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

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): The 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.

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.

Check your legal relationship to the participant… Place a check next to the box that indicates the Participant-Hired Worker’s legal relationship to the Participant/Employer.

Example: If the Participant-Hired Worker is the IRIS Participant’s Mother or Father, they would check “Parent.”

The participant receiving nonmedical care lives in the participant-hired worker’s home: Check either “Yes” to indicate the Participant/Employer lives in the Participant-Hired Worker’s home or “No” to indicate the Participant/Employer does NOT live in the Participant-Hired Worker’s home.

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.

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**EXAMPLE: F-01201A**

**IRIS Participant-Hired Worker Relationship Identification**

**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.

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

Date of Birth – Participant/Employer

Signature – Participant-Hired Worker

Signature – Participant Employer

Date Signed - Participant-Hired Worker

Date Signed - Participant Employer

**RELATIVE (BIOLOGICAL)**

- Parent *
- Son/Daughter (over 21) *
- Son/Daughter (under 21) * ±
- Adopted Child *
- Grandparent *
- Grandchild *
- Brother / Sister
- Uncle / Aunt
- Nephew / Niece
- Cousin

**RELATIVE (BY MARRIAGE/PARTNERSHIP)**

- Spouse *
- Domestic Partner * ±
- Step Parent *
- Step Child *
- Step Grandchild
- Step Brother / Step Sister
- Parent-in-Law
- Child-in-Law
- Brother-in-Law / Sister-in-Law

**NON-RELATED RELATIONSHIPS**

- Friend
- Neighbor
- Worker
- Ex-Husband / Ex-Wife

* 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.

☐ Yes  ☐ No  The participant receiving nonmedical care lives in the participant-hired worker’s home.

NOTE: It is the participant-hired worker’s responsibility to notify the participant’s fiscal employer agent should their living situation change.

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**

Participant-Hired Worker Signature

Date Signed

**SIGNATURE – Participant Employer**

Participant/Employer (or Representitive) Signature

Date Signed

mm/dd/yyyy

mm/dd/yyyy
Employee's Withholding Allowance Certificate: 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.

Box 1: The legal first name, middle initial, and last name of the PHW – as well as his/her home address, city, state, and ZIP code.

Box 2: The PHW’s Social Security number.

Box 3: Check the box that best describes the PHW’s marital status.

Box 4: Check if the PHW’s last name is different than what is shown on their Social Security card.

Box 5: Enter the number of allowances the PHW is claiming. This is typically the same number as is found on Line H of the Personal Allowances Worksheet but may differ.

Box 6: Enter any additional amount the Participant-Hired Worker wants withheld each pay period.

Box 7: Enter “Exempt” if claiming an exempt status.

Employee’s Signature: The signature of the Participant-Hired Worker.

Date: The date the form was signed.

Special Instructions for Claiming “Exempt”

If the Participant-Hired Worker is claiming “Exempt,” Box 5 should be left blank and “Exempt” should be written in Box 7.

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**

- **Employee’s Legal Name:** The Participant-Hired Worker’s legal name in last name, first name and middle initial format.
- **Social Security Number:** The Participant-Hired Worker’s Social Security Number.
- **Check Boxes:** Check the box that best describes the Participant-Hired Worker’s marital status.
- **Employee’s Address, City, State, and Zip Code:** The Participant-Hired Worker’s street address, city, state, and ZIP code.
- **Date of Birth:** The Participant-Hired Worker’s birthday in mm/dd/yyyy format.
- **Date of Hire:** The Participant-Hired Worker’s start date in mm/dd/yyyy format.

**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/Employer’s street address, city, state, and ZIP code.

**Instructions**

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

**Employee’s Section**

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

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

**Check Boxes:** Check the box that best describes the Participant-Hired Worker’s marital status.

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

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

**Date of Hire:** If the Participant-Hired Worker’s start date has been issued by the time this form is completed, enter it in mm/dd/yyyy format. Otherwise, it can be left blank to be completed by the FEA.

**Lines 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.

**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/Employer’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.

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**When to Complete Form WT-4**

The Form WT-4 only needs to be completed if the Participant-Hired Worker wants their State withholding to be different than the withholding claimed on the Form W-4.
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.
**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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**Table:**

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Document Title</th>
<th>Document Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wisconsin Driver’s License</td>
<td>WI Department of Transportation</td>
<td>Social Security Card</td>
</tr>
<tr>
<td>Issuing Authority</td>
<td>Issuing Authority</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>Document Number</td>
<td>Document Number</td>
<td>Document Number</td>
</tr>
<tr>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
<td>Expiration Date (if any) (mm/dd/yyyy)</td>
</tr>
</tbody>
</table>

