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): 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 his/her representative).

Date Signed: The date the form was signed by the Participant/Employer or his/her representative.

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<table>
<thead>
<tr>
<th>DEPARTMENT OF HEALTH SERVICES</th>
<th>STATE OF WISCONSIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of Medicaid Services</td>
<td>F-01201 (02/2017)</td>
</tr>
</tbody>
</table>

IRIS PARTICIPANT- HIRED WORKER SET-UP

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statue; however, completion of this form is an IRIS Program requirement. Both the participant-hired worker and the participant employer must sign and date the form 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 only for this purpose.

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

<table>
<thead>
<tr>
<th>SECTION I – PARTICIPANT-HIRED WORKER DEMOGRAPHICS (all fields must be filled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name – Participant-Hired Worker (Last, First, Mi)</td>
</tr>
<tr>
<td>PHW Last Name, First Name and Middle Initial</td>
</tr>
<tr>
<td>Mailing Address</td>
</tr>
<tr>
<td>PHW Address</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION II – PARTICIPANT EMPLOYER DEMOGRAPHICS (all fields must be filled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name – Participant/Employer (Last, First, Mi)</td>
</tr>
<tr>
<td>Participant/Employer's Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>Mailing Address</td>
</tr>
<tr>
<td>Participant/Employer Address</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>State</td>
</tr>
</tbody>
</table>

By signing below, I (we) agree the information on this form is accurate and I (we) have all supporting documentation in my possession. 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. Both signers also acknowledge that no hours worked prior to a passed background check will be authorized.

<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, POA, or Guardian Signature</td>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>
**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, he/she 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 date the Participant/Employer (or his/her representative) signed this form.

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

---

<table>
<thead>
<tr>
<th>Relative (Biological)</th>
<th>Relative (by Marriage/Partnership)</th>
<th>Non-Related Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent * ☑</td>
<td>Spouse * ☐</td>
<td>Friend</td>
</tr>
<tr>
<td>Son/Daughter (over 21) *</td>
<td>Domestic Partner * ☒</td>
<td>Neighbor</td>
</tr>
<tr>
<td>Daughter (under 21) * ☑</td>
<td>Step Parent *</td>
<td>Worker</td>
</tr>
<tr>
<td>Adopted Child *</td>
<td>Step Child *</td>
<td>Ex-Husband / Ex-Wife</td>
</tr>
<tr>
<td>Grandparent *</td>
<td>Step Grandchild</td>
<td></td>
</tr>
<tr>
<td>Grandchild *</td>
<td>Step Brother / Step Sister</td>
<td></td>
</tr>
<tr>
<td>Brother / Sister</td>
<td>Parent-in-Law</td>
<td></td>
</tr>
<tr>
<td>Uncle / Aunt</td>
<td>Child-in-Law</td>
<td></td>
</tr>
<tr>
<td>Nephew / Niece</td>
<td>Brother-in-Law / Sister-in-Law</td>
<td></td>
</tr>
<tr>
<td>Cousin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 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.

☐ 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.

<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>
INSTRUCTIONS

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

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 his/her 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.

EXAMPLE: W-4
Employee Withholding Allowance Certificate

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if both of the following apply.

• For 2018 you had a right to a refund of all federal income tax withheld because you had no tax liability, and
• For 2019 you expect a refund of all federal income tax withheld because you expect to have no tax liability.

If you’re exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren’t exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax you wish to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you’re having withheld compares to your projected total tax for 2019. If you use the calculator, you don’t need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you’re married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earner/Multi-Job Workers Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 of the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 555 or talk to a tax professional. See Pub. 555 or talk to a tax professional.

Nonresident alien. If you’re a nonresident alien, see Notice 1992-31, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

W-4
Employee’s Withholding Allowance Certificate

Form Department of the Treasury
Internal Revenue Service

Employee’s Social Security number

PHW First Name and Middle Initial PHW Last Name

Home address (number and street or rural route)

City, State and ZIP Code

Sign here

Date

For Privacy Act and Paperwork Reduction Act Notice, see page 4.

