IRIS Provider Paperwork

Provider Forms Examples

- F-01312: IRIS Provider Application
- W-9: Request for Taxpayer Identification Number and Certification
- F-00180C: Wisconsin Medicaid Program Provider Agreement and Acknowledgment of Terms of Participation for Waiver Service Provider Agencies or Individuals
- iLIFE IRIS Vendor Direct Deposit Form
- F-82064: Background Information Disclosure (BID)
- F-01246: Background Information Disclosure Addendum
- IRIS Adult Family Home Information
- iLIFE IRIS Provider Agreement

Note: The terms "Vendor" and "Provider" may be used interchangeably throughout this document.
## INSTRUCTIONS

### PROVIDER DEMOGRAPHICS
- **Organization Name:** The organization name, if applicable.
- **Provider’s Name:** The Provider’s full, legal name in last name, first name, middle initial format.
- **Telephone Number:** The Provider’s telephone number with Area Code.
- **Email Address:** The Provider’s email address.
- **Title:** The Provider’s title, if applicable.
- **Are you applying as:** Check the box that describes the Provider (Agency or Individual Practitioner).
- **Type of Application:** Check the box that describes the type of application (Initial Application or Reinstatement).
- **W-9 Exempt:** If Provider is W-9 exempt, check "Yes."

### BILLING AND CLAIMS CONTACT INFORMATION
- **Check all that apply:** If you use one address for all purposes, check all boxes that apply. Additional Rendering and Daily Operations Information is not needed if you use only one address.
- **National Provider Identifier:** The Provider’s National Provider ID, if applicable.
- **Tax Identification Number:** The Provider’s tax ID number.
- **Tax Qualifier:** The Provider’s tax ID number qualifier.
- **Organization Name:** The Provider’s organization name, if applicable.
- **Name – Contact Person:** The Provider’s contact person’s name.
- **Telephone Number:** The person’s telephone number with Area Code.
- **Email Address:** The person’s email address.
- **Fax Number:** The person’s fax number.
- **Address, City, State, Zip Code, and County:** The Provider’s street address, city, state, ZIP code, and county.

Continued on Page 2
INSTRUCTIONS

SERVICES TO BE PROVIDED
Services: Enter the services the Provider will provide. This information is optional but recommended.

Does this service require a license or certification?: Enter "Yes" or "No," as applicable.

LICENSING/CERTIFICATION
If licensure/certification is required for the service(s) to be provided, list license/certificate(s) Title, Type, Number, State in which Obtained, and Expiration Date. Each license/certificate required must be listed and attached to the application when submitted.

Signature – Provider: The Provider’s signature.

Date Signed: The date the form was signed by the Provider.

| SERVICES TO BE PROVIDED: List the service(s) you wish to provide. Please reference the IRIS Service Definition Manual for a complete list of allowable services. |
|---|---|---|---|---|
| **Services** | **Does this service require a license or certification?** | **Example:** | **Example:** |
| **"Supportive Home Care," "Snow Shoveling," etc.** | **"No"** | **"Supportive Home Care," "Snow Shoveling," etc.** | **"No"** |

**LICENSING / CERTIFICATION:** List all current licenses and certificates (if applicable). A copy of each is required with this application.

<table>
<thead>
<tr>
<th>Title of Licensure/Certification</th>
<th>Type of Licensure/Certification</th>
<th>Licensure/Certification Number</th>
<th>State in which Obtained</th>
<th>Expiration Date</th>
</tr>
</thead>
</table>

**IMPORTANT:** If service requires license or certification, licensing information must be listed and attached.

By signing below, I certify that background checks on all employees have been completed in accordance with the Wisconsin Caregiver Program.

If I am to provide specialized transportation, I certify that the vehicle used is and will be mechanically sound, has properly functioning lighting, safety, ventilation, and braking systems, and proper inflated tires without excessive wear. I further certify that proper licensing and insurance has been verified and is attached.

