TEMPUS UNLIMITED, INC.
Opportunities for Independence
formerly Cerebral Palsy of Massachusetts, Inc.

TO: Consumers of the PCA Program

FROM: Fiscal Intermediary Department

RE: Employment Packages

Welcome to the Tempus Unlimited, Inc. Fiscal Intermediary (FI) program. Enclosed please find all the forms you will need to return to us in order to start your participation in the FI Program. Also, enclosed are examples of properly completed forms to assist you. The following is a list of the forms and a brief description of their use:

Consumer Agreement: The Consumer Agreement explains how Tempus Unlimited, Inc. performs the Federal and State required paperwork in their role as a Fiscal Intermediary for the Consumer. The Consumer completes and signs this form.

SS-4 Application for Employer Identification Number (EIN): Each consumer is an employer in the FI program. You will need an Employer Identification Number (EIN) in order for Tempus Unlimited, Inc. to report tax withholding and other information for your PCAs, to the Internal Revenue Service. This form is required by the Federal Government. The Consumer completes and signs this form.

Form TA-1 Application for Original Registration: This application is similar to the SS-4 above, however it is required by the State of Massachusetts. The Consumer completes and signs this form.

8821 Tax Information Authorization: This form will allow Tempus Unlimited, Inc. to inspect and receive information about the tax forms indicated on line 3(b) and for the tax periods indicated on line 3(c) on form 8821. The Consumer completes and signs this form.

2678 Employer Appointment of Agent: This form will allow Tempus Unlimited, Inc. to file the appropriate forms with the Internal Revenue Service (IRS) as an agent of the Consumer. The Consumer completes and signs this form.

M-2848 Power of Attorney and Declaration of Representative: This form allows Tempus Unlimited, Inc. the Power of Attorney for the following forms we file on your behalf: The State Income Tax withholding and the TA-1 Application. The Consumer completes and signs this form.

Payroll Consent Form: By signing this form the Consumer is acknowledging that he/she is aware that Tempus Unlimited, Inc. subcontracts the payroll processing, tax payment and tax filing responsibilities with Sage Payroll Services powered by PayChoice. The Consumer completes and signs this form.

Tempus Unlimited, Inc. Grievance Policy: This policy explains how you would proceed in filing a grievance if you were ever unhappy with the services Tempus Unlimited, Inc. provides.

Tempus Unlimited, Inc. Notice of Privacy Practices (NNP): The NNP describes how Protected Health Information (PHI) about you may be used or disclosed, and how you may access this information.

Consent to the Use and Disclosure of Protected Health Information: By completing and signing this form the Consumer acknowledges consent/non consent regarding the release of PHI and permission to leave detailed voicemails on home/cell phone.

PCA Home Care Quality Workforce Council: This notice explains the purpose of the PCA Home Care Quality Workforce Council and provides information on recruiting PCAs.

Department of Industrial Accidents Notice to Employees: As an employer in Massachusetts you need to post this Notice where your PCAs can see it. In the event that one of your PCAs is injured while working for you, the name and telephone number of your Workers' Compensation Insurance Company are on the form. **Please fill in your name and address before posting.**

Change of Consumer Address Form: If you (Consumer) should move, we require a signed change of address form or a letter of instruction to make the change **(we cannot accept changes over the phone).** Payroll packages are mailed directly to the Consumer/Surrogate address and we cannot re-direct the payroll package unless we have received a signed request.

Emergency Notification System (Rapid Notify): We will use the system to notify you of office closings, important updates and other information that we need to provide quickly. You can register by completing the enclosed form or go to our webpage: www.Tempusunlimited.org and select Rapid Notify from the Main Menu.

Please complete these forms as soon as possible and return them via the fax at the number listed below or mail them to our office at the address listed below. Once we have received your completed FI forms **and you receive a prior approval from MassHealth** informing you of the number of hours you are authorized to use per week, we will mail timesheets and forms for your Personal Care Attendants (PCAs) to complete in order to process their payrolls.

If you have any questions, please contact Tempus Unlimited, Inc. at Toll-Free at 1-877-479-7577 Monday through Friday between the hours of 8:30AM and 4:30PM. One of our Consumer Relations Specialists will be happy to assist you.

MassHealth

Consumer Agreement for PCA Fiscal Intermediary Services

- I am a consumer of MassHealth-approved Personal Care Attendant Services (PCA Services).
- As a consumer of PCA services, I employ my own Personal Care Attendants (PCAs).
- I understand that the wages paid to my PCAs are established through a collective bargaining agreement between the PCA Quality Homecare Workforce Council (the Council) and the Union (SEIU Local 1199).
- As the employer of my PCAs, I must perform certain employer-required tasks such as paying federal and state employer-required taxes, buying workers' compensation insurance, and withholding taxes and union dues and fees from my PCAs' payments.
- I understand that MassHealth has hired companies called fiscal intermediaries (FIs) who can help consumers like me perform these employer-required tasks.
- I understand that the fiscal intermediary that my personal care management agency has chosen will be my FI.
- I understand that I must let my FI know, by filling out and signing this form and returning it to my FI, that I delegate to my fiscal intermediary the authority to perform these employer-required tasks on my behalf.
- I understand that my FI will perform certain employer-required tasks, but that I am responsible for:
  - completing all paperwork required by my FI. I understand that my FI will not be able to pay my PCAs if the paperwork is not completed and submitted to my FI in accordance with my FI's instructions.
  - notifying my FI any time I hire or fire a PCA, any time that I move, and any time one of my PCAs moves;
  - notifying my FI and my personal care management agency when I am admitted to a nursing facility or other inpatient facility. I understand that MassHealth and the FI cannot pay for activity time performed by my PCA when I am in a nursing facility or other inpatient facility, and that any payments made while I am in a nursing facility or inpatient facility are considered fraud and will be reported to the state Bureau of Special Investigations (BSI) for investigation, and may result in termination of my PCA services as well as other potential penalties;

