IRIS Participant-Hired Worker Paperwork

Participant-Hired Worker Forms Examples

- F-01201: IRIS Participant-Hired Worker Set-up
- F-01201A: IRIS Participant-Hired Worker Relationship Identification
- W-4: Employee Withholding Allowance Certificate (2020)
- 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 their representative).

Date Signed: The date the form was signed by the Participant/Employer or their 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 Statute; however, completion of this form is an IRIS Program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. A participant-hired worker may not begin working for a participant before the IRIS start date, indicated in the participant’s start date letter.

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

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

| SECTION I – PARTICIPANT-HIRED WORKER DEMOGRAPHICS (all fields must be filled) |
| Name – Participant-Hired Worker (Last, First, MI) | Male | Female | Date of Birth mm/dd/yyyy |
| Mailing Address | PHW Address City | City | Phone Number (###) ### - #### |
| PHW Last Name, First Name and Middle Initial | State | ZIP Code |

| SECTION II – PARTICIPANT EMPLOYER DEMOGRAPHICS (all fields must be filled) |
| Name – Participant/Employer (Last, First, MI) | Date of Birth mm/dd/yyyy | Master Client Index (MCI) ####### |
| Mailing Address | Participant/Employer Address City | City | Phone Number (###) ### - #### |
| Participant/Employer’s Last Name, First Name, Middle Initial | State | ZIP Code |

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 mm/dd/yyyy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant-Hired Worker Signature</td>
<td>Date Signed mm/dd/yyyy</td>
</tr>
<tr>
<td>SIGNATURE – Participant Employer</td>
<td>Date Signed mm/dd/yyyy</td>
</tr>
<tr>
<td>Participant/Employer, POA, or Guardian Signature</td>
<td>Date Signed 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, 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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### Table: IRIS Participant-Hired Worker Relationship Identification

<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>Adopted Child *</td>
<td>Step Parent *</td>
<td>Worker</td>
</tr>
<tr>
<td>Grandparent</td>
<td>Step Child *</td>
<td>Ex-Husband / Ex-Wife</td>
</tr>
<tr>
<td>Grandchild *</td>
<td>Step Grandchild</td>
<td></td>
</tr>
<tr>
<td>Brother / Sister</td>
<td>Step Brother / Step Sister</td>
<td></td>
</tr>
<tr>
<td>Uncle / Aunt</td>
<td>Parent-in-Law</td>
<td></td>
</tr>
<tr>
<td>Nephew / Niece</td>
<td>Child-in-Law</td>
<td></td>
</tr>
<tr>
<td>Cousin</td>
<td>Brother-in-Law / Sister-in-Law</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.

± 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.

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

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

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

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

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

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

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

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

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

Special Instructions for Claiming “Exempt”

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

The Form W-4 will need to be completed annually (by February) if the Participant-Hired Worker wishes to remain at “Exempt” status from year to year.
Employee's WI Withholding Exemption Certificate

**INSTRUCTIONS**

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

**EMPLOYER’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 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 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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**Employee’s Wisconsin Withholding Exemption Certificate/New Hire Reporting**

<table>
<thead>
<tr>
<th>Employee’s Section</th>
<th>Employer’s Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHW Last Name, First Name and Middle Initial</td>
<td>Social security number</td>
</tr>
<tr>
<td>Employer’s address, (number and street)</td>
<td>Single</td>
</tr>
<tr>
<td>Participant-Hired Worker’s Street Address</td>
<td>Married</td>
</tr>
<tr>
<td>City</td>
<td>Married, but withhold at higher Single rate</td>
</tr>
<tr>
<td>State</td>
<td>Note: If married but legally separated, check the Single box.</td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
</tbody>
</table>

**FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW**

Complete Lines 1 through 3.

1. (a) Exemption for yourself – enter 1

(b) Exemption for your spouse – enter 1

(c) Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent

(d) Total – add lines (a) through (c)

2. Additional amount per pay period you want deducted (if your employer agrees)

3. I claim complete exemption from withholding (see instructions). Enter “Exempt”.

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

**Signature:** Participant-Hired Worker Signature

Date Signed: Month Day Year

**EMPLOYEE INSTRUCTIONS:**

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

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

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

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

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

**WT-4 INSTRUCTIONS:** Provide your information in the employee section.

- **LINE 1:**
  - (a-c) Number of exemptions – Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1a-c (or you may enter into an agreement with your employer to have additional amounts withheld) (see instruction for line 2).
  - (c) Dependents – Those persons who qualify as dependents for federal income tax purposes may also be claimed as dependents for Wisconsin purposes. The term “dependents” does not include you or your spouse. Indicate the number of dependents that you are claiming in the space provided.

