JG

Jean Gottwald, Fiscal Agent

13648 S Lakeview Cir · Gordon, WI 54838
715-661-9101 · 888-689-7798 · Fax: 715-513-7347
Email: jlgfiscal@gmail.com

Family Care Provider:

The member/client you work for providing family care services has appointed me as their Fiscal Agent.

As the member's Fiscal Agent, I need to get new employee paperwork for anyone that will be providing services for the member. Please review the attached packet of information, fill out the necessary forms as indicated on the checklist and return them to me as soon as possible. Please note that I only need the completed forms returned, not any of the instructional materials.

Also, please note that the Member or Managing Party needs to sign the I-9 verifying the documents you provide as proof of identity. Please provide a copy of the documents you use for your ID. They also need to verify that all documents are completed and returned by initialing and signing the New Employee Checklist.

Payroll for services provided will be processed through me as the member's Fiscal Agent. Enclosed is the timesheet you should use. Please make sure you track your hours worked accurately (not exceeding the hours authorized). The timesheet needs to be signed by you and the Member/Managing Party and turned in to me by the 8th of the month. Checks are processed monthly and issued on the 20th.

If you have any questions, please feel free to reach out to me at one of the contacts listed above.

COMPLETE AND RETURN

FISCAL EMPLOYER AGENT - NEW EMPLOYEE CHECKLIST

Please complete all the forms on the list below, including this New Employee Checklist. Send originals to Jean Gottwald, Fiscal Agent before the employee begins to work.

Employee Name	Member Name	Managing Party Name

Forms required for all New Employees:
The Member/Managing Party should date and initial each item as it is completed. The Member/Managing Party should keep a copy of each document and **send the originals to Jean Gottwald, Fiscal Agent.**

Initial	Date	Form	What to return
		New Employee Checklist	This form
		Employee Data Form	Completed form only
		Employee and Employer Agreement	Completed form only
		I-9 (employee completes section 1, employer completes section 2)	Completed pages 1 and 2 only
		W-4 Employee's Withholding Allowance Certification	Completed form only
		WT-4 Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting	Completed form only
		Background Information Disclosure Form	Completed pages 1 and 2 only
		Employer Relationship Disclosure Form	Completed form only
		F-100180C Wisconsin Medicaid Program Provider Agreement and Acknowledgement of Terms of Participation	Completed form only
		Direct Deposit Form	Completed form and proof of account information

I have reviewed and verified the above forms for completeness and all forms are readable. As the Member/Managing Party, I understand that the employee forms need to be completed and returned in order to continue in my employ.

Member or Managing Party Signature _____ Date _____ Employee Signature _____ Date _____

Jean Gottwald, Fiscal Agent
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JEAN GOTTWALD, FISCAL AGENT

EMPLOYEE DATA FORM

EMPLOYEE CONTACT INFORMATION

Name: _____ _____ _____
First Middle Last

Physical Address: _____
Street, Apt/Unit #

_____
City, State, Zip Code

Mailing Address: _____
(if different) Street, Apt/Unit # or PO Box

_____
City, State, Zip Code

Phone # Home: _____ Cell: _____

Email: _____

Date of Birth: _____ Social Security Number: ___ - ___ - ____

Emergency Contact: _____ _____ _____
Name Phone Relationship

I want Jean Gottwald, Fiscal Agent to contact me by:

Phone: ( ) Yes ( ) No Email: ( ) Yes ( ) No Mail: ( ) Yes ( ) No

Have you ever had your driver's license in any state revoked or suspended? ( ) Yes ( ) No
In the past three years, have you had moving violations or motor vehicle accidents? ( ) Yes ( ) No
If yes, explain:

Please Read Carefully: Neither the acceptance of the employee paperwork nor entry into any type of employment relationship or employment agreement with a Member/Managing Party for the consideration of employment shall serve to create an actual or implied contract of employment with Jean Gottwald, Fiscal Agent.

I authorize investigation of all statements provided to the Member/Managing Party or contained in the employee paperwork. **I** understand that misrepresentation or omission of facts called for is cause for dismissal at any time without notice. I hereby give the Member/Managing Party permission to contact schools, previous employers (unless otherwise indicated), references, and others, and hereby release the Member/Managing Party from any liability as a result of such contact.

I understand that employment remains conditional until the results of the criminal background check have been received and approved. I also understand that the results of the criminal background check or any future criminal background checks may be shared with the approving entity (MCO, county, etc.) and/or the Member/Managing Party I work with.

Signature of Applicant: _____ ***Date:*** _____

COMPLETE AND RETURN

Employee and Employer Agreement

_____ has been hired by _____
(Employee) (Employer/Member)

Employee will provide care services through the self-directed services program to the Employer/Member.

Jean Gottwald, Fiscal Agent has been chosen to assist the member/employer with administrative tasks, enrollment setup and payroll services.

As the employee, I agree to:

- Complete all documents that are required to be an employee of a Fiscal member (your employer).
- Not begin working and filling out timesheets until I am given a start date from one of the following: Jean Gottwald, the MCO or your employer.
- Work with the employer to provide them with the best care and outcomes possible.
- Stay within the guidelines of what is authorized for hours worked and tasks required.
- Follow HIPAA and confidentiality requirements.
- Follow standard precautions and perform all work-related tasks in a safe manner.
- Report timesheets accurately. Failure to do this could result in fraud and/or abuse reporting.
- Report concerns of safety, health or well-being of the person I am caring for.
- Report work-related injury, within 24 hours to Jean Gottwald, Fiscal Agent at 1-715-661-9101.
- Notify Jean Gottwald, Fiscal Agent if I do not work within 90 days.