(continued on left half of page 2)

Acuerdo del consumidor para servicios de intermediario fiscal de PCA

- Soy un consumidor del programa autorizado de MassHealth, Personal Care Attendant Services [Servicios de ayudantes de atención individual ("Servicios PCA")].
- Como un consumidor de los Servicios PCA, contrato a mis propios Ayudantes de atención individual ("PCA").
- Entiendo que los salarios pagados a mis PCA se han establecido por medio de un acuerdo de negociación colectiva entre el PCA Quality Homecare Workforce Council (el Consejo) y el Sindicato (SEIU Local 1199).
- Como empleador de mis PCA, debo realizar ciertas tareas necesarias para el empleador tales como pagar los impuestos federales y estatales, adquirir el seguro de compensación al trabajador, y retener impuestos y cuotas del sindicato de mis pagos a los PCA.
- Entiendo que MassHealth ha contratado a unas compañías conocidas como intermediarios fiscales ("FI", por sus siglas en inglés), los cuales pueden ayudar a usuarios como yo, a realizar las tareas requeridas del empleador.
- Entiendo que el intermediario fiscal que mi agencia de atención individual seleccionó será mi FI.
- Entiendo que debo hacerle saber a mi FI, al completar y entregar este formulario a mi FI, que le delego a mi intermediario fiscal la autoridad para llevar estas tareas requeridas del empleador de parte mía.
- Entiendo que mi FI realizará ciertas tareas requeridas por el empleador, pero que yo soy responsable de:
  - completar todo el papeleo requerido por mi FI. Entiendo que mi FI no podrá pagar a mis PCA si el papeleo no está completado y remitido a mi FI de acuerdo con las instrucciones de mi FI.
  - notificar a mi FI siempre que contrate o despida a un PCA, siempre que yo cambie de dirección y siempre que cualquiera de mis PCA cambie de dirección;
  - notificar a mi FI y a mi agencia de atención individual cuando sea internado en una institución de atención especializada u otra institución para pacientes internos. Entiendo que MassHealth y el FI no pueden pagar por el tiempo de las actividades realizadas por mi PCA cuando yo esté

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- informing my PCA of the option of receiving their payment electronically through direct deposit in their bank account or through a debit card service offered by my FI. My FI can provide the forms needed for my PCA to request payment electronically; and
- making sure that my PCAs sign their activity forms (time sheets) each week, and fill them out correctly;
- making sure each of my PCA's activity forms accurately reflect the days and hours my PCA worked for me;
- sending my PCAs' completed activity forms to my FI, following my FI's instructions and in the timeframe provided by my FI;
- following the MassHealth regulations for the Personal Care Attendant Program. My personal care management agency can provide me with a copy of these regulations;

- I understand that MassHealth and the FI cannot pay my PCA if my PCA is on the List of Excluded Individuals/Entities (LEIE) maintained by the U.S. Department of Health and Human Services Office of Inspector General (OIG). My FI or my personal care management agency can provide me with more information about this.
- I understand that I must have prior authorization (PA) for PCA services from MassHealth and have sufficient units left on my PA before my FI can pay my PCAs. I understand I will be responsible for paying my PCAs if I do not have prior authorization from MassHealth or if I do not have sufficient units left on my PA on the days my PCAs worked.
- I understand that I may lose my eligibility for PCA services if I do not complete and return the required paperwork to my FI as instructed.
- I understand that if I have PCAs work for me and I am not eligible for MassHealth on the days my PCA works, that MassHealth and the FI are not responsible for paying my PCAs, and I will need to pay my PCAs on my own.
- I understand that I must sign certain forms that will allow the FI to act on my behalf. I understand that my PCAs cannot be paid until the forms, including the Consumer Agreement, are completed and returned to my FI. My FI will send me these forms.
- My Fiscal Intermediary will:

(continued on left half of page 3)

(proviene de la sección de la derecha de la página 1)

en una institución de atención especializada u otra institución para pacientes internos, y que cualquier pago que se haga mientras esté en una institución de atención especializada u otra institución para pacientes internos se considera fraude y será reportado al Departamento de investigaciones especiales (BIS, por sus siglas en inglés) para su respectiva investigación, pudiendo dar como resultado la terminación de los servicios de mi PCA al igual que otras multas posibles;

- informar a mi PCA sobre la opción de recibir su pago electrónicamente por medio de depósito directo en su cuenta bancaria o por medio de una tarjeta de débito ofrecida por mi FI. Mi FI puede proporcionar los formularios necesarios para que mi PCA solicite el pago electrónico; y
- comprobar que mis PCA firmen semanalmente su formulario de actividades (hoja de asistencia), y que las llenen correctamente;
- comprobar que los formularios de actividades de mi PCA reflejan con precisión los dias y horas en que mi PCA trabajó para mí;
- enviar los formularios de actividades de mis PCA completados a mi FI, de acuerdo a las instrucciones de mi FI, en el marco de tiempo proporcionado por mi FI;
- cumplir con los reglamentos de MassHealth sobre el Programa de ayudantes de atención individual. Mi agencia de atención individual me puede dar una copia de dichos reglamentos;

- Entiendo que MassHealth y el FI no pueden pagarle a mi PCA si dicha persona está en la Lista de individuos/entidades excluidas (LEIE, por sus siglas en inglés) que mantiene la Oficina del inspector general (OIG, por sus siglas en inglés) del Departamento de salud y servicios humanos de los E.E.U.U. Mi FI o mi agencia de atención individual puede proporcionarme más información sobre esto.
- Entiendo que debo tener autorización previa (PA, por sus siglas en inglés) para recibir servicios de PCA de MassHealth y tener suficientes unidades restantes en mi PA antes de que mi FI pueda pagarle a mis PCA. Entiendo que seré responsable de pagarles a mis PCA si no tengo autorización previa de MassHealth o si no tengo suficientes unidades restantes en mi PA en los días en que hayan trabajado mis PCA.
- Entiendo que puedo perder mi elegibilidad para los servicios PCA si no completo y devuelvo el papeleo requerido a mi FI tal como se indica.
- Entiendo que si tengo PCA que trabajen para mí y no soy elegible para MassHealth en los días en que trabaje mi PCA, MassHealth y mi FI no son responsables por pagarle a mis PCA y necesitaré pagarle a mi PCA por mi cuenta.