Cat. No. 10212/2021
Form W-4 (2019)

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 birthdate 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. For example: April 15, 2015

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 he/she has 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 his/her representative completing the form.

Title: “HHCSR” if being completed by the Participant/Employer or “POA” or “Guardian” if being completed by his/her representative.

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.
**EXAMPLE: I-9**

<table>
<thead>
<tr>
<th><strong>INSTRUCTIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> Participant-Hired Worker may be abbreviated as PHW throughout this form.</td>
</tr>
</tbody>
</table>

**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.

**Preparers and/or Translators 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 |

**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>PHW First Name</th>
<th>Middle Initial</th>
<th>Other Names the PHW has used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>Employee’s E-mail Address</th>
<th>Employee’s Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</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):
  
- [ ] 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:

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

**Signature of Employee**

**Participant-Hired Worker Signature**

**Preparer and/or Translator Certification (check one):**

- [ ] I did not use a preparer or translator.
- [ ] A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(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**

**Today’s Date (mm/dd/yyyy)**

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Address (Street Number and Name) | City or Town | State | ZIP Code |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Form I-9 07/17/17 N  
Page 1 of 3
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 identification 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 his/her 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 his/her 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

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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>List B</th>
<th>LIST C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents that Establish Both Identity and Employment Authorization</td>
<td>Documents that Establish Identity</td>
<td>Documents that Establish Employment Authorization</td>
</tr>
<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. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT</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>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
</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>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4. Voter’s registration card</td>
<td>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and</td>
<td>5. U.S. Military card or draft record</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>
</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and</td>
<td>6. Military dependent’s ID card</td>
<td>4. Native American tribal document</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>7. U.S. Coast Guard Merchant Mariner Card</td>
<td>5. U.S. Citizen ID Card (Form I-197)</td>
</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>8. Native American tribal document</td>
<td>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
</tr>
<tr>
<td></td>
<td>For persons under age 18 who are unable to present a document listed above:</td>
<td></td>
</tr>
<tr>
<td>10. School record or report card</td>
<td>10. School record or report card</td>
<td></td>
</tr>
<tr>
<td>11. Clinic, doctor, or hospital record</td>
<td>11. Clinic, doctor, or hospital record</td>
<td></td>
</tr>
<tr>
<td>12. Day-care or nursery school record</td>
<td>12. Day-care or nursery school record</td>
<td></td>
</tr>
</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.
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

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

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

Participant-Hired Worker’s Name

Address – Street City State

Participant-Hired Worker’s Street Address City State

ZIP Code

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;
**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

**STAGE OF WISCONSIN**

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.

---

**Name – Provider (Typed or Printed)**

**Participant-Hired Worker’s Full Printed Name**

<table>
<thead>
<tr>
<th>SIGNATURE – Provider</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<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>
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.

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.

---

**F-82064**

**Background Information Disclosure**

**Page 2 of 2**

<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></td>
<td></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></td>
<td></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></td>
<td></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**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</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></td>
<td></td>
</tr>
<tr>
<td>If Yes, explain, including when and where it happened.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, explain, including when and where it happened and the reason.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you been discharged from a branch of the US Armed Forces, including any reserve component?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, indicate the year of discharge: _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attach a copy of your DD214, if you were discharged within the last three (3) years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you resided outside of Wisconsin in the last three (3) years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, list each state and the dates you resided there.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, list each state and the dates you resided there.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you had a caregiver background check done within the last four (4) years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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

<table>
<thead>
<tr>
<th>Address – (Address, City, State, Zip Code)</th>
<th>Years at Residence</th>
<th>Any Other Names By Which You Have Been Known (Including Maiden Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant-Hired Worker’s Street Address, City, State, and Zip Code</td>
<td>#</td>
<td>Any other names the Participant-Hired Worker has used.</td>
</tr>
</tbody>
</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>Participant-Hired Worker’s Mother’s Maiden Name</td>
<td>Parent’s Current Name – (Last, First, Mi)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s Current Name – (Last, First, Mi)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Participant-Hired Worker’s Father’s Name in Last Name, First Name, Middle Initial Format | Father’s Name – (Last, First, Mi) |
|------------------------------------------------------------------------------------------|