I understand and agree that this application will not be processed until it is deemed complete by DHS. It is my responsibility to provide a complete application. I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubt is my responsibility.

I certify that the information in this document and all attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after provider approval has been awarded, may lead to suspension or termination of provider approval.

**SIGNATURE:** Provider

Provider Signature
Date Signed

**FAX**

**EMAIL**

**GROUND MAIL**

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>FAX</th>
<th>EMAIL</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GT Independence</td>
<td>888-972-3891</td>
<td><a href="mailto:customerservice@glindependence.com">customerservice@glindependence.com</a></td>
<td>215 Broadus St, Sturgis, MI 49091</td>
</tr>
<tr>
<td>ILIFE</td>
<td>414-918-4463</td>
<td><a href="mailto:IRIS.Vendor@ILIFEfms.com">IRIS.Vendor@ILIFEfms.com</a></td>
<td>6100 North Baker Road, Glendale, WI 53209</td>
</tr>
<tr>
<td>Outreach Health Services</td>
<td>877-901-5826</td>
<td><a href="mailto:Wisconsin@outreachhealth.com">Wisconsin@outreachhealth.com</a></td>
<td>204 3rd Avenue, Suite 110, P.O. Box 945, Oconomowoc, WI 53069</td>
</tr>
<tr>
<td>Premier Financial Management Services</td>
<td>888-302-3607</td>
<td><a href="mailto:vendorpaperwork@premier-fms.com">vendorpaperwork@premier-fms.com</a></td>
<td>10425 W North Ave, Suite 345, Milwaukee, WI 53226</td>
</tr>
</tbody>
</table>

Information contained in email messages may be privileged and confidential. There is some risk that any information in an email you send may be disclosed to, or intercepted by, unauthorized third parties. By agreeing to allow the use of email as a method of communication to Wi DHS, this indicates that you acknowledge and accept the possible risks associated with such communication.
INSTRUCTIONS

Box 1: The Provider’s name as it is shown on the person’s tax return.

Box 2: The Provider’s business/organization name (if different from the Provider’s name).

Box 3: Check one box to identify the Provider’s federal tax classification.

Box 4: If exemption codes apply, enter them here.

Box 5: The Provider’s street address.

Box 6: The Provider’s city, state, and ZIP code.

PART I

The Provider’s social security number or employer identification number (EIN), as appropriate. The number used here must match the Tax Identification Number and Tax Qualifier identified on the F-01312, IRIS Provider Application.

PART II

Signature of U.S. person: The Provider’s signature.

Date: The date the Provider signed this form.
### WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGMENT 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 (Provider Phone Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address – Street</strong></td>
<td><strong>City</strong></td>
</tr>
<tr>
<td><strong>Provider Street Address</strong></td>
<td><strong>State</strong></td>
</tr>
<tr>
<td><strong>ZIP Code</strong></td>
<td><strong>ZIP Code</strong></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(h)(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;
INSTRUCTIONS

Name – Provider: The Provider Agency’s name.

Signature – Provider: The Provider Agency Representative’s signature.

Date Signed: The date this form was signed by the Provider Agency Representative.

---

<table>
<thead>
<tr>
<th>DEPARTMENT OF HEALTH SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of Medicaid Services</td>
</tr>
<tr>
<td>F-00180C (07/2017)</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 Medicaid, Medicare, or Title XX services programs since the inception of those programs.

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

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

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

---

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

<table>
<thead>
<tr>
<th>Name – Provider (Typed or Printed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGNATURE – Provider Agency Rep's Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Agency Representative'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>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNATURE – Department of Health Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/14/17</td>
</tr>
</tbody>
</table>
INSTRUCTIONS

Vendor Name: The Provider’s name. Name must match the name on the account, whether an Individual Practitioner or Agency.

Address: The Provider’s street address, city, state, and ZIP code.

Tax Identification Number (EIN or Last Four Digits of SSN): The Provider’s tax ID number. The identifier used here must match the one used on the F-01312, IRIS Provider Application and the W-9, Request for Taxpayer Identification Number and Certification.

