Provider Start-up and Requirements Checklist

Provider start-up forms and required forms must be completed and submitted to iLIFE and credentialed before providing services to the participant. Individual agencies cannot provide services until background checks are completed.

<table>
<thead>
<tr>
<th>✓</th>
<th>Provider Start-up Forms</th>
<th>When Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Application (F-01312)</td>
<td>For all providers</td>
<td></td>
</tr>
<tr>
<td>Form W-9</td>
<td>For all providers</td>
<td></td>
</tr>
<tr>
<td>Wisconsin Medicaid Program Provider Agreement (F-00180C)*</td>
<td>For all providers</td>
<td></td>
</tr>
<tr>
<td>Vendor Direct Deposit Authorization Form*</td>
<td>For all providers</td>
<td></td>
</tr>
<tr>
<td>Background Information Disclosure (BID) (F-82064)</td>
<td>For individual providers</td>
<td></td>
</tr>
<tr>
<td>Background Information Disclosure Addendum (F-01246)</td>
<td>For individual providers</td>
<td></td>
</tr>
<tr>
<td>Credentialing Requirements List</td>
<td>Lists which professions require a copy of professional license and/or certificate</td>
<td></td>
</tr>
<tr>
<td>Copy of Liability Insurance Certificate*</td>
<td>If required for your profession</td>
<td></td>
</tr>
<tr>
<td>Copy of Professional License and/or Certificate*</td>
<td>If required for your profession</td>
<td></td>
</tr>
<tr>
<td>Copy of Driver’s License</td>
<td>If providing transportation</td>
<td></td>
</tr>
<tr>
<td>Adult Family Home Information Form*</td>
<td>If AFH provider with non-taxable income</td>
<td></td>
</tr>
<tr>
<td>Provider Agreement</td>
<td>Optional but recommended: For all new providers.</td>
<td></td>
</tr>
</tbody>
</table>

* See Provider Start-up and Requirements Documents (on the next page) for details.
Provider Start-up and Requirements Documents

This document provides additional information about some of the provider start-up and required documents. Please see the Provider Start-up and Requirements Checklist for a list of all required documents.

1. **Start-up documents**: One set of provider start-up documents is included in this packet. For additional forms, contact the participant’s consultant or find them online at iLIFEfms.com.

2. **Checklist**: The Provider Start-up and Requirements Checklist helps ensure all required documents are completed and submitted to iLIFE. Payments cannot be made if iLIFE is missing any required documents.

3. **Direct deposit (required)**: The provider must provide a signed Vendor Direct Deposit Authorization form and bank verification. The bank verification, such as a voided check, must include the account number, routing number, and account holder name.

4. **Wisconsin Medicaid Program Provider Agreement (required)**: This form is signed by the provider and is required before payments can be issued. One form is required per provider. If iLIFE does not receive the signed Medicaid Agreement form, iLIFE cannot process payments.

5. **Adult Family Home Information Form (required for AFH providers with non-taxable income)**: The AFH Information Form is required only if the AFH income is qualified to be non-taxable. The AFH is exempt from taxes and 1099 reporting only if the AFH qualifies based on the information provided on this form.

6. **Credentialing requirements (required)**: The Credentialing Requirements list identifies professions or services that require a license or certificate. For start-up processing, all providers must submit a copy of their current professional or service license, any certificates, and supporting documentation to iLIFE to become and remain an approved IRIS vendor. If iLIFE does not receive the required and updated service license, any certificates, and supporting documentation, iLIFE cannot process payments.

If you have questions, please call iLIFE at 1-888-800-5599.
IRIS PROVIDER APPLICATION

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. Applicants will not be considered as IRIS program service providers until all necessary paperwork is completed, submitted, and verified.

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

PROVIDER DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Organization Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Name (Last, First, MI)</td>
</tr>
<tr>
<td>Title</td>
</tr>
</tbody>
</table>

Are you applying as (choose one): [ ] Agency [ ] Individual Practitioner

Type of Application: [ ] Initial Application [ ] Reinstatement

W-9 Name (as shown on income tax return) | W-9 Business Name (if different from W-9 name)

W-9 Exempt: [ ] Yes [ ] No State of Wisconsin Department of Financial Institutions ID Number:

BILLING AND CLAIMS CONTACT INFORMATION

Check all that apply: [ ] Primary Office [ ] Mailing Address [ ] Billing Address

National Provider Identifier (if applicable): Wisconsin Provider Management Identifier (if applicable):