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- receive and process my PCAs' activity forms;
- write out my payroll checks for me in the name of each PCA that worked for me, unless my PCA has elected to be paid electronically;
- make correct withholdings from my PCAs' paychecks;
- make deductions for PCA union dues and fees in accordance with the collective bargaining agreement between the PCA Quality Homecare Workforce Council and the Union SEIU Local 1199, and send these monies to the Union;
- send all money withheld from my PCAs' paychecks to the proper agencies;
- pay my federal, state, and local employment taxes for me;
- pay my unemployment insurance taxes for me;
- purchase workers' compensation insurance in my name to cover my PCAs;
- send me the completed paychecks every two weeks for me to distribute to my PCAs deposit my PCAs' paychecks directly into my PCAs' bank accounts or pay my PCA through a debit card, if my PCA chooses to be paid electronically;
- perform other employer-required tasks such as getting employer identification numbers (EINs) and filling out, filing, and saving copies of other required employment forms;
- send me summaries of my payrolls, and my tax filings; and
- send me summaries (payroll cover sheets) that describe the number of PCA hours MassHealth authorized for me, the number of PCA hours I have used, and the number of PCA hours I have remaining on my prior authorization (PA). I understand I can share this information with my PCA, so I and my PCA know if there are sufficient hours left on my PA to have my PCA work and get paid.

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- Entiendo que debo firmar ciertos formularios que le permitirán al FI actuar en mi nombre. Entiendo que mis PCA no pueden recibir pagos hasta que los formularios, incluyendo el Acuerdo del consumidor, se hayan completado y devuelto a mi FI. Mi FI me enviará estos formularios.
- Mi Intermediario Fiscal:
  - recibirá y procesará los formularios de actividad de mis PCA;
  - escribirá por mí los cheques de nómina a nombre de cada uno de los PCA que hayan trabajado para mí; a menos que mi PCA haya elegido recibir pagos electrónicamente;
  - efectuará las retenciones correspondientes de los cheques de sueldo de mis PCA;
  - hará deducciones para las cuotas y aranceles del sindicato de PCA de acuerdo con la negociación colectiva entre el PCA Quality Homecare Workforce Council y el Sindicato (SEIU Local 1199); y enviará estos importes al sindicato;
  - enviará todo el dinero retenido de los cheques de sueldo de mis PCA a las agencias correspondientes;
  - pagará por mí mis impuestos de empleo federales, estatales y locales;
  - pagará mis impuestos del seguro por desempleo por mí;
  - obtendrá seguro de compensación al trabajador para mis PCA;
  - me enviará los cheques de pago completados cada dos semanas para que los distribuya a mis PCA, deposite directamente los cheques de pago en las cuentas bancarias de mis PCA, o pague por medio de una tarjeta de débito, si mi PCA escoge recibir pagos electrónicamente;
  - realizará otras tareas requeridas por el empleador como obtener números de identificación del empleador (EIN, por sus siglas en inglés) y llenar, archivar y guardar copias de otros formularios de empleo necesarios;
  - enviarme resúmenes de mis nóminas, y mis declaraciones de impuestos; y
  - enviarme resúmenes (resúmenes de nómina) que describan el número de horas de PCA que MassHealth autorizó para mí, el número de horas de PCA que he usado, y el número de horas de PCA que me restan en mi autorización previa (PA, por sus siglas en inglés). Entiendo que puedo compartir esta información con mi PCA, para que sepamos si hay suficientes horas restantes de PA para que mi PCA trabaje y reciba el pago.

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Here is my printed name

_____

Here is my signature

_____

OR

Here is my legal guardian's signature

_____

Today's date

_____

Commonwealth of Massachusetts
MassHealth

(proviene de la sección de la derecha de la página 3)

Mi nombre en letra de molde

_____

Mi firma

_____

O

La firma de mi Tutor legal

_____

Fecha de hoy

_____

Estado de Massachusetts
MassHealth

Form **SS-4**
(Rev. December 2017)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)
► Go to *www.irs.gov/FormSS4* for instructions and the latest information.
► See separate instructions for each line. ► Keep a copy for your records.

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)
PO BOX 936

5a Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)
RANDOLPH, MA 02368

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? ☐ Yes ☑ No

8b If 8a is "Yes," enter the number of LLC members ►

8c If 8a is "Yes," was the LLC organized in the United States? ☐ Yes ☐ No

9a **Type of entity** (check only one box). **Caution**. If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN)
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ►
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ►
- ☑ Other (specify) ► **HHCSR**
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ Military/National Guard
- ☐ Farmers' cooperative
- ☐ REMIC
- ☐ State/local government
- ☐ Federal government
- ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ►

9b If a corporation, name the state or foreign country (if applicable) where incorporated — State — Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ►
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) ► **HHCSR**
- ☐ Banking purpose (specify purpose) ►
- ☐ Changed type of organization (specify new type) ►
- ☐ Purchased going business
- ☐ Created a trust (specify type) ►
- ☐ Created a pension plan (specify type) ►

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year **DECEMBER**

13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.