Contact Name: The Provider’s contact’s name (if different than the Provider name).

Contact Phone Number: The Provider’s contact phone number.

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.

Type of Account: Check one option (Checking or Savings), and attach the documentation required for that type of account.

Vendor Signature: The Provider’s signature.

Date: The date the Provider signed this form.

---

EXAMPLE:

IRIS Vendor Direct Deposit Authorization

Instructions: 1. Vendor completes all information and signs at the bottom.

2. Attach a voided check or typed bank verification with the account and routing numbers and account holder’s name.

NOTE: To be effective for the pay date, submit this form at least five business days before the pay date.

Vendor Name: __Provider Name__

Address: __Provider Street Address, City, State, and ZIP Code__

Tax Identification Number (EIN or Last Four Digits of SSN): __###__

Contact Name: __Provider Contact Name__

Contact Phone Number: __Provider Phone Number__

Name of Financial Institution: __Provider Bank or Credit Union Name__

Routing Number: __########__

Account Number: __########__

Type of Account: Required Documents

- Checking
  - Attach either a voided check or a letter from the bank.
  - Must have the account holder’s name, routing and account numbers for the account.
  - Must be typed.
  - Starter checks may not be used.
  - Letter must be printed on bank letterhead.

- Savings
  - Attach a letter from the bank.
  - Must have the account holder’s name, routing and account numbers for the account.
  - Must be typed.
  - Must be printed on bank letterhead.

As an authorized representative of the Vendor Name listed above, I hereby authorize iLIFE to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my bank account at the financial institution noted above.

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.

Vendor Signature: __Provider Signature__ Date: __mm/dd/yyyy__

---

IMPORTANT:

A voided check or typed bank verification with the account and routing numbers and account holder’s name must be attached.
EXAMPLE: F-82064
Background Information Disclosure

Page 1

INSTRUCTIONS

Check the box that applies to you: Check “Other – Specify” and write “Vendor.”

Full Legal Name – (First and Middle): The Provider’s first name and middle name.

Legal Name – (Last): The Provider’s last name.

Birth Date: The Provider’s birth date.

Sex: Check the box that best describes the Provider’s sex.

Any Other Names…: Include any names that the Provider has been known by – including maiden name.

Race/Ethnicity: Check the box that best describes the Provider’s race.

Social Security Number: The Provider’s social security number.

Home Address, City, State, and ZIP Code: Enter the Provider’s street address, city, state, and ZIP code.

Business Name and Address: The Provider’s business 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
### INSTRUCTIONS

**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 Provider's initials.

**Name — The Person Completing This Form:** The Provider’s name.

**Date Signed:** The date this form was signed by the Provider.

---

<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**

**Provider Name**

**Date Submitted**

**NOTE:** This form required only for Individual Practitioners (Agency of One).
**INSTRUCTIONS**

**SECTION I**
Name: The Provider’s name in last name, first name, middle initial format.

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

Address, Years at Residence, and Any Other Names: For the past 3 years, list:
- The Provider’s Address (street address, city, state, and ZIP code)
- The number of years at that residence
- Any other names that the Provider 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 Provider has lived outside of Wisconsin in the past 3 years, this section will need to be completed. If the Provider 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 Provider’s address (street address, city, state, and ZIP code)
  **Repeat for each prior address until the total years at residence listed is equal to at least 3 years.**
- Mother’s Maiden Name: The Provider’s mother’s maiden name.
- Mother’s Current Name: The Provider’s mother’s current name in last name, first name, middle initial format.
- Father’s Name: The Provider’s name in last name, first name, middle initial format.