I understand that my timesheet needs to be turned in by the 8th of the month following the end of a month. Timesheet must be signed by employee and employer/member or their guardian or POA. Submission of timesheets after the due date will delay payment. The late timesheet will be processed on the following month's payroll date. I understand Jean Gottwald, Fiscal Agent is not responsible for payment of services if I provide duties to the member that are not approved, if I work more hours than approved by the Managed Care Organization or if the member is no longer eligible for services under this program.

I understand that I am the employee of _____ (enter employer name).

I understand that my employer is responsible for all employment actions which might include orientation, training, supervising, disciplinary action, termination, management and other employer-related functions.

I understand that Jean Gottwald, Fiscal Agent IS NOT my employer, but provides the payroll services and administrative tasks for my employer. If I have employment concerns, I need to discuss these with my employer/member.

Employee signature: _____ Date: _____

Employer/Member signature: _____ Date: _____

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888-689-7798
Fax: 715-513-7347

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

PLEASE INCLUDE COPIES OF YOUR DOCUMENTS

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Or Number of Exemptions

Step 4: Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
c/o Jean Gottwald Fiscal Agent 13648 S Lakeview Cir; Gordon, WI 54838		39-1887700

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

Employee's legal name *(first name, middle initial, last name)*			Social security number	☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note**: If married, but legally separated, check the Single box.
Employee's address *(number and street)*			Date of birth	
City	State	Zip code	Date of hire	

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

1. (a) Exemption for yourself – enter 1 . . . . . _____
   (b) Exemption for your spouse – enter 1 . . . . . _____
   (c) Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent . . . . . _____
   (d) Total – add lines (a) through (c) . . . . . _____
2. Additional amount per pay period you want deducted (if your employer agrees) . . . . . _____
3. I claim complete exemption from withholding (see instructions). Enter "Exempt" . . . . . _____

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

Signature _____ Date Signed _____ , _____

EMPLOYEE INSTRUCTIONS:

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

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

  You may complete and provide to your employer a new Form WT-4 at any time if the number of your exemptions INCREASES.

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

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

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

WT-4 Instructions – Provide your information in the employee section.

- **LINE 1:**
  (a)-(c) Number of exemptions – Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1(a)-(c) or you may enter into an agreement with your employer to have additional amounts withheld (see instruction for line 2).

  (c) Dependents – Those persons who qualify as your dependents for federal income tax purposes may also be claimed as dependents for Wisconsin purposes. The term "dependents" does not include you or your spouse. Indicate the number of dependents that you are claiming in the space provided.

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

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

  You must revoke this exemption (1) within 10 days from the time you expect to incur income tax liability for the year or (2) on or before December 1 if you expect to incur Wisconsin income tax liabilities for the next year. If you want to stop or are required to revoke this exemption, you must complete and provide a new Form WT-4 to your employer showing the number of withholding exemptions you are entitled to claim. This certificate for exemption from withholding will expire on April 30 of next year unless a new Form WT-4 is completed and provided to your employer before that date.

Employer's Section

Employer's name			Federal Employer ID Number
c/o Jean Gottwald, Fiscal Agent			39-1887700
Employer's payroll address *(number and street)*	City	State	Zip code
13648 S Lakeview Circle	Gordon	WI	54838
Completed by	Title	Phone number	Email
Jean Gottwald	Fiscal Agent	(715) 661-9101	jean.gottwald@gmail.com

EMPLOYER INSTRUCTIONS for Department of Revenue:

- If you do not have a Federal Employer Identification Number (FEIN), contact the Internal Revenue Service to obtain a FEIN.
- If the employee has claimed more than 10 exemptions OR has claimed complete exemption from withholding and earns more than $200.00 a week or is believed to have claimed more exemptions than they are entitled to, mail a copy of this certificate to: Wisconsin Department of Revenue, Audit Bureau, PO Box 8906, Madison WI 53708 or fax (608) 267-0834.
- Keep a copy of this certificate with your records. If you have questions about the Department of Revenue requirements, call (608) 266-2772 or (608) 266-2776.

EMPLOYER INSTRUCTIONS for New Hire Reporting:

- This report contains the required information for reporting a New Hire to Wisconsin. If you are reporting new hires electronically, you do not need to forward a copy of this report to the Department of Workforce Development. Visit https://dwd.wi.gov/uinh/ to report new hires.
- If you do not report new hires electronically, mail the original form to the Department of Workforce Development, New Hire Reporting, PO Box 14431, Madison WI 53708-0431 or fax toll free to 1-800-277-8075.
- If you have questions about New Hire requirements, call toll free (888) 300-HIRE (888-300-4473). Visit dwd.wi.gov/uinh/ for more information.

Background Information Disclosure (BID) For Entity Employees and Contractors

Purpose: State and federal law require background checks for certain types of employment, contract, or other roles involving contact with vulnerable persons receiving care or treatment. The information you provide on this form will be used to verify your eligibility for such a role. Providing inaccurate or incomplete information on this form may result in a forfeiture or other sanction, as provided in Wis. Stats. § 50.065(6)(c).