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

- **LINE 3:** Exemption from withholding – You may claim exemption from withholding of Wisconsin income tax if you had no liability for income tax last year, and you expect to incur no liability for income tax for this year. You may not claim exemption if your return shows tax liability before the allowance of any credit for income tax withheld. If you are exempt, your employer will not withhold Wisconsin income tax from your wages.

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

**Employer’s Section**

<table>
<thead>
<tr>
<th>Employer’s Section</th>
<th>Federal Employer ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer’s pay address (number and street)</td>
<td># # # # # # # # # #</td>
</tr>
<tr>
<td>Participant/Employer’s Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>City</td>
</tr>
<tr>
<td>State</td>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

**EMPLOYER INSTRUCTIONS for Department of Revenue:**

- **If you do not have a Federal Employer Identification Number (FEIN), contact the Internal Revenue Service to obtain a FEIN.**

- **If you have claimed more than 10 exemptions OR if you have claimed complete exemption from withholding and earn more than $200.00 a week OR if you have claimed more exemptions than he or she is entitled to, mail a copy of this certificate to: Wisconsin Department of Revenue, Audit Bureau, PO Box 8906, Madison WI 53708 or fax (608) 267-0834.**

- **Keep a copy of this certificate with your records. If you have questions about the Department of Revenue requirements, call (608) 266-2772 or (608) 266-2776.**
**INSTRUCTIONS**

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

**SECTION 1**

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

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

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

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

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

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

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

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

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

Signature of Employee: The PHW’s signature.

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

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

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<table>
<thead>
<tr>
<th>Employment Eligibility Verification</th>
<th>USCIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Homeland Security</td>
<td>Form I-9</td>
</tr>
<tr>
<td>U.S. Citizenship and Immigration Services</td>
<td>OMB No. 1615-0047</td>
</tr>
<tr>
<td>Expires 08/31/2019</td>
<td></td>
</tr>
</tbody>
</table>

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

- **Last Name (Family Name)**
- **First Name (Given Name)**
- **Middle Initial**
- **Other Names Used (if any)**
- **Address (Street Number and Name)**
- **Apt. Number**
- **City or Town**
- **State**
- **ZIP Code**
- **Date of Birth (mm/dd/yyyy)**
- **U.S. Social Security Number**
- **Employee’s E-mail Address**
- **PHW’s Email Address**
- **Employee’s Telephone Number**

I am aware that federal law provides for imprisoned 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:
    - An Alien Registration Number/USCIS Number
    - OR Form I-94 Admission Number
    - OR Foreign Passport Number
    - OR
    - Alien Registration Number/USCIS Number:
    - OR
    - Form I-94 Admission Number:
    - OR
    - Foreign Passport Number:
    - Date of Issuance:

Signature of Preparer or Translator: The PHW’s signature.

Date (mm/dd/yyyy): The date that the form was completed by the Participant-Hired Worker.

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

Date (mm/dd/yyyy): The date that the form was completed by the Participant-Hired Worker.

- **Last Name (Family Name)**
- **First Name (Given Name)**
- **Address (Street Number and Name)**
- **City or Town**
- **State**
- **ZIP Code**

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

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

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

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

– If a PHW provides an identifying document from List A, it is the only identification needed for this form.

– If the PHW does not provide an item from List A, then he/she will need to provide any combination of identification from both lists B and C.

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

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

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

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

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

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

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

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

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

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/work will expire soon. If an employee is unable to present a required document (or documents), the employer 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.

## List A
Documents that Establish Both Identity and Employment Authorization

| 1. | U.S. Passport or U.S. Passport Card |
| 2. | Permanent Resident Card or Alien Registration Receipt Card (Form I-551) |
| 3. | Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa |
| 4. | Employment Authorization Document that contains a photograph (Form I-766) |
| 5. | For a nonimmigrant alien authorized to work for a specific employer because of his or her status: |
|     a. | Foreign passport; and |
|     b. | Form I-94 or Form I-94A that has the following: |
|          1. | The same name as the passport; and |
|          2. | An endorsement of the 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 |
| 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 |

## List B
Documents that Establish Identity

| 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 |
| 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 |
| 3. | School ID card with a photograph |
| 4. | Voter’s registration card |
| 5. | U.S. Military card or draft record |
| 6. | Military dependent’s ID card |
| 7. | U.S. Coast Guard Merchant Mariner Card |
| 8. | Native American tribal document |
| 9. | Driver’s license issued by a Canadian government authority |

## List C
Documents that Establish Employment Authorization

| 1. | A Social Security Account Number card, unless the card includes one of the following restrictions: |
|     1. | NOT VALID FOR EMPLOYMENT |
|     2. | VALID FOR WORK ONLY WITH INS AUTHORIZATION |
|     3. | VALID FOR WORK ONLY WITH DHS AUTHORIZATION |
| 2. | Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) |
| 3. | Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal |
| 4. | Native American tribal document |
| 5. | U.S. Citizen ID Card (Form I-197) |
| 6. | Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| 7. | Employment authorization document issued by the Department of Homeland Security |

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

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.