Tax Identification Number: Tax Qualifier: [ ] EIN [ ] SSN

Organization Name

<table>
<thead>
<tr>
<th>Name – Contact Person</th>
<th>Telephone Number</th>
<th>Email Address</th>
<th>[ ] May be published in Provider Directory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax Number</td>
<td>Internet Address</td>
<td>[ ] May be published in Provider Directory</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

RENDERING PROVIDER CONTACT INFORMATION

Check all that apply: [ ] Primary Office [ ] Mailing Address [ ] Billing Address

National Provider Identifier (if applicable): Wisconsin Provider Management Identifier (if applicable):

Tax Identification Number: Tax Qualifier: [ ] EIN [ ] SSN

Organization Name

<table>
<thead>
<tr>
<th>Name – Contact Person</th>
<th>Telephone Number</th>
<th>Email Address</th>
<th>[ ] May be published in Provider Directory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax Number</td>
<td>Internet Address</td>
<td>[ ] May be published in Provider Directory</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

DAILY OPERATIONS CONTACT INFORMATION

Check all that apply: [ ] Primary Office [ ] Mailing Address [ ] Billing Address

National Provider Identifier (if applicable): Wisconsin Provider Management Identifier (if applicable):

Tax Identification Number: Tax Qualifier: [ ] EIN [ ] SSN

Organization Name

<table>
<thead>
<tr>
<th>Name – Contact Person</th>
<th>Telephone Number</th>
<th>Email Address</th>
<th>[ ] May be published in Provider Directory</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>
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.

<table>
<thead>
<tr>
<th>Services</th>
<th>Does this service require a license or certification?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 Licensure/Certification Obtained</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 properly 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 doubts 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 [Signature]

Date Signed

Please submit this application to your Fiscal Employer Agent (FEA) using ONE of the following methods:

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>FAX</th>
<th>EMAIL</th>
<th>GROUND MAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>GT Independence</td>
<td>888-972-3891</td>
<td><a href="mailto:customerservice@gtindependence.com">customerservice@gtindependence.com</a></td>
<td>215 Broadus</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>P. O. Box 945</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Osceola, WI 54020</td>
</tr>
<tr>
<td>Premier Financial Management</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</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td>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.
Request for Taxpayer Identification Number and Certification

> Go to www.irs.gov/FormW9 for instructions and the latest information.

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see What Name and Number To Give the Requester for guidelines on whose number to enter.

<table>
<thead>
<tr>
<th>1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Business name/disregarded entity name, if different from above</td>
</tr>
<tr>
<td>3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.</td>
</tr>
<tr>
<td>□ Individual/sole proprietor or single-member LLC</td>
</tr>
<tr>
<td>□ C Corporation</td>
</tr>
<tr>
<td>□ S Corporation</td>
</tr>
<tr>
<td>□ Partnership</td>
</tr>
<tr>
<td>□ Trust/estate</td>
</tr>
<tr>
<td>□ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) *</td>
</tr>
<tr>
<td>□ Other (see instructions) *</td>
</tr>
<tr>
<td>4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):</td>
</tr>
<tr>
<td>Exempt payee code (if any)</td>
</tr>
<tr>
<td>Exemption from FATCA reporting code (if any)</td>
</tr>
<tr>
<td>(Applies to accounts maintained outside the U.S.)</td>
</tr>
<tr>
<td>5 Address (number, street, and apt. or suite no.) See instructions.</td>
</tr>
<tr>
<td>Requester’s name and address (optional)</td>
</tr>
<tr>
<td>6 City, state, and ZIP code</td>
</tr>
<tr>
<td>7 List account number(s) here (optional)</td>
</tr>
</tbody>
</table>

**Part II Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

**Purpose of Form**

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.
By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See What is FATCA reporting, later, for further information.

**Note:** If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or a U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a “saving clause.” Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

**Backup Withholding**

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the instructions for Part II for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See Exempt payee code, later, and the separate instructions for the Requester of Form W-9 for more information.

Also see Special rules for partnerships, earlier.

**What is FATCA Reporting?**

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See Exemption from FATCA reporting code, later, and the Instructions for the Requester of Form W-9 for more information.

**Updating Your Information**

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

**Penalties**

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.
Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1
You must enter one of the following on this line; do not leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. Individual. Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. Sole proprietor or single-member LLC. Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or “doing business as” (DBA) name on line 2.

c. Partnership, LLC that is not a single-member LLC, C corporation, or S corporation. Enter the entity’s name as shown on the entity’s tax return on line 1 and any business, trade, or DBA name on line 2.

d. Other entities. Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. Disregarded entity. For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a “disregarded entity.” See Regulations section 301.7701-2(c)(2)(iii). Enter the owner’s name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, “Business name/disregarded entity name.” If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9.

