IRIS Participant-Hired Worker Paperwork

Participant-Hired Worker Forms Examples

- F-01201: IRIS Participant-Hired Worker Set-up
- F-01201A: IRIS Participant-Hired Worker Relationship Identification
- W-4: Employee Withholding Allowance Certificate (2021)
- WT-4: Employee’s WI Withholding Exemption Certificate
- Form I-9
- F-00180C: Wisconsin Medicaid Program Provider Agreement and Acknowledgment of Terms of Participation — For Waiver Service Provider Agencies or Individuals
- F-82064: Background Information Disclosure (BID)
- F-01246: Background Information Disclosure Addendum
- F-01201C: IRIS Participant Employer/Participant-Hired Worker Agreement
- iLIFE Participant-Hired Worker Payment Election Form
- F-01201B: IRIS Supportive Home Care/Self-Directed Personal Care/Respite Care Training Verification

Note: Participant-Hired Worker may be abbreviated as PHW throughout this document.
IRIS Participant-Hired Worker Set-Up

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01201 (09/2020)

IRIS PARTICIPANT-HIRED WORKER SET-UP

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. A participant-hired worker may not begin working for a participant before the IRIS start date, indicated in the participant’s start date letter.

Personally identifiable information on this form is collected to verify that the application is complete, and will be used for this purpose and the electronic visit verification enumeration process. As a result, all participant-hired workers must provide their email address in order for this form to be processed.

Completed forms should be submitted to the participant’s fiscal employer agent.

SECTION I

Name – Participant-Hired Worker: The PHW’s full, legal name in last name, first name, middle initial format.

Gender: Check the box that best describes the Participant-Hired Worker’s gender.

Date of Birth: The PHW’s birthdate in mm/dd/yyyy format.

Mailing Address, City, State, and ZIP: The Participant-Hired Worker’s street address, city, state, and ZIP code.

Phone Number: The Participant-Hired Worker’s telephone number with Area Code.

Email Address: The Participant-Hired Worker’s email address.

SECTION II

Name – Participant/Employer: The PHW’s full, legal name in last name, first name, middle initial format.

Date of Birth: The Participant/Employer’s birthdate in mm/dd/yyyy format.

Master Client Index (MCI): Participant/Employer’s MCI number.

Mailing Address, City, State, and ZIP: The Participant/Employer’s street address, city, state, and ZIP code.

Phone Number: The Participant/Employer’s telephone number with Area Code.

Email Address: The Participant/Employer’s email address.

Signature – Participant-Hired Worker: The PHW’s signature.

Date Signed: The date the form was signed by the Participant-Hired Worker.

Signature – Participant/Employer: The Participant/Employer’s signature (or the signature of their representative).

Date Signed: The date the form was signed by the Participant/Employer or their representative.
INSTRUCTIONS
Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

SECTION A: PARTIES:
Name – Participant-Hired Worker: The Participant-Hired Worker’s name in last name, first name format.
Name – Participant Employer: The Participant/Employer’s name in last name, first name format.

Participant Medicaid Identification Number (MCI): The Participant’s MCI.

SECTION B: RELATIONSHIP: Place a check next to the box that indicates the Participant-Hired Worker’s legal relationship to the Participant/Employer for tax purposes. (See page 2 for more details.)

SECTION C: LIVING SITUATION: Check either “Yes” to indicate the Participant and Participant-Hired Worker live in the same home or “No” to indicate they do not. If "Yes" is checked, write the Shared Home Address.

SECTION D: ELECTRONIC VISIT VERIFICATION (EVV) LIVE-IN IDENTIFICATION: If you answered "No" in Section C, do you qualify to be EVV live-in as defined in Section D? If the PHW meets one of the requirements in this section, they are to enter the address in Section C and provide a copy of one document from Column A (on the next page) or two documents from Column B (on the next page) to identify their permanent residency. Please note that this document will be completed annually for workers who qualify for the EVV live-in definition.
INSTRUCTIONS
Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

SECTION D: ELECTRONIC VISIT VERIFICATION (EVV) LIVE-IN IDENTIFICATION (continued from previous page): If you answered "No" in Section C, do you qualify to be EVV live-in as defined in Section D?, if the PHW meets one of the requirements in this section (on the previous page), they are to enter the address in Section C and provide a copy of one document from Column A or two documents from Column B to identify their permanent residency.