**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

**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. U.S. Passport or U.S. Passport Card</td>
<td>1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</td>
<td>1. Social Security Account Number card, unless the card includes one of the following restrictions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</td>
<td>(1) NOT VALID FOR EMPLOYMENT</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3. School ID card with a photograph</td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4. Voter's registration card</td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td>5. U.S. Military card or draft record</td>
<td>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</td>
<td></td>
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</tr>
<tr>
<td>a. Foreign passport; and</td>
<td>6. Military dependent's ID card</td>
<td>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</td>
<td></td>
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</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
<td>4. Native American tribal document</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) The same name as the passport; and</td>
<td>8. Native American tribal document</td>
<td>5. U.S. Citizen ID Card (Form I-197)</td>
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<td></td>
</tr>
<tr>
<td>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form</td>
<td>9. Driver's license issued by a Canadian government authority</td>
<td>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
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</tr>
<tr>
<td>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</td>
<td>10. School record or report card</td>
<td>7. Employment authorization document issued by the Department of Homeland Security</td>
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<tr>
<td></td>
<td>11. Clinic, doctor, or hospital record</td>
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<td></td>
<td>12. Day-care or nursery school record</td>
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</tbody>
</table>

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.
EXAMPLE: F-00180C  
Wisconsin Medicaid Program Provider Agreement and Acknowledgment of Terms of Participation – For Waiver Service Provider Agencies or Individuals  
Page 1

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

<table>
<thead>
<tr>
<th>Participant-Hired Worker’s Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant-Hired Worker’s Street Address</td>
<td>City</td>
</tr>
</tbody>
</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;
EXAMPLE: F-00180C

Wisconsin Medicaid Program Provider Agreement and Acknowledgment of Terms of Participation – For Waiver Service Provider Agencies or Individuals

Page 2

**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.

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**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>
</tr>
</thead>
<tbody>
<tr>
<td>Participant-Hired Worker’s Full Printed Name</td>
</tr>
<tr>
<td>SIGNATURE – Provider</td>
</tr>
<tr>
<td>Participant-Hired Worker’s Signature</td>
</tr>
<tr>
<td>Date Signed</td>
</tr>
<tr>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>Date Signed</td>
</tr>
<tr>
<td>8/14/17</td>
</tr>
</tbody>
</table>
### 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.

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### 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 of 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.
- Providing 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)
  - [ ] Household member (lives on premises, but is not a client)
  - [ ] 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>PHW’s First Name</th>
<th>PHW’s Middle Name</th>
<th>PHW’s Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Employee**

- **Position Title:** (Complete only if a prospective or current employee or contractor.)
- **Birth Date (MM/dd/yyyy):**
- **Sex:**
  - [ ] Male
  - [x] Female

**Other names the Participant-Hired Worker has used.**

- [ ] American Indian or Alaskan Native
- [ ] Asian or Pacific Islander
- [x] Black
- [ ] White
- [ ] Unknown
- **Social Security Number:** ###-##-####

**Home Address**

- **Participant/Hired Worker’s Street Address:**
- **City:**
- **State:**
- **ZIP Code:**

**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, 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 □

   If Yes, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.

   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts? Yes □ No □

   If Yes, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.

   You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.

3. IMPORTANT: Read before completing item 3.

   Wis. Stat. § 48.901 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. “All reports made under this section, notices provided under sub. (3)(bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential.” Reports and records may be disclosed only to 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.

---

**Continued on Page 2**
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.

---

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</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></td>
<td></td>
</tr>
<tr>
<td>If Yes, explain, including when and where it happened.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If Yes, explain, including when and where it happened.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If Yes, explain, including when and where it happened.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If Yes, explain, including credential name, limitations or restrictions, and time period.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes No
   If Yes, explain, including when and where it happened. 

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
   If Yes, explain, including when and where it happened and the reason.

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? Yes No
   If Yes, indicate the year of discharge: ________
   Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. 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.

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
   If Yes, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years? Yes No
   If Yes, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

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
   If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.

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.

Name – Person Completing This Form: Participant-Hired Worker’s Name
Date Submitted: mm/dd/yyyy
**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.

---

**BACKGROUND INFORMATION DISCLOSURE ADDENDUM—IRIS**

**INSTRUCTIONS:** Completion of this form is required under the provisions of Chapters 48.685 and 50.065 Wis. Stats. Failure to comply may result in a denial or termination of your employment.

Personally identifiable information on this form is collected to verify your identity and that the form is complete.

**SECTION I – APPLICANT INFORMATION**

<table>
<thead>
<tr>
<th>Name – (Last, First, MI)</th>
<th>Date of Birth</th>
<th>Date of Birth</th>
<th>mm/dd/yyyy</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHW’s Last Name, First Name, Middle Initial</td>
<td>Date of Birth</td>
<td>mm/dd/yyyy</td>
<td></td>
</tr>
</tbody>
</table>

Please list all the cities and states in which you have lived in the past three years, and the name by which you were known (if different from your name now). Please indicate the number of years you lived there.

**Address – (Address, City, State, Zip Code) | Years at Residence | Any Other Names By Which You Have Been Known (Including Maiden Name)**

<table>
<thead>
<tr>
<th>Participant-Hired Worker’s Street Address, City, State, ZIP Code</th>
<th>#</th>
<th>Any other names the Participant-Hired Worker has used.</th>
</tr>
</thead>
</table>

**SECTION II – ADDITIONAL APPLICANT INFORMATION**

Completion of this section is only required for applicants who have lived outside the state of Wisconsin in the past three years.