---

### WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

**FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS**

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

<table>
<thead>
<tr>
<th>Name of Provider (Typed or Printed—Must exactly match name used on all other documents)</th>
<th>Phone Number (###) ### - ####</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant-Hired Worker’s Name</td>
<td>City</td>
</tr>
<tr>
<td>Participant-Hired Worker’s Street Address</td>
<td>City</td>
</tr>
<tr>
<td>Address – Street</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>ZIP Code</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;
## Wisconsin Medicaid Program Provider Agreement and Acknowledgment of Terms of Participation – For Waiver Service Provider Agencies or Individuals

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

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

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

<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>42 CFR 431.107 &amp; 42 CFR 438.602(b)</td>
</tr>
<tr>
<td>F-00180C (07/2017)</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

<table>
<thead>
<tr>
<th>Name – Provider (Typed or Printed)</th>
<th>Participant-Hired Worker’s Full Printed Name</th>
</tr>
</thead>
</table>

<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>

<table>
<thead>
<tr>
<th>FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNATURE – Department of Health Services</td>
<td>Date Signed</td>
</tr>
<tr>
<td>[Signature]</td>
<td>8/14/17</td>
</tr>
</tbody>
</table>

EXAMPLE: F-00180C
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.

---

<table>
<thead>
<tr>
<th>F-82064</th>
<th>Page 2 of 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?</td>
<td>Yes No</td>
</tr>
<tr>
<td>If Yes, explain, including when and where it happened.</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 No</td>
</tr>
<tr>
<td>If Yes, explain, including when and where it happened.</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 No</td>
</tr>
<tr>
<td>If Yes, explain, including when and where it happened.</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 No</td>
</tr>
<tr>
<td>If Yes, explain, including credential name, limitations or restrictions, and time period.</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
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

Name – (Last, First, MI)  Date of Birth

PHW’s Last Name, First Name, Middle Initial  mm/dd/yyyy

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

Participant-Hired Worker’s Street Address, City, State, and ZIP Code  #  Any other names the Participant-Hired Worker has used.

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.

Current Address

PHW’s Current Address  City  State  Zip Code  County

Previous Address

PHW’s Previous Address  City  State  Zip Code  County

Mother’s Maiden Name

Participant-Hired Worker’s Mother’s Maiden Name  Mother’s Current Name – (Last, First, MI)

Father’s Name

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

Signatures

Participant-Hired Worker Signature  Date Signed

mm/dd/yyyy
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:</th>
<th>Name – Participant Employer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Participant-Hired Worker’s</td>
<td>The Participant/Employer’s</td>
</tr>
<tr>
<td>name in last name, first name</td>
<td>name in last name, first</td>
</tr>
<tr>
<td>format.</td>
<td>name format.</td>
</tr>
</tbody>
</table>

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.

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

If “Other”, please explain:

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Pay Rate</th>
<th>Unit Type (per hour, per day, etc.)</th>
<th>Units/Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive Home Care (SHC)</td>
<td>$5.00</td>
<td>“Per Hour,” “Per Day,” etc.</td>
<td>#</td>
</tr>
<tr>
<td>Self-Directed Personal Care (SDPC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite Care (R)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mileage</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If “Other”, please explain:

$5.00 Indicate the rate and the number of miles per month the participant-hired worker is authorized to provide.

$5.00 Per Mile

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

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
**Participant-hired Worker Payment Election Form**

**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.

---

<table>
<thead>
<tr>
<th><strong>Street Address:</strong></th>
<th><strong>PHW Street Address</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td>State: WI</td>
</tr>
</tbody>
</table>

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

---

**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.

---

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: 1-414-918-4463
Email: IRIS.EmployeeHandlingILIFEm1@ILIFEm1.com | Website: iLIFEm1.com
**INSTRUCTIONS**

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

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

**SECTION 1**

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

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

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

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

**SECTION II-IV**

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

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

*NOTE:* This must be after the issued start date.

**PAGE 2**

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

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

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

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

---

**DEPARTMENT OF HEALTH SERVICES**

**STATE OF WISCONSIN**

**F-01201B**

**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>Participant-Hired Worker Last Name, First Name</th>
<th>Participant/Employer Last Name, First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm/dd/yyyy</td>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>

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

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

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

**Required training completed on:**

- Example: *Reviewed MyCares.*

**SECTION IV – RESPITE CARE REQUIRED TRAINING**

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

**Participant/Hired Worker Signature**

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

**Date Signed**

**mm/dd/yyyy**

---

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.