SECTION E: ATTESTATIONS:
Participant-Hired Worker: The worker is responsible for notifying the FEA of any change in live-in status within seven (7) days.

Participant-Employer (Check if applicable): Check the appropriate check box based on the residency documents supplied by the PHW.

SIGNATURE – Participant-Hired Worker: The Participant-Hired Worker’s signature.

Date Signed: The date the Participant-Hired Worker signed this form.

SIGNATURE – Participant Employer: The Participant/Employer’s signature.

Date Signed: The date the Participant/Employer (or their representative) signed this form.

<table>
<thead>
<tr>
<th>Column A (Choose One)</th>
<th>Column B (Choose Two)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Current and valid State of Wisconsin driver’s license or state ID card</td>
<td>✓ Current or past month’s gas, electric, or phone service statement</td>
</tr>
<tr>
<td>□ Other current official ID card or license issued by a Wisconsin governmental body or unit</td>
<td>□ Current or past month’s bank statement</td>
</tr>
<tr>
<td>□ Real estate tax bill or receipt for the current year</td>
<td>□ Current or past month’s paycheck or paystub</td>
</tr>
<tr>
<td>□ Residential lease for current year</td>
<td></td>
</tr>
<tr>
<td>□ Check or other document issued by a unit of government within the last three months</td>
<td></td>
</tr>
</tbody>
</table>

SECTION E: ATTESTATIONS
Participant-Hired Worker: If I checked “Yes” in Section C above, I shall notify the participant’s Fiscal Employer Agent (FEA) within seven (7) days of a change in my living situation so that I may continue to provide paid services.

Participant-Employer (Check if applicable):
✓ I have examined the documentation above and attest that the address of the worker on the documentation provided matches that of the participant on this form.

☐ I attest that the documentation for the address provided is not an exact match to the participant, but the worker meets all criteria listed and required of a live-in relative.

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

SIGNATURE – Participant-Hired Worker Signature
Date Signed

SIGNATURE – Participant Employer Signature
Date Signed

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

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

‡ Per Wis. Statute 770.05, Domestic Partnership means you and your same sex partner have filed for Domestic Partnership, and have a certified copy of your Declaration of Domestic Partnership.
**Employee’s Withholding Allowance Certificate**

**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

Employee’s Withholding Allowance Certificate: The Form W-4 is used to withhold the correct amount of Federal income tax from pay. This is the portion that will need to be turned in. Some PHWs may separate the form here to keep the worksheet (page 3, not included here) for their records.

**Step 1:** The full name of the PHW – as well as their home address, city, state, and ZIP code.

**Step 1b:** The PHW’s Social Security number. If the PHW’s name does not match the name on their Social Security card, they should contact the SSA at 800-772-1213 or go to www.ssa.gov.

**Step 1c:** Check the box that best indicates the PHW’s filing status.

Complete Steps 2 through 4 of the Form W-4 ONLY if they apply to the PHW.

**Step 2:** Estimate withholding using options (a) and (b), or check the box for option (c).

**Step 3:** Enter amounts for each line, add them together, and write the total in box 3.

**Step 4:** Enter amounts for (a) Other Income, (b) Deductions, and (c) Extra withholding.

**Step 5:** The signature of the Participant-Hired Worker and the date the form was signed.

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**Special Instructions for Claiming “Exempt”**

If the PHW meets both conditions noted on the Form W-4, they can write “Exempt” in the space below Step 4(c) and complete steps 1 and 5 to claim exempt. No other steps on the Form W-4 should be completed.