Type

☒ Applicant/employee
☐ Contractor
☐ Student
☐ Volunteer
☐ Household member
☐ Other, specify: _____

Describe the position for which you are applying or renewing:
Caregiver

Applicant information

Name (First, Middle, Last): _____

Social Security number: _____ Date of birth (MM/DD/YYYY): _____

Sex: ☐ Male ☐ Female Phone number: _____

Address – Street: _____

City: _____ State: _____ ZIP code: _____

Have you had or used any other names, including prior to marriage?

☐ Yes ☐ No If yes, list each name fully: _____

Employer or organization verifying eligibility

Name of employer or organization that asked you to complete this form:
Jean Gottwald Fiscal Agent

Address – Street: 13648 S Lakeview Circle

City: Gordon State: WI ZIP code: 54838

Disclosures

If additional space is needed for answering the questions below, please use the additional page at the end of this form.

1. Pending criminal charges

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

If **yes**, describe the charge and indicate the name of the court, the state, city, month and year you were charged.

2. Convictions for crimes

Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts, or in another country? ☐ Yes ☐ No

If **yes**, describe the crime and indicate the name of the court, the state, city, month and year you were convicted.

3. Abuse or neglected or a child

Please note that Wis. Stat. § 48.981, *abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.

Has a government or regulatory agency (other than the police) ever found that you abuse or neglected a child? ☐ Yes ☐ No

If **yes**, describe the conduct and indicate the agency that made the finding, the state, city, month and year of the finding.

4. Abuse or neglect of an adult

Has a government or regulatory agency (other than the police) ever found that you abused or neglected an adult? ☐ Yes ☐ No

If **yes**, describe the conduct and indicate the agency that made the finding, the state, city, month and year of the finding.

5. Stealing or other misappropriation

Has a government or regulatory agency (other than the police) ever found that you stole or misappropriated (improperly took or used) a person's property (e.g., money, medications, etc.), identity, or financial information (e.g., credit card, checks, etc.)? ☐ Yes ☐ No

If **yes**, describe the conduct and indicate the agency that made the finding, the state, city, month and year it occurred.

6. Restriction on credential

Do you have a government issued credential that is not current or has been revoked, suspended, or that limits you in any way from providing care to clients? ☐ Yes ☐ No

If **yes**, identify the type of credential and indicate the credentialing agency, the restriction, and the state, city, month and year it was issued.

7. Denial, revocation, or limitation on license, certification, or registration

Has a government or regulatory agency ever denied, revoked, or limited your license, certification, or registration to provide care, treatment, or educational services? ☐ Yes ☐ No

If **yes**, indicate the license, certification, or registration type and indicate the issuing agency. Include a description of the denial, revocation, or limitation, and the state, city, month and year it was issued.

8. Denial, revocation, or limitation on ability to reside on certain premises

Has a government or regulatory agency ever denied, revoked or limited your ability to live on the premises of a facility that provides care or treatment? ☐ Yes ☐ No

If **yes**, describe the denial, revocation, or limitation and identify the issuing agency, the state, city, month and year issued.

9. Rehabilitation review

Have you ever requested a rehabilitation review from the Wisconsin Department of Health Services, a county department, private child placing agency, school board, or DHS-designated tribe? ☐ Yes ☐ No

If **yes**, indicate the agency that conducted the review, the outcome, month, and year of the review.

Note: You must provide a copy of your rehabilitation review letter to your employer or organization. Your employer or organization must verify your status with the agency that issued the decision.

10. Armed forces

Have you been discharged from a branch of the US Armed Forces, including any reserve component? ☐ Yes ☐ No

If **yes**, indicate the month and year of discharge.

Note: You must provide your DD214 to your employer/agency, if you were discharged within the last three (3) years.

11. Out-of-state residence

Have you resided outside of Wisconsin in the last three (3) years? ☐ Yes ☐ No

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

12. Government employee

Are you applying or renewing eligibility to work as a government employee for the State of Wisconsin (e.g. a state agency, treatment facility, institute, etc.)? ☐ Yes ☐ No

If **no**, skip to the attestation below. If **yes**, have you resided outside of Wisconsin in the last seven (7) years? ☐ Yes ☐ No

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

Review your responses and the following attestation carefully before signing.

Attestation

I have completed and reviewed this form. The information I provided is accurate and complete. I understand that providing inaccurate or incomplete information on this form may result in a forfeiture or other sanction, as provided in Wis. Stats. § 50.065(6)(c).

Signature — Person completing this form: _____

Date signed: _____

JEAN GOTTWALD, FISCAL AGENT

EMPLOYMENT RELATIONSHIP DISCLOSURE

Employee Name	***Employer/Member Name***

Instructions: Are you related to your employer? Tell us below what that relationship is. Complete each section. Sign and date the bottom of the form.

1. Service Recipient/Live-in Status:

☐ Yes ☐ No The person receiving services is a minor (less than age 18)

☐ Yes ☐ No I will be residing at the same address as my employer

2. Relationship Disclosure:

I am the following (check one):

☐ Spouse	☐ Parent	☐ Adoptive or Stepparent
☐ Child under age of 21	☐ Child over age of 21	☐ Sibling
☐ Grandparent	☐ Grandchild	☐ Domestic Partner
☐ No Relationship	☐ Other, please describe:	

_____

If parent was checked above, complete the following:

Yes	No	
☐	☐	My employer (my son or daughter) has a child or stepchild that lives in the home.
☐	☐	My employer is (1) a widow or widower, (2) divorced or (3) married and lives with a spouse but the spouse can't care for the child or stepchild due to a mental or physical condition. The spouse is unable to provide care for at least 4 straight weeks in 3 months.
☐	☐	My employer's child or stepchild is less than 18 years old or needs personal care from an adult. Care is needed for at least 4 straight weeks in 3 months due to a mental or physical condition.