Agricultural	Household	Other
0	0	0

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note**: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ►

16 Check **one** box that best describes the principal activity of your business.

☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ Wholesale-agent/broker ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) ► **HHCSR** ☐ Health care & social assistance ☐ Wholesale-other

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HHCSR

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☐ No
If "Yes," write previous EIN here ►

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name: **NICOLE SWIFT**
Designee's telephone number (include area code): **877-479-7577**
Address and ZIP code: **600 TECHNOLOGY CENTER DRIVE STOUGHTON, MA 02702**
Designee's fax number (include area code): **617-934-1191**

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.
Name and title (type or print clearly) ►
Applicant's telephone number (include area code)
Applicant's fax number (include area code)
Signature ► Date ►

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 12-2017)

CONSUMER'S DATE OF BIRTH **CONSUMER NUMBER**

Do I Need an EIN?

File Form SS-4 if the applicant entity does not already have an EIN but is required to show an EIN on any return, statement, or other document.[1] See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
Started a new business	Does not currently have (nor expect to have) employees	Complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–14 and 16–18.
Hired (or will hire) employees, including household employees	Does not already have an EIN	Complete lines 1, 2, 4a–6, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–18.
Opened a bank account	Needs an EIN for banking purposes only	Complete lines 1–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Changed type of organization	Either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership)[2]	Complete lines 1–18 (as applicable).
Purchased a going business[3]	Does not already have an EIN	Complete lines 1–18 (as applicable).
Created a trust	The trust is other than a grantor trust or an IRA trust[4]	Complete lines 1–18 (as applicable).
Created a pension plan as a plan administrator[5]	Needs an EIN for reporting purposes	Complete lines 1, 3, 4a–5b, 9a, 10, and 18.
Is a foreign person needing an EIN to comply with IRS withholding regulations	Needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits[6]	Complete lines 1–5b, 7a–b (SSN or ITIN optional), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is administering an estate	Needs an EIN to report estate income on Form 1041	Complete lines 1–6, 9a, 10–12, 13–17 (if applicable), and 18.
Is a withholding agent for taxes on non-wage income paid to an alien (i.e., individual, corporation, or partnership, etc.)	Is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	Complete lines 1, 2, 3 (if applicable), 4a–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is a state or local agency	Serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581[7]	Complete lines 1, 2, 4a–5b, 9a, 10, and 18.
Is a single-member LLC (or similar single-member entity)	Needs an EIN to file Form 8832, Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes[8], or is a foreign-owned U.S. disregarded entity and needs an EIN to file Form 5472, Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business (Under Sections 6038A and 6038C of the Internal Revenue Code)	Complete lines 1–18 (as applicable).
Is an S corporation	Needs an EIN to file Form 2553, Election by a Small Business Corporation[9]	Complete lines 1–18 (as applicable).

[1] For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity does not have employees.

[2] However, do not apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

[3] Do not use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

[4] However, grantor trusts that do not file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

[5] A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

[6] Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

[7] See also *Household employer* on page 4 of the instructions. **Note**: State or local agencies may need an EIN for other reasons, for example, hired employees.

[8] See *Disregarded entities* on page 4 of the instructions for details on completing Form SS-4 for an LLC.

[9] An existing corporation that is electing or revoking S corporation status should use its previously-assigned EIN.

Rev. 12/02

Massachusetts Department of Revenue

Form TA-1
Application for Original Registration

Check As Many As Apply

1. A 1. ☑ Employer under the Income Tax Withholding Law (payroll tax)
2. ☐ Withholding for Pension Plans, Annuities and Retirement Distributions

B 1. ☐ Sales/Use Tax on Goods Vendor
2. ☐ Sales/Use Tax on Telecommunications Services Vendor
3. ☐ Meals Tax on Food and All Beverages
4. ☐ Purchasing in MA for Out-of-State Resale Only

C ☐ Room Occupancy Excise

D ☐ Governmental or Charitable Exempt Purchaser
E ☐ Chapter 180 Organization Selling Alcoholic Beverages
F ☐ Use Tax Purchaser
G ☐ Boston Sightseeing Tour Surcharge
H ☐ Boston Vehicular Rental Transaction Surcharge
I ☐ Parking Facilities Surcharge in Boston, Springfield and/or Worcester
J ☐ Cigar and Smoking Tobacco Excise

Note: If you are selling cigarettes at retail, see instructions.

2. Federal Identification number

3. Social Security number

4. No. of locations

Principal Place of Business

5. Owner, partnership or legal corporate name

Name (cont'd.)
c/o TEMPUS UNLIMITED INC

6. Number and street
600 TECHNOLOGY CENTER DR

7. City or town
STOUGHTON

8. State
MA

9. Zip
02072—4708

10. (Area code) Telephone number
(877) 479—7577

General Information. If a corporation, trust, association, fiduciary, or partnership — you must complete Schedule TA-3.

11. Indicate type of organization:
☐ Corporation ☐ Trust or association ☑ Sole proprietor ☐ Fiduciary ☐ Partnership ☐ Other (specify): _____

12. Indicate type of business:
☐ Retail trade ☐ Wholesale trade ☐ Manufacturing ☐ Construction ☐ Governmental ☐ Finance ☐ Real estate ☐ Service
☑ Other (specify): _____ **13.** Describe nature of business: PERSONAL CARE

14. Business activity code 8050 **15.** Check applicable box: ☐ Profit ☐ Non-profit

16. If subsidiary corporation — Name of parent corporation ► / Federal Identification number

17. If sole proprietor (sole owner) — Name of owner ► / Social Security number

18. Reason for applying:
☐ Started new business ☐ Purchased existing business — enter name, address, and Federal Identification number of previous owner — Federal Identification number

☐ Organizational change — Federal Identification number and close date of previous organization **must** be entered, or application will be returned. ☐ Other (attach explanation) — Federal Identification number

Close date: Mo / Day / Yr

Background Information

19. Are any Massachusetts tax returns due or any Massachusetts taxes owed by your firm? ☐ Yes ☑ No. If yes, please explain:

20. Have you ever been issued a Certificate of Registration that was later revoked? ☐ Yes ☑ No. If yes, please explain:

Exempt Organizations

21. If you are applying for exempt purchaser status, be sure to include a copy of your IRS letter of exemption under Section 501(c)(3) of the Internal Revenue Code. Subordinate organizations covered under an IRS group exemption letter should include a copy of the group exemption ruling **and** a copy of the organization's directory page listing the organization as an approved subordinate. Both of the questions below must be answered.