This is the case even if the foreign person has a U.S. TIN.

Line 2
If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3
Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

If the entity/person on line 1 is a(n) . . .

- Corporation
- Individual
- Sole proprietorship, or
- Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.
- LLC treated as a partnership for U.S. federal tax purposes,
  - LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or
  - LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.
- Partnership
- Trust/estate

THEN check the box for . . .

- Corporation
- Individual/sole proprietor or single-member LLC
- Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
- Partnership
- Trust/estate

Line 4, Exemptions
If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.
- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
2—The United States or any of its agencies or instrumentalities
3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
4—A foreign government or any of its political subdivisions, agencies, or instrumentalities
5—A corporation
6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession
7—A futures commission merchant registered with the Commodity Futures Trading Commission
8—A real estate investment trust
9—An entity registered at all times during the tax year under the Investment Company Act of 1940
10—A common trust fund operated by a bank under section 584(a)
11—A financial institution
12—A middleman known in the investment community as a nominee or custodian
13—A trust exempt from tax under section 664 or described in section 4947
### Exemption from FATCA Reporting Code

The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person you are only submitting this form to determine whether the FATCA code and/or exempt payee code should be completed.

#### Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN below.**

- If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.
- If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner’s SSN (or EIN, if the owner has one). Do not enter the disregarded entity’s EIN. If the LLC is classified as a partnership, enter the entity’s EIN.

**Note:** See What Name and Number To Give the Requester, later, for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at [www.SSA.gov](http://www.SSA.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/Businesses](http://www.irs.gov/Businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. Go to [www.irs.gov/Forms](http://www.irs.gov/Forms) to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to [www.irs.gov/OrderForms](http://www.irs.gov/OrderForms) to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

- If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write “Applied For” in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on such payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note:** Entering “Applied For” means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

#### Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see Exempt payee code, earlier.

**Signature Requirements.** Complete the certification as indicated in items 1 through 5 below.
1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. “Other payments” include payments made in the course of the requester’s trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

<table>
<thead>
<tr>
<th>For this type of account:</th>
<th>Give name and SSN of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual</td>
<td>The individual</td>
</tr>
<tr>
<td>2. Two or more individuals (joint account) other than an account maintained by an FFI</td>
<td>The actual owner of the account or, if combined funds, the first individual on the account&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>3. Two or more U.S. persons (joint account maintained by an FFI)</td>
<td>Each holder of the account &lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>4. Custodial account of a minor (Uniform Gift to Minors Act)</td>
<td>The minor&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>5. a. The usual revocable savings trust (grantor is also trustee)</td>
<td>The grantor-trustee&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>b. So-called trust account that is not a legal or valid trust under state law</td>
<td>The actual owner&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>6. Sole proprietorship or disregarded entity owned by an individual</td>
<td>The owner&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A)(i))</td>
<td>The grantor*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For this type of account:</th>
<th>Give name and EIN of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Disregarded entity not owned by an individual</td>
<td>The owner&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>9. A valid trust, estate, or pension trust</td>
<td>Legal entity&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>10. Corporation or LLC electing corporate status on Form 8832 or Form 2553</td>
<td>The corporation</td>
</tr>
<tr>
<td>11. Association, club, religious, charitable, educational, or other tax-exempt organization</td>
<td>The organization</td>
</tr>
<tr>
<td>12. Partnership or multi-member LLC</td>
<td>The partnership</td>
</tr>
<tr>
<td>13. A broker or registered nominee</td>
<td>The broker or nominee</td>
</tr>
</tbody>
</table>

1 List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person’s number must be furnished.

2 Circle the minor’s name and furnish the minor’s SSN.

3 You must show your individual name and you may also enter your business or DBA name on the “Business name/disregarded entity” name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

4 List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see Special rules for partnerships, earlier.

*Note: The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.
The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at spam@uce.gov or report them at www.ftc.gov/complaint. You can contact the FTC at www.ftc.gov/idtheft or 877-IDENTHEFT (877-438-4338). If you have been the victim of identity theft, see www.IdentityTheft.gov and Pub. 5027.

Visit www.irs.gov/IdentityTheft to learn more about identity theft and how to reduce your risk.

**Privacy Act Notice**

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.
Wisconsin Medicaid Program Provider Agreement and Acknowledgement of Terms of Participation

For Waiver Service Provider Agencies or Individuals

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

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

Phone Number ____________________________

Address – Street ____________________________

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;
c) 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;

d) The names and addresses of any subcontractors who have had business transactions with the provider;

e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.

