.		First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
	X Employer/Member Signature	Date signed
Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code	
Employer/Member Name	Employer/Member Address	
For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.		

IMPORTANT REMINDER

The I-9 is a government document that must be completed by the Employee and the Employer. Lori Knapp Choice™ (LKC™) is not the Employer and cannot complete Section 2. If this document is not completed correctly, it will delay your start date.

Please call **608.326.0434** for assistance.



Employment Eligibility Verification

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

USCIS

Form I-9

OMB No.1615-0047

Expires 05/31/2027

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)		
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number	
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
		☐ 1. A citizen of the United States					
		☐ 2. A noncitizen national of the United States (See Instructions.)					
		☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)					
		☐ 4. An alien authorized to work until (exp. date, if any)					
		If you check Item Number 4. , enter one of these:					
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance	
Signature of Employee					Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the Preparer and/or Translator Certification on Page 3.

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

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)					
Expiration Date (if any)					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

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

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

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 percent or more in a disclosing entity.
 - b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity.
 - c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity.
 - d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the provider if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.



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- e. Is an officer or director of a disclosing entity that is organized as a corporation.
- 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 percent 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 percent 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 Online Handbooks, 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 at <https://www.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:
- 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.
 - 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.
 - 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.
 - 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.
 - 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 Handbooks 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:
- The provider agrees to provide only the items or services authorized by the MCO or IRIS program.
 - The provider agrees to accept the payment issued by the MCO or IRIS FEA as payment in full for provided items or services.
 - 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:
- 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.
 - 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.
 - 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. Stats. §§ 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. 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 from any work related to any state or federal health care program. The Misconduct Registry can be accessed at <https://wi.tmuniverse.com/search>.
- 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 from any work related to any state or federal health care program. OIG maintains an online database at <https://exclusions.oig.hhs.gov/>.
- 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 Background Information Disclosure (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 trainings is documented.
- q. Provider will maintain documentation that staff is trained annually on compliance, fraud, waste, and abuse.
- r. Provider ensures staff are 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](#) and the [IRIS \(Include, Respect, I Self-Direct\) Support Services Provider Training Standards](#), P-03071.
- s. Provider ensures staff are trained on the needs of the target group they are serving.
- t. Provider ensures staff are trained on the provision of the services being provided.
- u. As applicable, provider ensures staff have 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

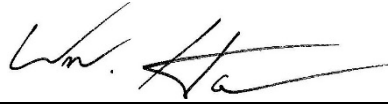
Title

FOR DMS USE ONLY (Do not write below this line.)

SIGNATURE – Department of Health Services

Date

9/13/2024

A handwritten signature in black ink, appearing to be "L. H. A.", is written over the signature line.

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

Children's Long-Term Support (CLTS) Waiver: Kenosha County Waiver Agency Standards of Training Verification for Parent/Guardian Hired Providers (Non-licensed/certified)

Participants: Information:

Participant/Child's Name (First and Last)	Parent/Guardian Name: (First and Last)	Service Coordinator Name: (First and Last)
Service Type: (Check all that Apply) ☐ Daily Living Skills Training ☐ Mentoring ☐ Respite* ☐ Specialized Childcare ☐ Specialized Transportation ☐ Personal Supports-Supervision/Attendant* ☐ Personal Supports-Chores* ☐ Family/Unpaid Caregiver Supports and Services		

*Training can take place before and during the first six months of employment.

Provider/Employee Information

Name- Last:	First:	M.I.	Date of Hire:
Address. Street:	City:	State:	Zip:

Provider named above will complete background and other service qualification requirements. Additionally, providers will receive training with participant's parent/guardian and when necessary, county waiver agency support and service coordinator (SSC), on the following requirements, to ensure provider is qualified to deliver services to the participant through CLTS Waiver funding. All provider training must be completed within 3 months of hire date.

Date of Completion	Service Provision and/or Training Requirement
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1. _____ 1. Provider is not listed on the Wisconsin Misconduct Caregiver Registry; does not have a substantiated finding of abuse, neglect, or misappropriation, and has not committed a crime that is substantially related to the provision of care or supervision of this service.
2. _____ 2. Provider is trained to safely deliver services, so as not to endanger the participant. Additionally, provider understands how to administer first aid for the participant when necessary.