3. Relationship Acknowledgement:

I may be exempt from some taxes. It depends on what I checked above. The back of this form shows what taxes I must pay. My local unemployment office can tell me more about FUTA and SUTA taxes.

I must notify Consumer Direct if this relationship changes. I have 5 days to do so. If I do not, I may have to pay back money that should have been withheld from my pay.

_____ _____ _____ _____

Employee Signature Date Employer/Representative Signature Date

INTERNAL USE ONLY:

Social Security (subject to tax)	Medicare (subject to tax)	SUTA (subject to tax)	FUTA (subject to tax)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00180C (09/2024)

STATE OF WISCONSIN
Wis. Stat. § 49.45(2)(a)9
Wis. Admin. Code § DHS 105.01
42 C.F.R. 431.107 and 42 C.F.R. 438.602(b)

WISCONSIN MEDICAID
PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

Standard Agreement / Acknowledgement for
Home and Community-Based Waiver Service (Adult Long-Term Care) Providers

By signature of its authorized representative below, the provider identified below agrees to and acknowledges the conditions of participation and terms of reimbursement set forth in this agreement:

Note: The provider's name used below **must** exactly match the name used on **all** other Medicaid documents

The provider's participation in Wisconsin Medicaid is subject to the following terms and conditions:

1. **FEDERAL COMPLIANCE:** Under 42 C.F.R. § 431.107 of the federal Medicaid regulations, the provider agrees to:
   a. Keep any records necessary to disclose the extent of services provided to waiver participants for a period of **ten (10) years** and to retain the records and documents according to the terms provided by Wis. Admin. Code chs. DHS 101–108, except for the retention period specified in Wis. Admin. Code DHS § 106.02(9)(e)2.
   b. On request, provide to the Wisconsin Department of Health Services (DHS), the Secretary of the U.S. Department of Health and Human Services (HHS), or the State Medicaid Fraud Control unit any information maintained under paragraph a. of this section and any information regarding payments claimed by the provider for furnishing services under Wisconsin Medicaid, including home and community-based waiver services.
   c. If the provider is a hospital, nursing facility, provider of home health care, personal care services, or hospice, comply with the advance directives requirements specified in 42 C.F.R. Part 489, Subpart I and 42 C.F.R. § 417.436(d).
   d. Provide DHS, the managed care organization (MCO), or the IRIS (Include, Respect, I Self-Direct) program with its National Provider Identifier (NPI), if eligible for an NPI.
   e. Include its NPI (if eligible for an NPI) on all claims submitted under Wisconsin Medicaid, including home and community-based waiver services.
   f. Comply with the disclosure requirements in 42 C.F.R. Part 455, Subpart B, which includes all disclosure requirements from 455.100 through 455.106.
      i. For the purposes of this agreement, the person with an ownership or control interest means a person or corporation that:
         a. Has an ownership interest totaling 5 percent or more in a disclosing entity.
         b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity.
         c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity.
         d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the provider if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.
         e. Is an officer or director of a disclosing entity that is organized as a corporation.
         f. Is a partner in a disclosing entity that is organized as a partnership.

F-00180C

      ii. The provider, any fiscal agent, or affiliated managed care entity shall furnish to DHS:
         a. The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include, as applicable, the primary business address, every business location, and any P.O. Box address.
         b. Date of birth and Social Security number (SSN) (in the case of an individual).
         c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.
         d. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
         e. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
         f. The name, address, date of birth, and SSN of any managing employee of the disclosing entity (or fiscal agent or managed care entity).
         g. A provider must submit, within 35 days of the date on a request by the HHS or DHS, full and complete information about:
            1. The ownership of any subcontractor with whom the provider has had any business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

2. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.

h. The provider must disclose to DHS the entity of any person who:
1. Has ownership or controlling interest in the provider or is an agent or managing employee of the provider.
2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

iii. Disclosure, as required in this agreement, from any provider or disclosing entity is due at any of the following times:
a. Upon the provider or disclosing entity submitting the provider application.
b. Upon the provider or disclosing entity executing this agreement.
c. Upon request of DHS during the revalidation of enrollment process under 42 C.F.R. § 455.414.
d. Within 35 days after any change in ownership of the disclosing entity.