**NOTE:**
This form required only for Individual Practitioners (Agency of One).

---

**DEPARTMENT OF HEALTH SERVICES**
Division of Medicaid Services
F-01246 (02/2017)

**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>Provider’s Last Name, First Name, Middle Initial</td>
<td>Date of Birth mm/dd/yyyy</td>
</tr>
<tr>
<td>Provider’s Address (street address, city, state, and ZIP code)</td>
<td>Years at Residence</td>
</tr>
<tr>
<td>Any Other Names By Which You Have Been Known (Including Maiden Name)</td>
<td>#</td>
</tr>
<tr>
<td>Provider’s Street Address, City, State, and ZIP Code</td>
<td>Any other names the Provider 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>Provider’s Current Address City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Address</td>
<td>Provider’s Previous Address City</td>
<td>State</td>
<td>Zip Code</td>
<td>County</td>
</tr>
<tr>
<td>Previous Address</td>
<td>Provider’s Previous Address City</td>
<td>State</td>
<td>Zip Code</td>
<td>County</td>
</tr>
<tr>
<td>Previous Address</td>
<td>Provider’s Previous Address City</td>
<td>State</td>
<td>Zip Code</td>
<td>County</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s Maiden Name</th>
<th>Provider’s Mother’s Current Name in Last Name, First Name, Middle Initial Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Father’s Name in Last Name, First Name, Middle Initial Format</td>
<td></td>
</tr>
</tbody>
</table>

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**
Provider Signature mm/dd/yyyy
INSTRUCTIONS
Note: Adult Family Home may be abbreviated as AFH throughout this form.

Name of Adult Family Home:
The AFH’s name.

Address, City, State, ZIP: The AFH’s street address, city, state, and ZIP code.

Contact Person: The AFH contact person’s name.

Phone Number: The contact person’s telephone number.

Email Address: The contact person’s email address.

Questions 1 through 6: Check the appropriate box to answer each question, and supply additional information as necessary.

AFH Contact Signature: The signature of the AFH contact person named above.

Date: The date the AFH contact person signed this form.

EXAMPLE:
IRIS Adult Family Home Information

IRIS Adult Family Home Information

Intructions: 1. Complete only if providing Adult Family Home (AFH) services.
2. AFH Contact Person signs at the bottom.
3. Attach a copy of your current AFH Certificate or your extension letter from the State of Wisconsin. Failure to do so may delay payment.

Name of Adult Family Home: 

Address: AFH Street Address

City: State Zip: 

Contact Person: AFH Contact Name

Phone Number: 

Email Address: AFH Contact Email Address

According to § 131 of the IRS tax code, certain foster care payments are not taxable as income. The purpose of this form is to assist iLIFE in determining whether this is the case. If it appears that you qualify, you have the option of requesting that a 1099, or equivalent form, not be prepared at year end by iLIFE for you. However you are responsible for determining whether payments made to you are taxable or not, and paying the taxes on that income if it is taxable. iLIFE will not be held responsible for any taxes, interest or penalties on income paid to you.

Please answer all of the questions noted below or the form will be returned to you. If you do not complete this form or if iLIFE does not receive this form, you may be issued a 1099 at year end. Even if you are issued a 1099 form, it is up to you and your tax advisor to determine if the amount needs to be claimed as taxable income.

1. Are you subject to back-up withholding?
   □ Yes
   □ No

2. How is your business organized?
   □ Corporation
   □ Individual/Sole Proprietor
   □ Partnership
   □ LLC
   □ Other, please specify:

3. Is the Adult Family Home also your primary home?
   □ Yes
   □ No

4. Number of adult clients, please specify number

5. Do you provide respite care?
   □ Yes
   □ No

6. I am requesting that iLIFE not issue a 1099-Misc, or equivalent form, as my Adult Living Facility is exempt from state and federal taxes.
   □ Yes
   □ No

I have read and understand the information on this sheet. To the best of my knowledge, the answers that I have provided above are true and correct. I understand that I solely am responsible for determining the taxability and reporting of income. iLIFE will not be held responsible for any taxes, interest or penalties on income paid to me.

AFH Contact Signature: 

AFH Contact Signature: 

Date: mm/dd/yyyy

NOTE:
This form only required for Adult Family Homes.