The Form W-4 will need to be completed annually (by February) if the Participant-Hired Worker wishes to remain at “Exempt” status from year to year.
**EXAMPLE: WT-4**

**Employee’s WI Withholding Exemption Certificate**

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

**PHW Last Name, First Name and Middle Initial**

**Participant-Hired Worker’s Street Address**

**City**

**State**

**Zip Code**

**Date of Birth**

**Date of Hire**

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

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

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

**Line 3:** Enter “Exempt” if the criteria from the instructions is met.

**Signature:** The Participant-Hired Worker’s signature.

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

**Employer’s Section:**

**Participant/Employee’s Name**

**Participant/Employee’s Address**

**City**

**State**

**Zip Code**

**Employer’s Section:**

**Employer’s Name:** The IRIS Participant’s full legal, printed name.

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

**Employer’s Payroll Address, City, State, and ZIP Code:** The Participant/Employee’s street address, city, state, and ZIP code.

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

**Title:** “HHCSR” if being completed by the Participant/Employer or “POA” or “Guardian” if being completed by their representative.
**INSTRUCTIONS**

*Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.*

**SECTION 1**

**Completed by the Participant-Hired Worker.**

Last Name, First Name, Middle Initial: Participant-Hired Worker’s full, legal name in last name, first name, middle initial format.

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

Address, Apt. Number, City or Town, State, ZIP Code: Participant-Hired Worker’s current address, city, state, and ZIP code. Note: P.O. Boxes are not acceptable.

Date of Birth: Participant-Hired Worker’s birthdate in mm/dd/yyyy format.

U.S. Social Security Number: Participant-Hired Worker’s Social Security Number.

E-mail Address: Participant-Hired Worker’s email address.

Telephone Number: Participant-Hired Worker’s telephone number with Area Code.

I attest, under penalty of perjury, that I am: Check the box that best describes the Participant-Hired Worker’s citizenship status. Include additional required information if specified for that section.

Signature of Employee: The PHW’s signature.

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

Preparer and/or Translator Certification: This section is only completed if the PHW uses a translator to complete this form. Check the appropriate box to indicate if a preparer or translator is used.

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**Employment Eligibility Verification**

Department of Homeland Security

U.S. Citizenship and Immigration Services

**Form I-9**

OMB No. 1615-0047

Expires 10/31/2022

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

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

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

<table>
<thead>
<tr>
<th>PHW Last Name</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Last Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street Number and Name)</td>
<td>Apt. Number</td>
<td>City or Town</td>
<td>State</td>
</tr>
<tr>
<td>Date of Birth (mm/dd/yyyy)</td>
<td>U.S. Social Security Number</td>
<td>Employee’s E-mail Address</td>
<td>Employee’s Telephone Number</td>
</tr>
<tr>
<td>mm/dd/yyyy</td>
<td># # #</td>
<td>PHW’s Email Address</td>
<td>(#) # # - # #</td>
</tr>
</tbody>
</table>

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

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

1. A citizen of the United States
2. A noncitizen national of the United States (See instructions)
3. A lawful permanent resident (Alien Registration Number/USCIS Number):
   - Alien Registration Number/USCIS Number:
4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy):
   - Some aliens may write “N/A” in the expiration date field. (See instructions)

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number:
2. Form I-94 Admission Number:
3. Foreign Passport Number:

Country of Issuance:

Signature of Employee

Participant-hired worker Signature

mm/dd/yyyy

Preparer and/or Translator Certification (check one):

1. Did not use a preparer or translator:
2. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(QR Code - Section 1 Do Not Write In This Space)

Preparer and/or Translator Certification:

([Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.])

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

Signature of Preparer or Translator

mm/dd/yyyy

Last Name (Family Name)

First Name (Given Name)

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

Employer Completes Next Page
Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

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

**Employee Info:** Participant-Hired Worker’s first name, last name, middle initial and citizenship status.

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

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

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

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

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

**Signature of Employer:** The IRIS Participant/Employer’s signature or signature of his/her POA or Guardian if they are completing this form on the Participant/Employer’s behalf.