2. **WISCONSIN MEDICAID:** The provider's participation in Wisconsin Medicaid, including home and community-based waiver services, is subject to the following terms and conditions:
a. **Laws, rules, regulations, and policies.** The provider agrees to comply with federal and state laws, rules, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program. This includes, but is not limited to, the caregiver background checks, a waiver participant's rights granted under federal and state law, including the right to refuse medication and treatment, and policy communications published by DHS.
b. **Provider handbooks.** The provider agrees to comply with the applicable terms, conditions, and restrictions that are set forth in the internet-based Family Care, Family Care Partnership, Program of All-Inclusive Care for the Elderly (PACE), or IRIS Online Handbooks, bulletins, Adult Long-Term Care Updates, and other communications regarding changes in state or federal law, policy, reimbursement rates and formulas, departmental interpretation, procedural directives such as billing and prior authorization procedures, and specific reimbursement changes, which are issued by DHS under Wis. Admin. Code § DHS 108.02(2) and (4). The Online Handbook, bulletins, and Adult Long-Term Care Updates are available to the provider through the ForwardHealth Portal at https://www.forwardhealth.wi.gov. The omission of any applicable term, condition, or restriction from this section does not excuse the provider from complying with that term, condition, or restriction.
c. **Actual knowledge not required.** The provider agrees to comply with all applicable terms, conditions, and restrictions governing the provider's participation in Wisconsin Medicaid, including the home and community-based waiver programs, regardless of whether the provider has actual knowledge of those terms, conditions, and restrictions.
d. **Claim submission.** The provider agrees to comply with all claim submission requirements as defined by the program that authorized the service, and from which the provider is seeking reimbursement. This includes, but is not limited to: DHS, the MCO, or IRIS fiscal employer agent (FEA), including electronic and web-based submission methodologies that require the input of secure and discrete access codes but not written provider signatures. The provider has the sole responsibility for maintaining the privacy and security of any access code used to submit information to DHS, the MCO, or IRIS FEA. Any person who submits information to DHS, the MCO, or IRIS FEA, using the provider's access code does so on behalf of the provider, regardless of whether the provider gave permission to use the access code, otherwise revealed the access code to the person, or had knowledge that the person knew the access code or used it to submit information to DHS, the MCO, or IRIS FEA.
e. **Confidentiality.** The provider is subject to applicable federal and state laws regarding confidentiality and disclosure of medical records or other health information, including the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for all services, information, transactions (including electronic transactions), privacy, and security regulations.
f. **Repayment.** The provider is responsible for repayment to DHS, the MCO, or IRIS program of any overpayment based on any information submitted by the provider or by any third party in the provider's name or NPI or using the provider's access code, with or without the provider's knowledge or consent, regardless of the manner in which the information was submitted.
g. **Sanctions.** The provider is subject to sanctions that may be imposed by DHS under Wis. Stat. § 49.45(2)(a)13 and Wis. Admin. Code § DHS 106.08 based on information submitted by the provider or by any third party in the provider's name or NPI or using the provider's access code, with or without the provider's knowledge or consent, regardless of the manner in which the information was submitted.

3. **WRITTEN POLICIES FOR EMPLOYEES:** An entity that receives or makes payments under a state Medicaid plan or any waiver of such plan totaling at least $5,000,000 annually shall establish written policies for all employees and contractors according to 42 U.S.C. § 1396a(68).

4. **CIVIL RIGHTS COMPLIANCE:** The provider agrees to all of the following:
a. In accordance with the provisions of Section 1557 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C. § 18116), Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 701 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.), and regulations implementing these Acts, found at 45 C.F.R. Parts 80, 84, 91, and 92, the provider shall not exclude, deny benefits to, or otherwise discriminate against any person on the basis of sex, race, color, national origin, disability, or age in admission to, participation in, in aid of, or in receipt of services and benefits under any of its programs and activities, and in staff and employee assignments to patients, whether carried out by the provider directly or through a sub-contractor or any other entity with which the provider arranges to carry out its programs and activities.
b. The provider will comply with all assurance, notice, grievance procedures, and other requirements in the aforementioned federal regulations found at 45 C.F.R. Parts 80, 84, 91, and 92.
c. The provider will ensure meaningful access to individuals with limited English proficiency (LEP) at no cost to the LEP individuals, in compliance with 42 U.S.C. § 2000d, et seq., and 42 U.S.C. § 18116, and 45 C.F.R. Parts 80 and 92.

d. The provider will ensure that its communications with individuals with disabilities are as effective as its communications with others in its health programs and activities, including its electronic and information technology communications, and it provides appropriate auxiliary aids and services, in compliance with Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 et seq.) and 42 U.S.C. § 18116, and their respective implementing regulations found in 28 C.F.R. Part 35 and 45 C.F.R. Part 92.
e. The provider agrees to cooperate with DHS, the MCO, or IRIS program, in any complaint investigations, monitoring, or enforcement related to civil rights compliance of the provider or its subcontractors.