Participant's safety plan is:

3. _____ 3. Provider is trained to recognize and appropriately respond in the event of an emergency, including protocol for contacting local emergency response systems, and the prompt notification of the county waiver agency.

Any emergency situations or incidents where the participant's health or safety may have been compromised during a session, must be immediately reported to the participant's support and service coordinator (SSC)

SSC agency name, contact staff, and phone number: _____

4. _____ 4. Provider is trained on participant specific information, including individual needs, functional capacities, strengths, abilities, preferences, goals, and family/participant's culture. Additionally, provider has received in-depth training on the participant's individual daily living skills needs and level of assistance for bathing, grooming, toileting, eating, transfers, mobility, learning, communication, and other related tasks. If necessary, provider has also received training on using any adaptive aids or equipment the participant needs for day to day functions.

Detailed Information on the participant's specific information is outlined below:

Participants strengths, interests, and hobbies:

If provider will be conducting mentoring sessions: list how the participant's and provider's interests are similar and how will those interests be incorporated into sessions.

Participant's and their family's relevant cultural needs and preferences:

Participant's cognitive abilities and concerns:

Participant's communication abilities, strengths, and concerns:

Participant's grooming, bathing, toileting, and dressing strengths and concerns:

Participant's dietary concerns, eating habits, and need for eating/feeding assistance:

Participant's mobility strengths and concerns and need for assistance with transfers within home and community:

Participant requires specialized equipment that will be utilized by provider during sessions

☐ No ☐ Yes, equipment includes:

Participant's Goals:

☐ Provider reviewed a copy of participant's most recent CLTS Waiver Individualized Service Plan (ISP) Goals and Outcomes Page.

5. _____ 5. Provider is trained on the participant's specific positive behavioral support plan so provider is able to safely and appropriately respond to challenging and unexpected behaviors participant may display during services.

Current Positive Behavioral Supports and Strategies for Participant:

Participant has an active Behavior Intervention Plan through school, therapy service, or other agency?

☐ No ☐ Yes, and provider has reviewed this/these behavior intervention plan(s)

6. _____ 6. Provider acknowledges and agrees that the participant may not be put into isolation or seclusion and cannot be restrained in any way during sessions. Providers are prohibited from these actions except in cases where a specific participant behavior plan has received Department of Health Services (DHS) approval. All violations of this policy must be immediately reported to the county waiver agency.

Participant has an approved DHS restrictive measures plan

☐ No ☐ Yes: Provider has received comprehensive training on this plan by county waiver agency AND participant's parent/guardian.

7. _____ 7. Provider Is trained on county waiver agency/contract agency policies, procedures, and expectations for providers including confidentiality of participant information according to federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.

8. _____ 8. Provider received training on billing and payment processes, record keeping, incident and mandated reporting requirements, and name/contact information of the county waiver agency service coordinator as well as contract agency.

9. _____ 9. Provider will be providing transportation services to the participant

☐ No ☐ Yes

If Yes, parent/guardian has reviewed the following and copies are on file with the county waiver agency:

- ☐ Provider's has a valid driver's license
☐ Provider has valid car insurance coverage
☐ Parent/Guardian has reviewed the provider's vehicle and attests that it is in sound working order and provider will be able to safely and legally provide transportation services to the participant.

10. _____ 10. Provider has a professional license or meets Medicaid certification for personal care services or nursing

☐ No ☐ Yes and a copy of the _____ license/certification has been received by the county waiver agency.

11. _____ 11. Provider has prior training related to the participant's specific disability of _____ or general training in ☐ developmental disabilities, ☐ mental health, and/or ☐ physical disabilities.

☐ **Prior training**

☐ **No prior training:** Parent/Guardian exempts provider from needing prior training and feels provider can safely, ethically, and appropriately deliver services to the participant. Parent/Guardian has provided provider with training on participant's specific diagnosis by sharing the following information:

12. _____ 12. Provider has received prior training on professional ethics and interpersonal skills as well as understanding and respecting participant direction, individuality, independence, and rights. Additionally, Provider has received prior training on how to handle conflicts and complaints with participants, respecting personal property, and understanding cultural differences and family relationships.