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

**Title of Employer:** “Employer” if the Participant/Employer is completing the form or “Employer’s POA” or “Employer’s Guardian” if applicable.

**Last Name and First Name:** The last and first name of the Participant, or their POA or Guardian, completing this form.

**Employer’s Business or Organization Name:** “IRIS Participant”

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

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**Check Every Time!**

Make sure to refer to the document being used for each field. Titles, issuing authorities, etc. may change based on when/where the document was issued.

Examples:
- Department of Transportation vs. Department of Motor Vehicles
- Social Security Administration vs. Department of Homeland Security

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

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

**Signature of Employer or Authorized Representative**

**Participant/Employer or Representative Signature**

**Today’s Date (mm/dd/yyyy)**

**Title of Employer or Authorized Representative**

**Employer, Employer’s POA, or Employer’s Guardian**

**Last Name of Employer or Authorized Representative**

**First Name of Employer or Authorized Representative**

**Participant/Employer Last Name**

**Participant/Employer First Name**

**Employer’s Business or Organization Name**

**Employer’s Business or Organization Address (Street Name and Number)**

**City or Town**

**State**

**ZIP Code**

**IRIS Participant**

**Participant/Employer’s Street Number and Street Name**

**City**

**State**

**ZIP Code**

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**Key Rules of Documenting Required Identification in SECTION 2**

When documenting required identification, employers or their authorized representative must:
- The person who examines the documents must be the same person who signs Section 2.
- The examiner of the documents and the employee must both be physically present during the examination of the employee’s documents.
- Employers cannot refuse to hire someone just because the document(s) presented by the employee/worker will expire soon. If an employee is unable to present a required document (or documents), the employee can present an acceptable receipt in lieu of a document from the Lists of Acceptable Documents.
- DO NOT USE abbreviations or acronyms.
- Documents cannot be expired.
- Employers CANNOT specify which document(s) they will accept from an employee.
LISTS OF ACCEPTABLE DOCUMENTS  
All documents must be UNEXPIRED  
Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

<table>
<thead>
<tr>
<th>LIST A</th>
<th>Documents that Establish Both Identity and Employment Authorization</th>
<th>LIST B</th>
<th>Documents that Establish Identity</th>
<th>LIST C</th>
<th>Documents that Establish Employment Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>U.S. Passport or U.S. Passport Card</td>
<td>1.</td>
<td>Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>2.</td>
<td>ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3.</td>
<td>School ID card with a photograph</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4.</td>
<td>Voter's registration card</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td>5.</td>
<td>U.S. Military card or draft record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Foreign passport; and</td>
<td>6.</td>
<td>Military dependent's ID card</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Form I-94 or Form I-94A that has the following:</td>
<td>7.</td>
<td>U.S. Coast Guard Merchant Mariner Card</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td>The same name as the passport; and</td>
<td>8.</td>
<td>Native American tribal document</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</td>
<td>9.</td>
<td>Driver's license issued by a Canadian government authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>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</td>
<td>10.</td>
<td>School record or report card</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For persons under age 18 who are unable to present a document listed above:</td>
<td>11.</td>
<td>Clinic, doctor, or hospital record</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Refer to the instructions for more information about acceptable receipts.
INSTRUCTIONS
Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

This form is used for Participant-Hired Workers.

Name of Provider: The full, legal name of the Participant-Hired Worker.

Telephone Number: The Participant-Hired Worker’s telephone number with Area Code.

Address – Street, City, State, and ZIP Code: The Participant-Hired Worker’s city, state, and ZIP code.