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

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

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

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

<table>
<thead>
<tr>
<th>Name – Provider (Typed or Printed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNATURE – Provider</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>[Signature]</td>
<td>8/14/17</td>
</tr>
</tbody>
</table>
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: ________________________________________________________________

Address: ___________________________________________________________________

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

Contact Name: _______________________________________________________________

Contact Phone Number: _______________________________________________________

Name of Financial Institution: _________________________________________________

Routing Number: ____________________________________________________________

Account Number: ____________________________________________________________

<table>
<thead>
<tr>
<th>Type of Account</th>
<th>Required Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking</td>
<td>Attach either a voided check or a letter from the bank.</td>
</tr>
<tr>
<td></td>
<td>• Must have the account holder’s name, routing and account numbers for the account.</td>
</tr>
<tr>
<td></td>
<td>• Must be typed.</td>
</tr>
<tr>
<td></td>
<td>• Starter checks may not be used.</td>
</tr>
<tr>
<td></td>
<td>• Letter must be printed on bank letterhead.</td>
</tr>
<tr>
<td>Savings</td>
<td>Attach a letter from the bank.</td>
</tr>
<tr>
<td></td>
<td>• Must have the account holder’s name, routing and account numbers for the account.</td>
</tr>
<tr>
<td></td>
<td>• Must be typed.</td>
</tr>
<tr>
<td></td>
<td>• Must be printed on bank letterhead.</td>
</tr>
</tbody>
</table>

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: ___________________________________________ Date: __________

P.O. Box 91760 | Milwaukee, WI 53209 | Phone: 1-888-800-5599 | Fax: 1-414-918-4463
Email: IRIS.Vendor@iLIFEfms.com | Website: iLIFEfms.com

(7/2017)
BACKGROUND INFORMATION DISCLOSURE (BID)

- PENALTY: Knowingly providing false information or omitting information may result in a forfeiture of up to $1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).

- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.

- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.

- Refer to DQA form F-82064A, BID Instructions, for additional information.

Check the box that applies to you.

- Employee / Contractor (including new applicant)
- Applicant for a license, certification, or registration (including continuation or renewal)
- Household member (lives on premises, but is not a client)
- Other – Specify: ________________________________

NOTE: If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Full Legal Name – First Middle Last

Position Title (Complete only if a prospective or current employee or contractor.) Birth Date (MM/dd/yyyy) Sex

- Male
- Female

Any Other Names By Which You Have Been Known (Including Maiden Name)

Race / Ethnicity (Check ONLY one.) Social Security Number

- American Indian or Alaskan Native
- Asian or Pacific Islander
- Black
- White
- Unknown

Home Address City State Zip Code

Business Name and Address – Employer or Care Provider (Entity)

A “NO” answer to all questions does not guarantee employment, residency, a contract, or regulatory approval. Note: The areas below that are designated for responses are expandable.

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

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
   - Yes
   - No

   If Yes, list each charge, when it occurred or the date of the charge, and the city and state where the court is located. You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

   Yes
   No

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

   If Yes, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.

   Yes
   No

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

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

   Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect?
   - Yes
   - No

   If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

   Yes
   No
4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?
   If Yes, explain, including when and where it happened.
   Yes ☐ No ☐

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?
   If Yes, explain, including when and where it happened.
   Yes ☐ No ☐

6. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person?
   If Yes, explain, including when and where it happened.
   Yes ☐ No ☐

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?
   If Yes, explain, including credential name, limitations or restrictions, and time period.
   Yes ☐ No ☐

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?
   If Yes, explain, including when and where it happened.
   Yes ☐ No ☐

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?
   If Yes, explain, including when and where it happened and the reason.
   Yes ☐ No ☐

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

4. Have you resided outside of Wisconsin in the last three (3) years?
   If Yes, list each state and the dates you resided there.
   Yes ☐ No ☐

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years?
   If Yes, list each state and the dates you resided there.
   Yes ☐ No ☐

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

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe?
   If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.
   Yes ☐ No ☐

Read and initial the following statement.