☐ **Prior training:**

☐ **No prior training:** Parent/Guardian is exempting provider from needing this training. They feel that the provider will be able to safely, ethically, and appropriately provide services to the participant due to the following reasons:

13. _____ 13. Provider has prior training on providing quality homemaking and household services, including understanding good nutrition, special diets, and meal planning and preparation. Provider has been trained on how to maintain a clean, safe, and healthy home environment. The provider is able to respect the participant's preferences in housekeeping, shopping and home making tasks.

☐ **Prior training:**

☐ **No prior training:** Parent/Guardian has provided training on this topic to provider as it relates to the participant's dietary needs and family's household preferences. Expectations of provider for maintaining household needs during services includes: (*Chores to be done during SHC-Chores sessions must be explained in full)

Signatures

Our signatures below indicate the named employee has met all required provider standards for this service at this time.

Signature of Employee	Date
Signature of Participant's Parent or Legal Guardian	Date
Signature of Support and Service Coordinator representing CWA	Date

Training Review

All providers must review this training information with the participant's parent/guardian every 4 years during the provider's renewal background check process. Significant changes to the participant's needs warrants a new verification of training form to be completed. Please indicate below dates of reviews and any minor updates to training that was warranted for the participant.

Date of Review	Additional Training Provided by Parent/Guardian	Initials for all parties



COUNTY OF KENOSHA

John T. Jansen, Director
Department of Human Services

Ron Rogers, Director
Division of Children & Family Services
Job Center / Human Services Building
8600 Sheridan Road, Suite 200
Kenosha, Wisconsin 53143-6512
(262) 697-4500
Fax: (262) 605-6570

Kenosha County Waiver Agency Policies and Expectations for Providers paid by a Financial Management Service

Re: _____
(CLTS Participant Name)

This document outlines policies and expectations for providers who are utilizing a Financial Management Service (FMS) agency and have agreed to provide services for a child funded through a Children's Long-Term Support (CLTS) Medicaid Waiver. Below is a summary of what must be agreed to before you can provide services. You must also complete all necessary tasks with the identified FMS agency.

1. The CLTS Waiver client and their parent/guardian is your employer, not the CLTS Waiver agency or Kenosha County.

- I agree to involve the participant and/or guardian in decisions about the participant's care and services s/he receives from me.

2. Providers are unable to restrain, isolate, or seclude a child while they are providing services to a client.

- I agree to provide care/services in the least restrictive manner and setting necessary, while still ensuring the safety of the participant. Any breach in this policy must be reported to the service coordinator within 24 hours of the incident

3. Providers must contact the appropriate service coordinator and the client's parent/guardian to report all critical incidents that occur during a service within 24 hours.

- I agree to report any injuries to the client, injuries to the provider, emergency situations, suspected abuse or neglect of the client, medications errors, significant property damage, and any other concerning incidents or accidents that cause harm to the service coordinator in a detailed report.
- I further acknowledge that I am a mandated reporter and will report all concerns of abuse/neglect which could include sexual abuse, physical abuse, neglect and sexual activity between minors. These concerns will be reported to the client's service coordinator and to Child Protective Services (CPS). CPS can be reached Monday through Friday 8 am to 5 pm via Kenosha County's Access Line at (262) 605-6582. Report after hours concerns to 262-657-7188.

4. You must keep records of when you worked with the client for 7 years.

- I understand that I may be asked to produce records by Kenosha County Waiver Agency.

- I acknowledge that I may need to provide additional documentation as required for the service I am providing.

5. Providers' wages are based on the CLTS participant's needs and the rate standards created by Wisconsin Department of Health Services for each service performed.

6. Providers must engage with the client and their family in a professional capacity, should adhere to appropriate dress and language, and display a respectful demeanor toward the client and their family.

- I agree to be respectful of the family's cultural needs/preferences, rules of their home, and follow through on all required duties of the service I am performing.
- I agree to treat the participant, and their family members, with dignity and respect, free from any verbal, physical, emotional and/or sexual abuse.
- I agree to treat the participant fairly and will not discriminate based on race, national origin, gender, age, religion, disability, or sexual preference.

7. Providers should exercise a calm demeanor when in conflict with the client/family or other relevant providers the client engages with. Providers may contact the client's service coordinator for assistance with disputes between the provider and client/family or other relevant parties.