Continued on Page 2

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00180C (07/2017)

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION
FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

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

Name of Provider (Typed or Printed—Must exactly match name used on all other documents) Phone Number
(###) ###-####

<table>
<thead>
<tr>
<th>Address – Street</th>
<th>Participant-Hired Worker’s Name</th>
<th>City</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

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

1. To provide only the items or services authorized by the managed care organization or IRIS program.
2. To accept the payment issued by the managed care organization or IRIS program as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the managed care organization or IRIS program.
5. To keep any records necessary to disclose the extent of services provided consistent with the provider’s business type.
6. To provide, upon request by the managed care organization, the IRIS program, or the Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based waiver services under Wisconsin’s Medicaid program including the caregiver background check law.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant’s status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant’s right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants for a period of ten (10) years and to furnish upon request to the DHS, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. This requirement includes retaining all records and documents according to the terms provided by Wis. Admin. Code § DHS 106.02(a)-(d); (f)-(g).
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the managed care organization and upon request, to the Department in writing:
   a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;
   b) The names and addresses of all persons who have a controlling interest in the provider;
### Wisconsin Medicaid Program Provider Agreement and Acknowledgment of Terms of Participation – For Waiver Service Provider Agencies or Individuals

**Name – Provider:** The Participant-Hired Worker name.

**Signature – Provider:** The Participant-Hired Worker signature.

**Date Signed:** The date this form was signed by the Participant-Hired Worker.

### DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00180C (07/2017)

- Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;
- The names and addresses of any subcontractors who have had business transactions with the provider;
- The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.

12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI). Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.

13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.

14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

### Modifications to this agreement cannot and will not be agreed to. Altering this agreement in any way voids the Department of Health Services’ signature. This agreement is not transferable or assignable.

<table>
<thead>
<tr>
<th>Name – Provider (Typed or Printed)</th>
<th>SIGNATURE – Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant-Hired Worker’s Full Printed Name</td>
<td>Date Signed</td>
</tr>
<tr>
<td>Participant-Hired Worker’s Signature</td>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>

### FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)

<table>
<thead>
<tr>
<th>SIGNATURE – Department of Health Services</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8/14/17</td>
</tr>
</tbody>
</table>
**EXAMPLE: F-82064**

**Background Information Disclosure**

Page 1

**INSTRUCTIONS**

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

Check the box that applies to you: Check “Employee/Contractor (including new applicant)”

**Legal Name – (First and Middle):** The Participant-Hired Worker’s legal first and middle names.

**Legal Name – (Last):** The Participant-Hired Worker’s legal last name.

**Position Title:** Enter “Employee.”

**Any Other Names…** Include any names that the Participant-Hired Worker has been known by – including maiden name.

**Birth Date:** The PHW’s birthdate in mm/dd/yyyy format.

**Sex:** Check the box that best describes the Participant-Hired Worker’s sex.

**Race/Ethnicity:** Check the box that best describes the Participant-Hired Worker’s race.

**Social Security Number:** Participant-Hired Worker’s Social Security Number.

**Home Address, City, State, and Zip Code:** Enter the Participant-Hired Worker’s street address, city, state, and ZIP code.

**Business Name and Address:** The Participant/Employer’s name and address (street address, city, state, and ZIP code).

**SECTION A**

For each question, check either “Yes” or “No.” Note: Some questions require additional information. Please read carefully.

---

**BACKGROUND INFORMATION DISCLOSURE (BID)**

- **Penalty:** Knowingly providing false information or omitting information may result in a forfeiture of up to $1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).
- **Completion:** This form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- **Social Security Number:** Your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- **Refer to DQA form F-82064A, BID Instructions, for additional information.**

---

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

- **Employee / Contractor (including new applicant)**
- **Applicant for a license, certification, or registration (including continuation or renewal)**
- **Other – Specify:**

**NOTE:** If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the Appendix, F-82065, and submit both forms to the address noted in the Appendix Instructions.