5. **TERMS OF REIMBURSEMENT:** Reimbursement of the provider for services and items properly provided under Wisconsin Medicaid, including the home and community-based waiver programs, is governed by this agreement and the terms of reimbursement as are now in effect in the Online Handbooks and Adult Long-Term Care Updates, or as may later be amended. All claims are subject to post-payment audit and recoupment if the claim or the underlying transaction fails to comply with the applicable laws, regulations Online Handbook, Adult Long-Term Care Updates, or program guidance. Terms of reimbursement include, but are not limited to:
   a. The provider agrees to provide only the items or services authorized by the MCO or IRIS program.
   b. The provider agrees to accept the payment issued by the MCO or IRIS FEA as payment in full for provided items or services.
   c. The provider agrees to make no additional claims or charges for provided items or services.
6. **ON-SITE INSPECTIONS:** The provider must permit the Centers for Medicare & Medicaid Services, HHS, DHS, or their agents or designated contractors to conduct unannounced on-site inspections of any and all provider locations per 42 C.F.R. § 455.432.
7. **SUBMISSION OF CLAIMS:** The provider understands and agrees that every time the provider signs and submits a claim, whether done electronically or otherwise, the provider certifies that:
   a. The claim complies with all federal and state Medicaid laws and regulations including, but not limited to, the Online Handbook, all Adult Long-Term Care Updates, and other program guidance.
   b. The claim is truthful, accurate, and complete and contains services and items that have been furnished or caused to be furnished in accordance with applicable federal and state Medicaid laws.
   c. The provider has not offered, paid, or received any illegal remuneration or any other thing of value in return for referring an individual to a person for the furnishing of any service or item, or for arranging for the furnishing of any service or item for which payment may be made in whole or in part under Medical Assistance in violation of 42 U.S.C. § 1320a-7b, Wis. Stat. § 946.91(3), or any other federal or state anti-kickback statutes.
   d. The provider has not engaged in or committed fraud or abuse. “Fraud” includes any act that constitutes fraud under applicable federal or state law.
   e. The payment of claims will be from federal and state funds, or both; that compliance with the above requirements is a condition precedent to payment and conditioned upon compliance with all state and federal Medicaid laws, regulations, the Online Handbook, Adult Long-Term Care Updates, and all other program guidance, and therefore, no payment shall be made for services in violation of said requirements; any claim submitted or caused to be submitted or any statement made or used in violation of the above requirements constitutes a false or fraudulent claim for purposes of liability under 31 U.S.C. § 3729 and/or Wis. Stats. §§ 49.485 and 49.49; and that any false claim or statement of concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law.
8. **FALSE CLAIMS:** Any acts or omissions by the provider’s staff or any entity acting on the provider’s behalf shall be deemed those of the provider, including any acts and/or omissions in violation of federal or state criminal and civil false claims statutes.
9. **EXTRAPOLATION TO DETERMINE OVERPAYMENT:** Extrapolation under Wis. Admin. Code § DHS 105.01(3)(f) may be used as a method to calculate the amount owed by the provider to Wisconsin Medicaid when it has been determined, as a result of an investigation or audit conducted by DHS, the Department of Justice (DOJ) Medicaid fraud control unit, HHS, the Federal Bureau of Investigation, or an authorized agent of any of these entities, based on a sample of claims, that the provider was overpaid.
10. **INACTIVE STATUS:** Failure by the provider to submit claims for payment for more than a 12 consecutive month period may result in the provider being placed on inactive status. A provider is not eligible for reimbursement for services provided while on inactive status. A provider placed on inactive status must reapply to Wisconsin Medicaid to reactivate their status.
11. **LICENSURE:** The provider certifies that the provider and each person employed by it for the purpose of providing services hold all licenses or similar entitlements and meet other requirements specified in federal or state statute, regulation, rule, or program authority for the provision of the service.
12. **VOLUNTARY TERMINATION:** The provider may terminate its certification to participate in Wisconsin Medicaid as provided under Wis. Admin. Code § DHS 106.05.
13. **INVOLUNTARY TERMINATION:** DHS may terminate or suspend the provider’s certification under this agreement as provided in Wis. Admin. Code § DHS 106.06.
14. **DURATION:** This agreement will remain in full force and effect as long as the provider is certified to participate in Wisconsin Medicaid under Wis. Admin. Code ch. DHS 105 and/or in the Medicaid home and community-based services waiver programs under the IRIS Waiver or Family Care Waiver.
15. **STATEMENT OF MATERIAL FACT:** The provider acknowledges that any statement made in this agreement or in the provider application process constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made by the provider for a benefit or payment, or for use in determining rights to such benefit or payment. Under Wis. Stat. § 49.49(1d) and (4m), if any such statements or representations are false, the provider may be subjected to criminal or other penalties.
16. **ATTESTATIONS:** The provider acknowledges and attests compliance to all statements below.
   a. Provider has written policies regarding testing for communicable diseases, as well as protocols in place for positive results, for all staff.