A. Are you exempt from paying U.S. income taxes? ☐ Yes ☑ No. B. Are you exempt from paying local property taxes? ☐ Yes ☑ No.

Location of business

Federal Identification number _____

22. Trade name

Trade name (cont'd.)

23. Number and street **(PO box is not acceptable)**

24. City or town **25.** State **26.** Zip

27. (Area code) Telephone number ( ) —

28. Send certificate to: ☐ Principal place of business ☐ Location of business.

29. Send tax forms to: ☑ Principal place of business ☐ Location of business ☐ Other.
If "Other," complete Schedule TA-4.

Convention Center Financing District

30. Check here if your business location is within a Convention Center Financing District: ☐ (see pages 24–26 of instructions).

31. Check here if your business location is within a hotel, motel or other lodging establishment in Boston or Cambridge: ☐

Filing Frequencies

32. Is this location seasonal? (See instructions) ☐ Yes ☐ No.
If "yes," check month(s) or partial month(s) business operates.

Check month(s)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Withholding												
Sales/Use on Goods												
Sales/Use on Telecom. Services												
Meals												
Room Occupancy												

33. Indicate 12-month **estimate** of tax to be withheld, collected or paid for **each** applicable tax. **Check the appropriate box(es).**

Check appropriate box	$0–$100	$101–$1,200	$1,201–$25,000	over $25,000
Withholding		✔		

Check appropriate box(es)	$0–$100	$101–$1,200	over $1,200
Sales/Use on Goods			
Sales/Use on Telecom. Services			
Meals			
Room Occupancy			
Use Tax Purchaser			

Tax Type Information

Withholding

34. Date you were first required to withhold taxes at this location. Mo Day Yr

35. Number of employees in Massachusetts:

Sales/Use Tax on Goods

36. Date you were first required to collect sales/use tax at this location. Mo Day Yr

Sales/Use Tax on Telecommunications Services

37. Date you were first required to collect sales/use tax on telecommunications services at this location. Mo Day Yr

Meals Tax on Food and All Beverages

38. Check if you serve: ☐ Food ☐ Beer ☐ Wine ☐ Alc. bev.

39. Check if food/beverage vending machine: ☐

40. Date you were first required to collect meals tax. Mo Day Yr

41. Name and address on liquor license at this location.

42. Seating capacity:

Room Occupancy

43. Date you were first required to collect room occupancy tax. Mo Day Yr

44. Locality code

45. Number of rooms:

Use Tax Purchaser

46. Date you were first required to pay use tax. Mo Day Yr

Convention Center Financing Surcharges

47. Date you were first required to collect: a. Boston Sightseeing Tour Surcharge. Mo Day Yr

b. Boston Vehicular Rental Transaction Surcharge. Mo Day Yr

c. Parking Facilities Surcharge in Boston, Springfield and/or Worcester. Mo Day Yr

Cigar and Smoking Tobacco Excise

48. Date you were first required to collect cigar and smoking tobacco excise. Mo Day Yr

Mail to: Massachusetts Department of Revenue, Data Integration Bureau, PO Box 7022, Boston, MA 02204.

I hereby certify that the statements made herein have been examined by me and are, to the best of my knowledge and belief, true and correct. Signed under the pains and penalties of perjury. The signing of this application is evidence that you may be individually and personally responsible for any sums required to be paid to the Commonwealth, under MGL, Chapters 62B, Sec. 5; 64G, Sec. 7B; 64H, Sec. 16 and 64I, Sec. 17.

Your signature	Title	Date
	NICOLE SWIFT	600 TECHNOLOGY CENTER DRIV

Form **8821**

(Rev. January 2018)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

► **Go to *www.irs.gov/Form8821* for instructions and the latest information.**

► **Don't sign this form unless all applicable lines have been completed.**

► **Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you.**

OMB No. 1545-1165

For IRS Use Only

Received by:

Name

Telephone

Function

Date

1 Taxpayer information. Taxpayer must sign and date this form on line 7.

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number	Plan number (if applicable)

2 Appointee. If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached** ► ☐

Name and address	
TEMPUS UNLIMITED, INC. **600 TECHNOLOGY CENTER DRIVE** **STOUGHTON MA 02072**	CAF No. **0303-00848R** PTIN Telephone No. **877-479-7577** Fax No. **617-934-1191** Check if new: Address ☑ Telephone No. ☐ Fax No. ☑

3 Tax Information. Appointee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

☑ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters
INCOME TAX WITHHOLDING AND EMPLOYEMENT TAX	**940,940R, 940EZ, 941,941R,941X,941(C) 843,W-2, W-2(C), W3, W-3(C),SS-4, 147C**	**QUARTERS 1,2,3,4 2018 - 2020**	**TAX LIABILITY**

4 Specific use not recorded on Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip lines 5 and 6 . . . . . ► ☑

CONSUMER'S DATE OF BIRTH

5 Disclosure of tax information (you **must** check a box on line 5a or 5b unless the box on line 4 is checked):

a If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ► ☑

Note. Appointees will no longer receive forms, publications, and other related materials with the notices.

b If you don't want any copies of notices or communications sent to your appointee, check this box . . . . . ► ☐

6 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 box and attach a copy of the Tax Information Authorization(s) that you want to retain. . . . . ► ☑

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 6 instructions.