[Initial] 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 __________________________ Date Submitted __________________________
BACKGROUND INFORMATION DISCLOSURE ADDENDUM—IRIS

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

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

SECTION I – APPLICANT INFORMATION

<table>
<thead>
<tr>
<th>Name – (Last, First, MI)</th>
<th>Date of Birth</th>
</tr>
</thead>
</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></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></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></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s Maiden Name</th>
<th>Mother’s Current Name – (Last, First, MI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Father’s Name – (Last, First, MI)</th>
</tr>
</thead>
<tbody>
<tr>
<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**

**Date Signed**
Credentialing Requirements List

Vendors in the following occupations or fields must send a copy of the license and/or certificate. Failure to send a copy of the license and/or certificate will delay payment.

Please note not all occupations listed here can receive payment through the IRIS program.

- Acupuncturist
- Adult Family Home (1-2 bed)
- Adult Family Home (3-4 bed)
- Advanced Practice Nurse Prescriber
- Anesthesiologist Assistant
- Art Therapist
- Athletic Trainer
- Audiologist
- Behavior Analyst
- Camp
- Chiropractic Radiological Technician
- Chiropractic Technician
- Chiropractor
- Clinical Substance Abuse Counselor
- Clinical Supervisor In Training
- Community-based Residential Facility (CBRF) (only for respite services)
- Controlled Substances Special Use Authorization
- Contractor (Trade Professions)
- Dance Therapist
- Dental Hygienist
- Dentist
- Dietitian
- Drug or Device Manufacturer
- Hearing Instrument Specialist
- Home Medical Oxygen Provider
- Independent Clinical Supervisor
- Intermediate Clinical Supervisor
- Licensed Midwives
- Licensed Practical Nurse
- Licensed Radiographer
- Limited X-Ray Machine Operator Permit
- Marriage and Family Therapist
- Massage Therapist or Bodywork Therapist
- Music Therapist
- Nurse - Midwife
- Occupational Therapist
- Occupational Therapy Assistant
- Optometrist
- Orthoptist
- Perfusionist
- Personal Emergency Response System (PERS) Installer
- Personal Trainer
- Pharmacist
- Pharmacy (In State)
- Pharmacy (Out of State)
- Physical Therapist
- Physical Therapist Assistant
- Physician
- Physician Assistant
- Podiatrist
- Prevention Specialist
- Prevention Specialist in Training
- Prevocational Services
- Private Pract. School Psychologist
- Professional Counselor
- Prosthetist
- Psychologist
- Residential Care and Apartment Complex (RCAC)
- Registered Nurse
- Registered Sanitarian
- Respiratory Care Practitioner
- Sign Language Interpreter
- Sign Language Interpreter (Restricted)
- Social Worker
- Social Worker - Advanced Practice
- Social Worker - Independent
- Social Worker - Licensed Clinical
- Social Worker - Training Certificate
- Speech-Language Pathologist
- Substance Abuse Counselor
- Substance Abuse Counselor in Training
- Taxi and Transportation Services
- Teacher
- Veterinarian
- Veterinary Technician
- Wholesale Distributor of Prescription Drugs

Adult Family Home Information

Instructions: 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: __________________________________________________________________________

City: ____________________________________________ State: ________ Zip: ________________

Contact Person: ____________________________________________________________________

Phone Number: (_______) ________ - _______________

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?
   Individual/Sole Proprietor
   Corporation
   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: _____________________________________________ Date: ________________
Provider Agreement

Instructions: 1. Participant completes the top, and provider completes the bottom.
   2. Participant and provider sign at the bottom.

_____________________________________ (Participant), hereafter referred to as Participant, and
_____________________________________ (Provider), hereafter referred to as Provider, do hereby enter into the
following agreement:

The Participant requires the following tasks and duties to be performed by the Provider:

The Provider agrees to provide/arrange for training as described below:

The Provider agrees to perform the tasks as outlined above according to the following schedule:

☐ Monday  ☐ Tuesday  ☐ Wednesday  ☐ Thursday  ☐ Friday  ☐ Saturday  ☐ Sunday
☐ Other: ________________________________________________________________

Services will be provided at the rate of $___________ per  ☐ Hour  ☐ Day  ☐ Week  ☐ One Time

The Participant and Provider understand that these services are provided under Medicaid regulations and
that we may not charge in excess of the amount agreed upon with this document.

After the Provider has performed the services per this agreement, claims are due to iLIFE per the iLIFE Provider
Payment Schedule.

Provider FEIN: ____________________________________________________________

Name: ______________________________________________________________________________

Address: _____________________________________________________________________________

City: ___________________________ State: ________ Zip: _____________________

Phone: __ __ __ - __ __ __ - __ __ __ __

Provider Signature: __________________________________________________________ Date: ____________

Participant or Guardian Signature: ____________________________________________ Date: ____________

OPTIONAL