<table>
<thead>
<tr>
<th>Full Legal Name – First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHW’s First Name</td>
<td>PHW’s Middle Name</td>
<td>PHW’s Last Name</td>
</tr>
</tbody>
</table>

- **Birth Date (mm/dd/yyyy)**
- **Sex**: Male  
- **Social Security Number**

<table>
<thead>
<tr>
<th>Home Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant/Hired Worker’s Street Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

**Participant/Employer’s Name and Address (Street Address, City, State, and Zip Code)**

A “NO” answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

Note: The areas below that are designated for responses are expandable.

**SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION**

1. **Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?**
   - **Yes**  
   - **No**  
   - You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

2. **Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?**
   - **Yes**  
   - **No**  
   - You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.

3. **IMPORTANT:** Read before completing item 3.

   Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. “All reports made under this section, notices provided under sub. (3)(b) and records maintained by an agency and other persons, officials, and institutions shall be confidential.” Reports and records may be disclosed only to the persons identified in this section.

   **If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.**

   - **Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect?**
   - **Yes**  
   - **No**  
   - **If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.**
SECTION A (continued)
For each question, check either “Yes” or “No.” Note: Some questions require additional information. Please read carefully.

SECTION B
For each question, check either “Yes” or “No.” Note: Some questions require additional information. Please read carefully.

Read and initial the following statement: The Participant-Hired Worker’s initials.

Name – The Person Completing This Form: The Participant-Hired Worker’s name.

Date Signed: The date this form was signed by the Participant-Hired Worker.

---

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?</td>
<td>Yes No</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? | Yes No |
|   |   |
|   |   |

| 6. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person? | Yes No |
|   |   |
|   |   |

| 7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? | Yes No |
|   |   |
|   |   |

---

SECTION B – OTHER REQUIRED INFORMATION

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services?</td>
<td>Yes No</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? | Yes No |
|   |   |
|   |   |

| 3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? | Yes No |
|   |   |
|   |   |

| 4. Have you resided outside of Wisconsin in the last three (3) years? | Yes No |
|   |   |
|   |   |

| 5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? | Yes No |
|   |   |
|   |   |

| 6. Have you had a caregiver background check done within the last four (4) years? | Yes No |
|   |   |
|   |   |

| 7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? | Yes No |
|   |   |
|   |   |

---

Read and initial the following statement.

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name – Person Completing This Form</td>
<td>Date Submitted</td>
</tr>
<tr>
<td>Participant-Hired Worker’s Name</td>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>
**INSTRUCTIONS**

*Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.*

**SECTION I**

**Name:** The Participant-Hired Worker’s name in last name, first name, middle initial format.

**Date of Birth:** The Participant-Hired Worker’s birthdate in mm/dd/yyyy format.

**Address, Years at Residence, and Any Other Names:** For the **past 3 years**, list:
- The Participant-Hired Worker’s Address (street address, city, state, and ZIP code)
- The number of years at that residence
- Any other names that the PHW went by while at that location

**Report for each prior address until the total years at residence listed is equal to at least 3 years.**

**SECTION II**

If the PHW has lived outside of Wisconsin in the past 3 years, this section will need to be completed. If the PHW has NOT lived outside of Wisconsin for the past 3 years, skip to the Signature and Date Signed fields.

Section II includes:
- **Current Address/Previous Address, City, State, ZIP Code, and County:** For the **past 3 years**, list:
  - The PHW’s address (street address, city, state, and ZIP code)
  - The number of years at that residence
  - Any other names that the PHW went by while at that location
  - Repeat for each prior address until the total years at residence listed is equal to at least 3 years.
- **Mother’s Maiden Name:** The PHW’s mother’s maiden name.
- **Mother’s Current Name:** The PHW’s mother’s current name in last name, first name, middle initial format.
- **Father’s Name:** The PHW’s name in last name, first name, middle initial format.

**Signature:** The PHW’s signature.

**Date Signed:** The date this form was signed by the PHW.
EXAMPLE: F-01201C
IRIS Participant Employer/Participant-Hired Worker Agreement

INSTRUCTIONS:
Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

PAGE 1
Name – Participant-Hired Worker:
The Participant-Hired Worker’s name in last name, first name format.