b. Provider has documentation to support all attestations made within this application and agrees to provide DHS such documentation upon request.
c. Provider has written policies and procedures in place to address staff shortages.
d. Provider has a continuity of operations plan, specifically related to emergency or disaster preparedness.
e. If a member or participant experiences a medical emergency while in the presence of the provider, provider will call 911 to access emergency services and wait with the member or participant until the first responders are on-site, have assessed the situation, and have taken the member or participant into their care if needed.
f. Provider has policies and procedures in place for hiring that include review of Wisconsin DOJ results and the Background Information Disclosure (BID) form, F-82064. Provider's policies and procedures include action the provider will take based on results of the background check, in compliance with Wis. Stat. § 50.065(2)(bb), (br), and (2m) and Wis. Admin. Code §§ DHS 12.06 and 12.115.
g. Provider completes Wisconsin DOJ criminal and caregiver background checks at its own expense for all persons who will provide care to members and participants, whether an employee or contractor of an entity or a sole proprietor, prior to the person(s) providing direct services to a member or participant and at a minimum every four (4) years thereafter or any time the organization or agency has a reason to believe a new check should be performed.
h. Pursuant to Wis. Admin. Code chs. DHS 12 and 13, prior to providing services that result in direct contact with members or participants, provider verifies all persons who will provide care to members or participants, whether an employee or contractor of an entity or a sole proprietor do not appear on the list of excluded individuals on the DHS Wisconsin Misconduct Registry. The provider will remove any employee found on the Misconduct Registry from any work related to any state or federal health care program. The Misconduct Registry can be accessed at https://wi.tmuniverse.com/search.
i. Provider understands that the U.S. DOJ may impose civil monetary penalties on anyone who hires an excluded individual or entity. Provider agrees to check the HHS Office of Inspector General (OIG) online List of Excluded Individuals/Entities database (Exclusions Database) for all new hires and at least quarterly for existing employees to ensure that no excluded employees work in any capacity related to any state or federal health care program. The provider will remove any employee found in the OIG Exclusions Database from any work related to any state or federal health care program. OIG maintains an online database at https://exclusions.oig.hhs.gov/.
j. As applicable, provider shall have written policy and train its staff to immediately report all allegations of misconduct, including abuse and neglect of a member or participant or misappropriation of a member's or participant's property.
k. Provider will require, via written policy and procedures, that persons, whether an employee or contractor of an entity or a sole proprietor, report criminal convictions or investigations to their immediate supervisor as soon as possible, but no later than the next working day per Wis. Admin. Code § DHS 12.07(1).
l. In compliance with Wis. Admin. Code DHS § 12.10, provider shall retain in its personnel files the following documents related to all persons providing direct care to members and participants: pertinent Background Information Disclosure (BID) form, F-82064, and search results from the Wisconsin DOJ, DHS, and the Wisconsin Department of Safety and Professional Services, as well as out-of-state records, tribal court proceedings, and military records, in accordance with searches required in Wis. Stat. § 50.065(2) and Wis. Admin. Code § DHS 12.08. Provider shall make these documents available to DHS upon request.
m. Provider ensures staff is able to perform skills as required in their position description prior to initial performance.
n. Provider ensures and documents qualifications of each staff member, including academic preparation and relevant experience, verification of current license, certifications, and/or registrations to practice in Wisconsin that are applicable to, or required by, the staff member's duties. Upon request, the provider will supply any applicable documentation to DHS.
o. Provider ensures staff working with frail elders or disabled populations have documented experience with the population that the staff will work with or provider has plans to ensure staff is adequately trained.
p. Provider maintains a training plan for each staff member who provides or will provide direct care to members or participants and has a mechanism for ensuring that all necessary training has been completed prior to performing work and that completion of all trainings is documented.
q. Provider will maintain documentation that staff is trained annually on compliance, fraud, waste, and abuse.
r. Provider ensures staff are trained on DHS recording and reporting requirements for documentation, critical incident reporting, and other information and procedures necessary for the staff to ensure the health and safety of members and participants receiving supports. The applicable requirements are documented in the Family Care Contract, Family Care Partnership, and PACE: Managed Care Organization Contracts and the IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards, P-03071.
s. Provider ensures staff are trained on the needs of the target group they are serving.
t. Provider ensures staff are trained on the provision of the services being provided.
u. As applicable, provider ensures staff have been trained or will be trained on the needs, strengths, and preferences of the individual(s) being served, prior to providing direct care.
v. Provider ensures all staff are trained on rights and privacy provisions applicable to providers, members, and participants in Wisconsin, including rights and privacy provisions guaranteed under HIPAA, Wis. Stat. ch. 146, and the Family Care Contract, Family Care Partnership, and PACE: Managed Care Organization Contracts and the IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards.
w. Provider will refrain from influencing an individual to either not enroll in or to disenroll from another MCO or the IRIS program.

By signature, the provider or authorized representative swears or affirms under penalty of perjury that the information given in this agreement is true and accurate. By signature, the provider certifies that they have read the LTC Waiver Provider Online Handbook and all regulations.

Name – Provider (Employee)	
NPI	Medicaid-Assigned Provider ID

Address

Street Address Line 1 _____

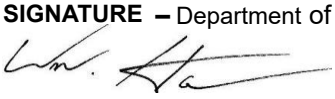
Street Address Line 2 _____

City State ZIP+4 Code

SIGNATURE – Provider	Date Signed

Title

FOR DMS USE ONLY (Do not write below this line.)

SIGNATURE – Department of Health Services	Date
	9/13/2024

Note*:* All five pages of this agreement must be returned together.

Payroll Schedule and Timesheet Reminders

Timesheets:

Monthly: Timesheets are due on the 8th of the month. Payroll periods go from the 1st of the month to the last day of each month. Paychecks are issued on the 20th of the following month.
Bi-weekly: Follow payroll schedule provided. Timesheets are due on Tuesdays. Paychecks are issued that Friday.

Submitting – timesheets can be submitted by:

- **Mailing**: Jean Gottwald, Fiscal Agent; 13648 S Lakeview Circle; Gordon, WI 54838
- **Faxing:** 24-hour fax line at 715-513-7347
- **Emailing:** scanned or text a clear snapshot of your timesheet to**:** jean.gottwald@gmail.com or 715-661-9101

When completing timesheet:

* Write clearly and in dark blue or black ink only.
* Enter only one shift/one day per line. If your shift carries over into another day, enter that day on a separate line.
* Enter time in and time out to the nearest quarter hour.
* Enter total number of hours worked on each individual timesheet.
* Use correct service codes. Timesheets should not have descriptions of types of work being done.
    - Respite T1005
    - Chore Lawn / Snow Removal S5121
    - Supportive Home Care – Attendant S5125
    - Supportive Home Care – Routine S5130
    - Supportive Home Care – Supervision S5135
* Mileage is to be reported using the mileage log provided.
* If you are claiming an overnight pay rate – please indicate in place of Total Hours Worked
* Use only the most up to date/current timesheet
* Stay within your authorized hours, miles, or services
* Employee and Member/Employer sign the timesheet before submitting.

Updating personal information

Please notify us of any changes. An address change may be reported with a Notification of Address/Phone Change form (please contact us if one is needed). You can also go to our website at www.jgfiscal.com obtain the *Notification of Address – Phone Change* form. If other personal information has changed (name, marital status, number of exemptions, etc.) a new W-4 and WT-4 will need to be completed. Please contact our office at 715-661-9101 or email jean.gottwald@gmail.com so we can get you the correct form to fill out to update your information.