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’s Signature</th>
<th>Date Signed mm/dd/yyyy</th>
</tr>
</thead>
</table>

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

**STATE OF WISCONSIN**

---

**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.

---

<table>
<thead>
<tr>
<th>Name – Participant-Hired Worker (Last, First)</th>
<th>Name – Participant Employer (Last, First)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant-Hired Worker Last Name, First Name</td>
<td>Participant/Employer Last Name, First Name</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

---

**PARTICIPANT-HIRED WORKER SERVICES:**

- **Supportive Home Care (SHC):**
  - [ ] Sunday
  - [ ] Monday
  - [X] Tuesday
  - [ ] Wednesday
  - [ ] Thursday
  - [ ] Friday
  - [ ] Saturday

- **Self-Directed Personal Care (SDPC):**
  - [ ] Sunday
  - [ ] Monday
  - [ ] Tuesday
  - [ ] Wednesday
  - [ ] Thursday
  - [ ] Friday
  - [ ] Saturday

- **Respite Care (R):**
  - [ ] Sunday
  - [ ] Monday
  - [ ] Tuesday
  - [ ] Wednesday
  - [ ] Thursday
  - [ ] Friday
  - [ ] Saturday

- **Other:**
  - [ ] Sunday
  - [ ] Monday
  - [ ] Tuesday
  - [ ] Wednesday
  - [ ] Thursday
  - [ ] Friday
  - [ ] Saturday

If “Other”, please explain:

**PAY RATE:**

- **$5.55:**
  - “Per Hour,” “Per Day,” etc.
  - #

---

**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):**

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

---

**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 reected for payment.

**SIGNATURE – Participant-Hired Worker**

**Date Signed**

**mm/dd/yyyy**

**Participant-Hired Worker Signature**

**Date Signed**

**mm/dd/yyyy**

**SIGNATURE – Participant Employer**

**Date Signed**

**mm/dd/yyyy**

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

**Date Signed**

**mm/dd/yyyy**
INSTRUCTIONS

Note: Participant-hired worker may be abbreviated as PHW throughout this form.

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.

---

### 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.

<table>
<thead>
<tr>
<th>Participant-hired Worker Name:</th>
<th>PHW First Name, Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHW Employee ID Number:</td>
<td># # # #</td>
</tr>
<tr>
<td>Last four digits of PHW Social Security number:</td>
<td># # # #</td>
</tr>
<tr>
<td>Participant Employer Name:</td>
<td>Participant Employer First Name, Last Name</td>
</tr>
</tbody>
</table>

**Payment Option:**
- iLIFE Pay Card
- Checking Account
- Savings Account

**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.iiiifinance.com/Ilife/Pay-Card/terms-and-conditions-flyer.pdf](http://www.iiiifinance.com/Ilife/Pay-Card/terms-and-conditions-flyer.pdf)

**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
- Savings Account

**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

---

P.O. Box 91760 | Milwaukee, WI 53209 | Phone: 1-888-800-5599 | Fax: 1-414-937-2034
Email: IRISEmployment@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

**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 his/her representative) signed this form.

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

---

**DEPARTMENT OF HEALTH SERVICES**

**STATE OF WISCONSIN**

**Division of Medicaid Services**

**F-01201B (02/2017)**

**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.

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

<table>
<thead>
<tr>
<th>Name – Participant-Hired Worker Last Name, First Name</th>
<th>Name – Participant Employer (Last, First)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth – Participant-Hired Worker</td>
<td>Anticipated Employment Start Date</td>
</tr>
<tr>
<td>mm/dd/yyyy</td>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>

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

- [ ] Employee is oriented to participant’s place of care.
- [ ] Employee is oriented to participant’s place of care.
- [ ] 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 is oriented to participant’s place of care.
- [ ] 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.

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**SIGNATURE – Employee**

**Participant-Hired Worker Signature**

**Date Signed**

**SIGNATURE – Participant**

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

**Date Signed**

By signing below, you agree the information on this form is accurate. Both signers also acknowledge that no hours worked prior to a passed background check will be authorized.