Name – Participant Employer:
The Participant/Employer’s name in last name, first name format.

Date of Birth – Participant-Hired Worker:
The Participant-Hired Worker’s birthdate in mm/dd/yyyy format.

The participant requires... Enter the tasks the Participant-Hired Worker will provide.

The participant employer agrees... Enter the training the Participant/Employer will provide for the Participant-Hired Worker.

Participant-Hired Worker Schedule:
Check the days of the week the Participant-Hired Worker will provide services or enter an explanation of the schedule in the “Other” field.

Participant-Hired Worker Services:
Enter the Pay Rate, Unit Type, and Units per Week for each service that the Participant-Hired Worker will provide or an explanation in the “Other” field.

PAGE 2
Signature – Participant-Hired Worker:
The Participant-Hired Worker’s signature.

Date Signed: The date the Participant-Hired Worker signed this form.

Signature – Participant Employer:
The date the Participant/Employer (or their representative) signed this form.

Date Signed: The date the Participant/Employer (or their representative) signed this form.

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01201C (02/2017)

IRIS PARTICIPANT EMPLOYER / PARTICIPANT - HIRED WORKER AGREEMENT

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute, however, completion of this form is an IRIS Program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. Participant-hired worker may not begin working for participant employer until they have received a mailed start date letter.

Personally identifiable information on this form is collected to verify that the application is complete, and will be used only for this purpose.

Completed forms should be submitted to the participant’s Fiscal Employer Agent.

| Name – Participant-Hired Worker Last Name, First Name | Name – Participant Employer Last Name, First Name |
| Date of Birth – Participant-Hired Worker mm/dd/yyyy |
| The participant employer requires the following tasks and duties to be performed by the participant-hired worker: |
| Example: “Supportive home care (SHC), mileage trips, personal care, etc.” |

The participant employer agrees to provide/arrange for worker training as described below:

Example: “On first day of employment, the employee will receive a schedule of my daily living activities and they will help me get dressed and ready for the day.”

Participant-Hired Worker Schedule – Indicate Day(s) of the Week Participant-Hired Worker Will Provide Service(s)

<table>
<thead>
<tr>
<th>Service</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive Home Care (SHC)</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>Self-Directed Personal Care (SDPC)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Respite Care (R)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Mileage</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
</tbody>
</table>

If “Other”, please explain:

Participant-Hired Worker Services – Indicate Which Service(s), Pay Rate(s), Unit Type(s) and Units Per Week the Participant-Hired Worker will Provide

<table>
<thead>
<tr>
<th>Service</th>
<th>Pay Rate</th>
<th>Unit Type (per hour, per day, etc.)</th>
<th>Units/Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive Home Care (SHC)</td>
<td>$$. $$</td>
<td>“Per Hour,” “Per Day,” etc.</td>
<td>#</td>
</tr>
<tr>
<td>Self-Directed Personal Care (SDPC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite Care (R)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mileage</td>
<td>Indicate the rate and the number of miles per month the participant-hired worker is authorized to provide</td>
<td>$$. $$</td>
<td>Per Mile</td>
</tr>
</tbody>
</table>

BY SIGNING BELOW:

I (We) understand that the services are provided under Medicaid regulations and that I (we) may not charge in excess of the amount authorized on the participant employer’s plan. After the participant-hired worker has performed the service(s) per this agreement, time reports are due to the participant’s Fiscal Employer Agent.

Both signers agree to only submit time reports within the hours authorized. Without prior approval, excess hours claimed above the authorization may be rejected for payment.

<table>
<thead>
<tr>
<th>SIGNATURE – Participant-Hired Worker</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant-Hired Worker Signature</td>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGNATURE – Participant Employer</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant/Employer (or Representative) Signature</td>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>
Participant-hired Worker Payment Election Form

Instructions: 1. Participant-hired worker completes all information and signs at the bottom.
2. Attach required documents and return form to iLIFE.
NOTE: This document replaces all prior Payment Election forms. If you have more than one IRIS employer, the payment method selected on this form will apply to all payments made by iLIFE.