7 Signature of taxpayer. If signed by a corporate officer, partner, guardian, partnership representative, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

► **IF NOT COMPLETE, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.**

► **DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.**

Signature | Date

HHCSR

Print Name | Title (if applicable)

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

Part 1: Why you are filing this form...

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN) ☐☐ – ☐☐☐☐☐☐☐

2 Employer's or payer's name (not your trade name)

3 Trade name (if any)

4 Address

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (*Check all that apply.*)

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☐	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☐	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	☐	☐

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

X Sign your name here

Date / /

Print your name here

Print your title here HCSR

Best daytime phone

Now give this form to the agent to complete.

Part 3: **Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.**

6 Agent's employer identification number (EIN) 04 – 3770718

7 Agent's name (not trade name) Tempus Unlimited, Inc.

8 Trade name (if any)

9 Address

600 Technology Center Drive
Number Street Suite or room number

Stoughton | MA | 02072
City State ZIP code

Foreign country name | Foreign province/county | Foreign postal code

☑ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

X **Sign your name here**

Print your name here

Print your title here Intake Coordinator

Date / /

Best daytime phone 1-877-479-7577

Form M-2848
Power of Attorney and Declaration of Representative

Rev. 7/14

Massachusetts Department of Revenue

See separate instructions. Please print or type.

Part 1. Power of Attorney

A Name of taxpayer(s) or principal reporting corporation | Social Security number(s)

Number and street, including apartment number or rural route | Federal Identification number

City/Town | State | Zip

B Hereby appoint(s) the following individual(s) as attorney(s)-in-fact to represent the taxpayer(s) before any office of the Massachusetts Department of Revenue for the following tax matter(s) (specify the type(s) of tax and year(s) or period(s) (date of death if estate tax)):

Name	Address	Telephone number
		CONSUMER'S DATE OF BIR

Type of tax (individual, corporate, etc.)	**Year(s) or period(s)** (date of death if estate tax)

C The attorney(s)-in-fact (or any of them) are authorized, subject to any limitations set forth below or to revocation, to receive confidential information and to perform any and all acts that the principal(s) can perform with respect to the above specified tax matters, such as the authority to sign any agreements, consents or other documents.The authority does not include the power to substitute another representative (unless specifically added below) or the power to receive refund checks.

List any specific additions or deletions to the acts otherwise authorized in this power of attorney:

D Originals of notices and other written communications go to the taxpayer(s). Send copies of all notices and all other written communications addressed to the taxpayer(s) in proceedings involving the above tax matters to:

1 ☑ the appointee first named above, or

2 ☐ (name of another appointee designated above) _____

This power of attorney revokes all earlier powers of attorney on file with the Department of Revenue for the same tax matters and years or periods covered by this power of attorney, except the following (specify to whom granted, date and address including Zip code or attach copies of earlier powers):

E **Signature of or for taxpayer(s) or principal reporting corporation.** If signed by a corporate officer, partner, or fiduciary on behalf of the taxpayer, I certify that I have the authority to execute this power of attorney on behalf of the taxpayer and/or principal reporting corporation.

Signature | Title (if applicable) | Date

If signing for a taxpayer who is not an individual or a principal reporting corporation, type or print your name

Signature | Title (if applicable) | Date

PERSONAL CARE

F If the power of attorney is granted to a person other than an attorney, certified public accountant, public accountant or enrolled agent, the taxpayer(s) signature must be witnessed or notarized below.

The person(s) signing as or for the taxpayer(s) (check and complete one):

☐ is/are known to and signed in the presence of the two disinterested witnesses whose signatures appear here:

Signature of witness — Date

Signature of witness — Date

☐ appeared this day before a notary public and acknowledged this power of attorney as a voluntary act and deed.

Signature of notary — Date

Part 2. Declaration of Representative.

All representatives must complete this section.

I declare that I am not currently under suspension or disbarment from practice within the Commonwealth or in any jurisdiction, that I am aware of regulations governing the practice of attorneys, certified public accountants, public accountants, enrolled agents and others, and that I am one of the following:

1 a member in good standing of the bar of the highest court of the jurisdiction shown below;
2 duly qualified to practice as a certified public accountant or public accountant in the jurisdiction shown below;
3 enrolled as an agent under the requirements of Treasury Department Circular No. 230;
4 a bona fide officer of the taxpayer organization or principal reporting corporation;
5 a full-time employee of the taxpayer;
6 a member of the taxpayer's immediate family (spouse, parent, child or sibling);
7 a fiduciary for the taxpayer;
8 other (attach statement)

and that I am authorized to represent the taxpayer identified in Part 1 for the tax matters specified there.

Designation (insert appropriate number from above list)	**Jurisdiction** (state, etc.) **or enrollment card number**	Signature	**Date**
1	MA - BBO#556841		

PERSONAL CARE

TEMPUS UNLIMITED, INC.
Opportunities for Independence
formerly Cerebral Palsy of Massachusetts, Inc.

Consent to Use Payroll Processing Agent

Tempus Unlimited, Inc. processes payrolls and related tax filings as the Fiscal Intermediary (FI) for consumers in the Personal Care Attendant (PCA) Program using a payroll processing agent, Sage Payroll Services powered by PayChoice.

I understand that Tempus Unlimited, Inc., my IRS approved Employer Agent, is using Sage Payroll Services powered by PayChoice, a reporting agent, to perform some of its Employer Agent tasks on my behalf. I understand that Sage Payroll Services powered by Paychoice is performing the following Employer Agent tasks and I concur with this:

- Printing and mailing payroll registers, checks and direct deposit stubs to consumers.
- Processing Automated Clearing House transactions for PCAs enrolled in the direct deposit program.
- Withholding and depositing with the IRS all appropriate federal income tax, social security and Medicare taxes.
- Depositing all appropriate employer taxes with the IRS including employer social security taxes, Medicare taxes and FUTA taxes.
- Withholding and depositing state income taxes.
- Depositing all appropriate employer taxes with the Commonwealth of Massachusetts including SUTA and State Health Insurance Taxes.
- Filing appropriate reports with the IRS including Form 941, Form 940 or Form 940EZ and Forms W-2 and W-3.
- Filing appropriate reports with the Commonwealth of Massachusetts including Form 1, Form WR-1 and Health Insurance Quarterly Contribution Report.