8. Providers must keep identifying information regarding the client you are working with confidential.

- I will keep the participant's information confidential, unless the law permits disclosure. I acknowledge this agreement remains in effect even after employment is terminated.
- I will not release any information regarding the participant without consent from the participant or his/her guardian. This includes taking pictures of the client without parent consent or posting client pictures/information online.
- This notice also serves as a release of information in order for me to discuss the participant with the CLTS Service Coordinator.

I, _____, understand that as a paid Children's Long-Term
(Print name)
Support (CLTS) Waiver provider, I am required to follow all policies and expectations as outlined in this document. I further acknowledge that failure to follow these policies may result in my termination or denial of payment.

Provider Signature

Date

Parent/Guardian Signature

Date



COUNTY OF KENOSHA

John T. Jansen, Director
Department of Human Services

Ron Rogers, Director
Division of Children & Family Services
Job Center / Human Services Building
8600 Sheridan Road, Suite 200
Kenosha, Wisconsin 53143-6512
(262) 697-4500
Fax: (262) 605-6570

Request for Child Protective Services ACCESS Employee Search Request

The purpose of this form is to gather information and authorization to complete Child Protective Services (CPS) background checks from the following and is not for re-release except to the subject of the record.

- Child Protective Services Background Check (includes the use of the State of Wisconsin's automated EWISACWIS system and/or CPS case files).

This completed form should be faxed to Kenosha County Division of Children and Family Services (KDCDFS), to fax number 262-697-4585. The form should be to the attention of Access.

A separate form must be completed for each individual background check request. You should receive a response within 10 business days of the date the request was received. If you haven't received a response within this time frame, please contact Access at 262-605-6582, and include the name of the person you submitted a request for.

The purpose of this request is a CPS background check of Wisconsin record for Children's Long-Term Support (CLTS) Waiver program providers.

Information for individual the request is on:

Name (Last, First, Middle): _____

Social Security Number: _____ Birthdate: _____

Provide all other legal names (maiden, married, hyphenated) and include names used that were not legal changes, alternate spellings and initials used.

Agency Requesting Contact Information (Information can be returned to):

CLTS Agency Contact Person: _____

Email: _____ Requesting CLTS Agency: _____

Telephone: _____ FAX: _____

My signature hereby authorizes KDCDFS to conduct the search and release the information to the above listed CLTS agency.

Signature of individual the request is on:

_____ Date: _____

Printed name of individual the request is on: _____

FOR ACCESS OFFICE USE ONLY:

Individual background check is cleared and this individual can be hired:

☐ YES ☐ NO



KENOSHA COUNTY

John Jansen, Director
Department of Human Services

Ron Rogers, Director
Division of Children & Family Services
Job Center / Human Services Building
8600 Sheridan Road, Suite 200
Kenosha, Wisconsin 53143-6512
(262) 697-4500
Fax: (262) 605-6570

Request for Child Protective Services ACCESS Employee Search

The purpose of this form is to gather information and authorization to complete Child Protective Services (CPS) background checks from the following and is not for re-release except to the subject of the record.

- Child Protective Services Background Check (includes the use of the State of Wisconsin's automated eWiSACWIS system and/or CPS case files).

This completed form should be emailed to: Backgrounds@kenoshacountywi.gov

A separate form must be completed for each individual background check request. You should receive a response within 10 business days of the date the request was received. If you haven't received a response within this time frame, please contact Access at 262-605-6582, and include the name of the person you submitted a request for.

The purpose of this request is a CPS background check of Wisconsin record for Children's Long-Term Support (CLTS) Waiver program providers.

Information must be returned to (DO NOT LEAVE BLANK):

CLTS Agency Contact Person: _____

Requesting CLTS Agency: _____

Email: _____ Telephone: _____

Information for individual the request is on:

Name (Last, First, Middle): _____

Social Security Number: _____ Birthdate: _____

Provide all other legal names (maiden, married, hyphenated) and include names used that were not legal changes, alternate spellings and initials used: _____

My signature hereby authorizes KDCDFS to conduct the search and release the information to the above listed CLTS agency. Signature of individual the request is on:

_____ Date: _____

Printed name of individual the request is on: _____

FOR ACCESS USE ONLY:

Individual background check is cleared and this individual can be hired:

☐ YES ☐ NO