Participant-hired Worker Name: PHW First Name, Last Name
PHW Employee ID Number: # ####
Last four digits of PHW Social Security number: # # # #
Participant Employer Name: Participant Employer First Name, Last Name

☐ iLIFE Pay Card
No additional documentation required. iLIFE is not responsible for lost or stolen cards or funds. By choosing this option, you agree that you have read and accept the terms of this card, which may be found at http://www.illifefinancialmanagement.com/iLife/Pay-Cards/terms-and-conditions-flyer.pdf

Street Address: PHW Street Address
City: City State: WI ZIP: ####

NOTE: iLIFE pay cards cannot be mailed to P.O. boxes. iLIFE pay cards need to be activated immediately upon receipt of mailed card or you may experience a delay in payment and/or cancellation of the card.

OR

☐ Checking Account
Attach either a voided check or a typed letter from the bank (on bank letterhead) that has the participant-hired worker’s name, the routing number, and the account number. Starter checks may not be used.

☐ Savings Account
Attach a typed letter from the bank (on bank letterhead) that has the participant-hired worker’s name, the routing number, and the account number.

Name of Financial Institution: __________________________
Routing Number: __________________________ Account Number: __________________________

I hereby authorize iLIFE to initiate credit entries, debit entries and adjustments to the financial institution account type or pay card option noted above.

This authorization replaces all prior direct deposit and payment election forms I may have submitted. This authorization is to remain in full force and effect until iLIFE receives written notice from me of its termination, in such time and manner as to allow iLIFE and the financial institution a reasonable opportunity to act on it. I understand that to be effective for the pay date, I must submit this form at least five business days before the pay date.

Participant-hired Worker Signature: __________________________ Date: mm/dd/yyyy

Participant-hired Worker Name: The PHW’s name in first name, last name format.
PHW Employee ID Number: The PHW’s worker number.
Last four digits of Participant-hired Worker’s Social Security number: The last four digits of the PHW’s Social Security number.
Participant Employer Name: The Participant/Employer’s name in first name, middle initial, last name format.
Payment Option: Check one option: iLIFE Pay Card, Checking Account, or Savings Account.
iLIFE Pay Card: If checked, include PHW’s street address, city, state and ZIP code.
Direct Deposit: If Checking Account or Savings Account checked, include:
- Name of Financial Institution: The name of the financial institution affiliated with the checking or savings account to be used for direct deposit.
- Routing Number: The routing number of the account to be used.
- Account Number: The account number of the account to be used.
Participant-hired Worker Signature: The signature of the Participant-Hired Worker.
Date: The date the form was signed.
INSTRUCTIONS

Note: Participant-Hired Worker may be abbreviated as PHW throughout this form.

NOTE: This form is required but does not need to be submitted with the start-up forms. Please complete after the Participant-Hired Worker’s issued start date.

SECTION 1

Name – Participant-Hired Worker: The Participant-Hired Worker’s name in last name, first name format.

Name – Participant Employer: The Participant/Employer’s name in last name, first name format.

Date of Birth – Participant-Hired Worker: The Participant-Hired Worker’s birthdate in mm/dd/yyyy format.

Anticipated Start Date: Enter the date the Participant-Hired Worker will likely start in mm/dd/yyyy format.

SECTION II-IV

Check the box(es) that best describe the required training that the Participant-Hired Worker will need.

Required training completed on: Enter the date the training was completed and any notes about what was covered in the training.

NOTE: This must be after the issued start date.

PAGE 2

Signature – Participant-Hired Worker: The Participant-Hired Worker’s signature.

Date Signed: The date the Participant-Hired Worker signed this form.

Signature – Participant Employer: The date the Participant/Employer (or their representative) signed this form.

Date Signed: The date the Participant/Employer (or their representative) signed this form.