_____

Printed Consumer Name

_____

Date

_____

Consumer Signature

February 2017

Notice of Privacy Practices

This notice describes how Protected Health Information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

This notice is provided on behalf of Tempus Unlimited, Inc., formerly Cerebral Palsy of Massachusetts, Inc.

PURPOSE: This notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. Protected Health Information is information that may identify the Consumer and that relates to the consumer's past, present or future physical or mental health, and may include name, address, phone numbers and other identifying information.

We are required to give you this Notice and to maintain the privacy of your Protected Health Information. We must abide by this Notice, but we reserve the right to change the privacy practices described in it. A current version of this Notice may be obtained from the Agency website, www.tempusunlimited.org, and will be posted in our Offices. You may also request a current copy by sending a written request to the Agency at Compliance Department, 600 Technology Center Drive, Stoughton, MA 02072

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your Protected Health Information. We create a record of the care and services you receive at the Agency. We need this record to provide services to you and to comply with certain legal requirements. This Notice will tell you about the ways we may use and disclose your information. We also describe your rights and certain obligations we have to use and disclose your Protected Health Information.

If you believe your Privacy Rights have been violated, you may make a complaint to us or to the US Secretary of Health and Human Services at: http://www.hhs.gov/. To file a complaint with us, you may send a letter describing the violation to the Agency at Compliance Department, 600 Technology Center Drive, Stoughton, MA 02072. There will be no retaliation for filing a complaint.

WHO WILL FOLLOW THIS NOTICE: This notice describes the practices of Tempus Unlimited, Inc., health care professionals, employees, volunteers and others who work in any of the Agency Programs that you may participate in.

Your Privacy Rights:

You have the following rights relating to your Protected Health Information and may:

- Obtain a current paper copy of this Notice.
- Inspect or obtain a copy of Agency created documents. Your request to obtain a copy of these documents must be in writing or in a format that allows us to verify the requestor as the Consumer or Guardian or other designated individual.
- Request that we amend your Protected Health Information (PHI), if you feel the information is incomplete or incorrect.
- Obtain a record of certain disclosures of Protected Health Information.
- Make a reasonable request to have confidential communications of your Protected Health Information sent to you by alternative means or at alternative locations.
- We will obtain your written permission for uses and disclosures of your Protected Health Information sent to you by alternative means or at alternative locations.
- We will obtain your permission for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing or in a format that allows us to verify the requestor as the Consumer or Guardian or other designated individual.

Our Responsibilities:

We are required to protect the privacy of your Protected Health Information, abide by the terms of the Notice, and make the notice available to you and to notify you if we are unable to agree to a requested restriction or an alternative means of communication.

Examples of Uses and Disclosures

We will use your Protected Health Information to provide services. We may provide reports or other information to your doctor or other authorized persons who are involved in your care.

- Business Associates: We may share some of your Protected Health Information with outside people or companies who provide services for us, such as our payroll provider.
- Notification: We may use or disclose your Protected Health Information to notify a family member or other person involved in your care, unless you tell us not to do so.
- Communication with Family: We may share your Protected Health Information with a Family member, a close personal friend, or a person that you identify, if we determine they are involved in your care or in payment for your care, unless you tell us not to do so.
- Contacts: We may contact you to provide appointment reminders.
- Public Health: We may give your Protected Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and is required by law.
- Communicable Disease: We may disclose your Protected Health Information to a person who may have been exposed to a communicable disease or may be otherwise at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.
- Law Enforcement: We must disclose your Protected Health Information for law enforcement purposes as required by law.
- As Required by Law: We must disclose your Protected Health Information when required by federal, state or local law.
- Health Oversight: We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight Agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.
- Abuse or Neglect: we must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect.
- Legal Proceedings: We may disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process.
- Required Uses and Disclosures: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.
- To Avoid Harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
- For Specific Government Functions: In certain situations, we may disclose Protected Health Information of veterans. We may disclose your Protected Health Information for national security activities required by law.
- Right to Receive Notifications of Data Breach: You have the right to be notified if there is a breach of any of your unsecured Protected Health Information that we hold or control. Protected Health Information is “unsecured” if it is not protected by a technology or methodology that makes it unreadable, like encryption. The notice must be made within 60 days from when we become aware of the breach.

Consent to the Use and Disclosure of Protected Health Information

I hereby give my consent for Tempus Unlimited, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). I understand that Tempus Unlimited, Inc. and its health care professionals and staff may use this information to plan my care, communicate with other health professionals concerning my care, document services for payment /reimbursement and conduct routine health care operations, such as quality assurance (monitoring the need, appropriateness, and quality of services provided) and staff training.

I have been given a Notice of Privacy Practices that fully explains the uses and disclosures that Tempus Unlimited, Inc. will make with my health information. I understand and have been given the right to review the *Notice of Privacy Practices* before signing this consent. Tempus Unlimited, Inc. has given sufficient time for me to review the *Notice of Privacy Practices* and has answered any questions I may have had to my satisfaction.

I understand that I do not have to consent to the use or disclosure of my health information for treatment, payment, and health care operations, but that if I do not consent, Tempus Unlimited, Inc. may refuse to provide me health care services unless applicable state or federal law requires Tempus Unlimited, Inc. to provide such services. If Tempus Unlimited, Inc. does agree to my requested restrictions, it is bound by this agreement.