PLEASE COMPLETE AND RETURN

JEAN GOTTWALD, FISCAL AGENT
PAYROLL DIRECT DEPOSIT AUTHORIZATION FORM

I hereby authorize Jean Gottwald, Fiscal Agent to electronically deposit my paycheck on each payday directly into the account listed below. I also authorize to make any necessary debit or adjustment entries to the listed account in the event that an error was made in any credit entries.

I understand this direct deposit authorization will remain in effect until I have given written notification to Jean Gottwald, Fiscal Agent of my wish to change my account information.

_____

Employee Name

Bank Account Information

_____

Name of Bank

☐ **Checking Account**

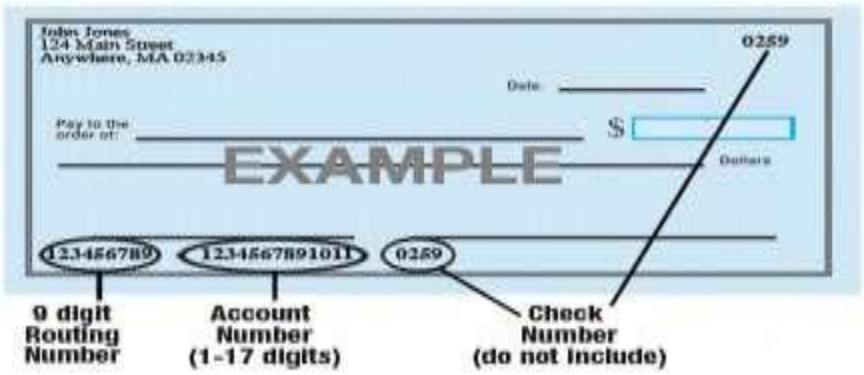
☐ **Savings Account**

_____

9 Digit Routing Number

_____

Account Number



Please attach a photocopy of a check, or a voided check or another form of account authorization.

_____ _____

Employee Signature **Date**

Jean Gottwald, Fiscal Agent
13648 S Lakeview Circle; Gordon, WI 54838
Email: jean.gottwald@gmail.com
Phone: 715-661-9101
888-689-7798
Fax: 715-513-7347

ATTENTION

Timesheets received after the due date of the **8th of the month** will be paid with the following payroll. NO EXCEPTIONS!
The program and/or Fiscal Agent are not responsible for paying hours that exceed the authorized hours.

Self-Direct Supports Timesheet for:

Employee Name: Your name

Person Receiving Services (member): Client's name

Period Beginning: 1/1/2025
First day of the month or pay period

Period Ending: 1/31/2025
Last day of the month or pay period

Date Month/Day/Year	Service Code	Time In: Hour: Minute*	AM/PM	Time Out: Hour: Minute*	AM/PM	Total Hours Worked
1/4/2025	S5125	9:00	am	11:00	am	2
1/11/2025	S5125	6:00	pm	9:00	pm	3
1/18/2025	S5125	11:00	am	1:00	pm	2
1/25/2025	S5125	4:00	pm	7:00	pm	3

* Time should be entered to the nearest quarter hour (i.e. :00, :15, :30, :45)

Total hours this page: 10

Total hours all pages: _____

Page _____ of _____

Member/POA/Guardian Signature	**Date signed:**	**As the person receiving services or authorized representative, I certify that the employee's hours shown on this timesheet are correct and that the work was performed satisfactorily during the time period above.**
_____	_____	
Employee Signature	**Date signed:**	**I certify that I worked the hours shown on the timesheet on the days indicated and that this timesheet has been certified by the person receiving services or authorized to sign for the person receiving services. Also, I understand that payment for services provided are subject to payroll taxes.**
_____	_____	

It is your responsibility to verify that your completed timesheet has been received by Jean Gottwald, Fiscal Agent. If sent via email, a return message will be sent. If you request verification that your timesheet was received, please contact Jean Gottwald, Fiscal Agent at one of the contacts listed below.

Submit timesheet to: Jean Gottwald, Fiscal Agent; 13648 S Lakeview Circle; Gordon, WI 54838

Email: jean.gottwald@gmail.com Website: jgfiscal.com **Cell phone: 715-661-9101** **Fax #: 715-339-2775**
Email: jlgfiscal@gmail.com Toll Free: 888-689-7798

ATTENTION

Monthly filers - timesheets are due by the 8th of the following month.
Bi-weekly filers - reference the payroll schedule - timesheets due by Tuesday.
The program and/or Fiscal Agent are not responsible for paying hours that exceed the authorized hours.

Self-Direct Supports Timesheet for:

Employee Name: _____ **Period Beginning:** _____

Person Receiving Services (member): _____ **Period Ending:** _____

Date Month/Day/Year	Service Code	Time In: Hour: Minute*	AM/PM	Time Out: Hour: Minute*	AM/PM	Total Hours Worked

* Time should be entered to the nearest quarter hour (i.e. :00, :15, :30, :45)

Total hours this page: _____

Page _____ of _____

Total hours all pages: _____

Member/POA/Guardian Signature	**Date signed:**	**As the person receiving services or authorized representative, I certify that the employee's hours shown on this timesheet are correct and that the work was performed satisfactorily during the time period above.**
_____	_____	
Employee Signature	**Date signed:**	**I certify that I worked the hours shown on the timesheet on the days indicated and that this timesheet has been certified by the person receiving services or authorized to sign for the person receiving services. Also, I understand that payment for services provided are subject to payroll taxes.**
_____	_____	

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