<table>
<thead>
<tr>
<th>Current Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHW’s Current Address</td>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
<td>County</td>
</tr>
<tr>
<td>Previous Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td>County</td>
</tr>
<tr>
<td>PHW’s Previous Address</td>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
<td>County</td>
</tr>
<tr>
<td>Previous Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td>County</td>
</tr>
</tbody>
</table>

**Mother’s Maiden Name**

**Mother’s Current Name – (Last, First, MI)**

**Father’s Name – (Last, First, MI)**

**Participant-Hired Worker’s Father’s Name in Last Name, First Name, Middle Initial Format**

I acknowledge that the information on this form is accurate to the best of my knowledge. By signing below, I agree to have a background check run.

I further acknowledge that an out-of-state background check may increase processing time, if applicable.

**SIGNATURE – Applicant**

<table>
<thead>
<tr>
<th>Participant-Hired Worker Signature</th>
<th>Date Signed</th>
<th>mm/dd/yyyy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 be providing 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 be providing 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.

F-01201C Page 2

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.

SIGNATURE – Participant-Hired Worker

Participant-Hired Worker Signature

SIGNATURE – Participant Employer

Participant/ Employer (or Representative) Signature

Date Signed

mm/dd/yyyy

mm/dd/yyyy
### 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:** The PHW’s worker number.

**Last four digits of PHW 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.

---

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

**NOTE:** iLIFE pay cards cannot be mailed to P.O. boxes.

**OR**

**Direct Deposit**

- **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

---

**Additional Information:**

- P.O. Box 91760 | Milwaukee, WI 53209 | Phone: 1-888-800-5599 | Fax: 1-414-937-2034
- Email: IRIS.Emplpoyment@iLIFEfms.com | Website: iLIFEfms.com

(6/2017)
**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**

**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**

**STATE OF WISCONSIN**

**IRIS SUPPORTIVE HOME CARE / SELF-DIRECTED PERSONAL CARE / RESPITE CARE TRAINING VERIFICATION**

**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.

Please fill out the appropriate section(s) based on services that will be provided.

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

**SECTION I – PARTICIPANT-HIRED WORKER DEMOGRAPHICS (all fields must be filled)**

| Participant-Hired Worker Last Name, First Name | Participant/Employer Last Name, First Name |
| Date of Birth – Participant-Hired Worker | Anticipated Employment Start Date |
| mm/dd/yyyy | mm/dd/yyyy |

**SECTION II – SUPPORTIVE HOME CARE REQUIRED TRAINING**

- [ ] Employee is oriented to participant’s place of care.
- [ ] Employee safely performs cares and duties.
- [ ] Employee knows what to do in an emergency situation*.
- [ ] Employee works effectively with participants and respects their choices.
- [ ] Employee is familiar with homemaking/household services.
- [ ] Employee uses gloves as appropriate while assisting with participant’s cares.
- [ ] Employee understands participant’s disability, diagnosis and related needs.
- [ ] Employee is familiar with participant’s daily schedule, needs, and duties.
- [ ] Employee is aware of the participant’s back-up plan.

**Required training completed on:**

*Example: *Reviewed exits, showed where supplies are kept. Reviewed MyCares plan.*

**SECTION III – SELF-DIRECTED PERSONAL CARE REQUIRED TRAINING**

- [ ] Employee is oriented to participant’s place of care.
- [ ] Employee safely performs cares and duties.
- [ ] Employee knows what to do in an emergency situation*.
- [ ] Employee works effectively with participants and respects their choices.
- [ ] Employee uses gloves as appropriate while assisting with participant’s cares.
- [ ] Employee understands participant’s disability, diagnosis and related needs.
- [ ] Employee is familiar with participant’s daily schedule, needs, and duties.
- [ ] Employee is aware of the participant’s back-up plan.

**Required training completed on:**

*Example: *Reviewed MyCares.*

**SECTION IV – RESPITE CARE REQUIRED TRAINING**

- [ ] Employee is oriented to participant’s place of care.
- [ ] Employee safely performs cares and duties.
- [ ] Employee knows what to do in an emergency situation*.
- [ ] Employee works effectively with participants and respects their choices.
- [ ] Employee uses gloves as appropriate while assisting with participant’s cares.
- [ ] Employee understands participant’s disability, diagnosis and related needs.
- [ ] Employee is familiar with participant’s daily schedule, needs, and duties.
- [ ] Employee is aware of the participant’s back-up plan.

**Required training completed on:**

*Example: *I do not have a Respite Care Worker.*

*Emergency Response*: employee knows how to evacuate the participant in an emergency, and knows how to respond to emergencies related to the participant’s health and safety.

**SIGNATURE – Employee**

**Date Signed**

**Participant-Hired Worker Signature**

**Date Signed**

**SIGNATURE – Participant**

**Date Signed**

**Participant/Employer (or Representative) Signature**

**Date Signed**