The following person(s) have my consent regarding my health information. **You have my permission** to release information to them or **I am adding the access** of the following persons:

Name_____ Relationship_____

Name_____ Relationship_____

I understand that I have the right to object to the use and/or disclosure of my health information to family members. **You do not have my permission** to release information to them or **I am revoking the access** of the following persons:

Name_____ Relationship_____

Name_____ Relationship_____

Password: I would like to have a password added to my account. Information will not be disclosed over the phone unless the following password is used:

Password_____ Effective Date: _____

Permission to leave detailed voicemails on my home or cell phone voicemail:

Yes, you have my permission No, you do not have my permission

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Tempus Unlimited, Inc. has already taken action based on my earlier consent. **This consent will be in effect, if not revoked, until one month after the termination date of your Program**.

_____ _____ _____

Signature of Consumer/Surrogate Legal or Personal Representative **Printed Name** **Date**

Consentimiento para el Uso y la Divulgación de Información Protegida de Salud

Por este medio le doy mi consentimiento a Tempus Unlimited, Inc. para utilizar y divulgar información protegida de salud (PHI) sobre mí para llevar a cabo tratamiento, pago y operaciones de atención médica (TPO). Entiendo que Tempus Unlimited, Inc. y sus profesionales del cuidado de salud y empleados pueden utilizar esta información para planificar mi cuidado, comunicarse con otros profesionales del cuidado de salud con respecto a mi caso, documentar servicios para pago/reembolso y gestionar operaciones del cuidado de salud rutinarias tales como el aseguramiento de calidad (monitorear la necesidad, aptitud y calidad de los servicios provistos) y el entrenamiento del personal.

Me han dado un Aviso de Prácticas de Privacidad que explica plenamente los usos y las divulgaciones que Tempus Unlimited, Inc. hará con mi información de salud. Entiendo y se me ha dado el derecho de revisar el *Aviso de Prácticas de Privacidad* antes de firmar este consentimiento. Tempus Unlimited, Inc. ha dado suficiente tiempo para yo poder revisar el *Aviso de Prácticas de Privacidad* y ha contestado cualquier pregunta la cual pude haber tenido a mi satisfacción.

Entiendo que no tengo que dar el consentimiento al uso o divulgación de mi información de salud para tratamiento, pago y operaciones de atención médica, pero si no consiento, Tempus Unlimited, Inc. tiene el derecho de denegar proveerme servicios de cuidado de salud a menos que la ley aplicable del estado o federal le requiera a Tempus Unlimited, Inc. facilitar esos servicios. Si Tempus Unlimited, Inc. está de acuerdo con mis restricciones pedidas, es obligado por el presente acuerdo.

La(s) siguiente(s) persona(s) tiene(n) mi consentimiento con respecto a mi información de salud. **Usted tiene mi permiso** para divulgarles información o **le estoy añadiendo acceso** a la(s) siguiente(s) persona(s):

Nombre_____ Relación_____

Nombre_____ Relación_____

Entiendo que tengo el derecho a objetar al uso y/o divulgación de mi información de salud a familiares. **Usted no tiene mi permiso** para divulgarles información a ellos o **le estoy revocando el acceso** de las siguientes personas:

Nombre_____ Relación_____

Nombre_____ Relación_____

Contraseña: Me gustaría añadirle una contraseña a mi cuenta. Información no será discutida por teléfono amenos que la siguiente contraseña sea usada:

Contraseña:_____ Fecha de vigencia: _____

Permiso para dejar mensajes de voz detallados en mi grabadora de mensajes en mi hogar o teléfono celular:

Si, usted tiene mi permiso No, usted no tiene mi permiso

Entiendo que puedo revocar este consentimiento por escrito pero que la revocación no estará en efecto hasta el punto que Tempus Unlimited, Inc. ya haya tomado acción basada en mi consentimiento anterior. **Este consentimiento estará en efecto, de no ser revocado, hasta un mes luego de la fecha de terminación de su programa.**

_____ _____ _____

Firma del Consumidor/Delegado Representante Legal o Personal **Nombre impreso** **Fecha**

TEMPUS UNLIMITED, INC.
Opportunities for Independence
formerly Cerebral Palsy of Massachusetts, Inc.

Policy & Procedure: Grievances

Tempus Unlimited, Inc. processes payrolls and related tax filings as the Fiscal Intermediary (FI) for consumers in the Personal Care Attendant (PCA) Program. Tempus Unlimited, Inc. is obligated to provide these services in a professional, courteous and timely manner. Consumers should feel free to voice their concerns whenever they believe these standards are not being met.

I. If a consumer is unhappy with the service or a representative of the FI, a telephone call should be placed to a Payroll & Customer Service Supervisor of the FI department at Tempus Unlimited, Inc. The call can be placed through our toll-free number, 877-479-7577. The Supervisor will review the circumstances regarding the complaint and attempt to resolve the issue within 24 hours of receiving the call. The consumer will be informed of the resolution by telephone.

II. If a consumer is not satisfied with the action taken by the Supervisor; a telephone call should be placed to the Payroll & Customer Service Manager of the FI department at Tempus Unlimited, Inc. The call can be placed through our toll-free number, 877-479-7577. The Payroll & Customer Service Manager will review the circumstances regarding the complaint and attempt to resolve the issue within 24 hours of receiving the call. The consumer will be informed of the resolution by telephone.

III. If a consumer is not satisfied with the action taken by the Payroll & Customer Service Manager; the consumer should submit their grievance in writing to the Chief Executive Officer (CEO)/FI Director of Tempus Unlimited, Inc., Larry Spencer at 600 Technology Center, Stoughton, MA 02072. The CEO/FI Director will conduct an investigation of the circumstances through telephone interviews, personal interviews and/or reviews of written or printed documents relating to the issues.

IV. Within ten days of receiving the written grievance, the CEO/FI Director will issue a decision in writing to the consumer.

V. If the consumer is dissatisfied with the decision of the CEO/FI Director, the grievance will be transferred to the appropriate parties at MassHealth.