"Money Follows the Person (MFP)" Waiver Participant Agreement for Fiscal Intermediary Services for Self-Directed Waiver Services

- I am a MassHealth "Money Follows the Person (MFP)" Community Living Waiver or Residential Supports Waiver participant and have elected to use MFP self-directed waiver services.
- In electing self-directed waiver services, I employ my own Direct Care Workers.
- I understand that if I am self-directing personal care services, the wages paid to my Direct Care Workers providing personal-care services are established through a collective bargaining agreement between the PCA [Personal Care Attendant] Quality Homecare Workforce Council (the Council) and the Service Employees International Union (SEIU Local 1199). If I am receiving self-directed waiver services, such as adult companion, chore, homemaker, individual support and community habilitation, or peer support, I understand that the wages for these services are established by the Executive Office of Health and Human Services.
- As the employer of my Direct Care Workers, I must perform employer-required tasks, such as paying federal and state employer-required taxes, buying workers' compensation insurance, and withholding taxes and fees from my Direct Care Worker's payments. I understand that union dues are required for personal-care services.
- I understand that MassHealth has hired companies called fiscal intermediaries (FIs) who help waiver participants like me perform these employer-required tasks.
- I understand that the fiscal intermediary chosen by my MFP Waiver Case Manager will be my FI.
- I understand that by filling out and signing this form and returning it to my FI, I must let my FI know that I delegate to him/her/them the authority to perform these employer-required tasks on my behalf.

(continued on left half of page 2)

Acuerdo de exención del participante de "El dinero sigue a la persona" para servicios intermediarios fiscales para servicios autodirigidos de exención

- Soy un participante de la exención de vivienda comunitaria o de apoyo residencial de "El dinero sigue a la persona" (MFP, por sus siglas en inglés) de MassHealth y he optado por usar los servicios autodirigidos de exención de MFP.
- Al elegir servicios autodirigidos de exención, empleo a mis propios Trabajadores de atención directa.
- Entiendo que si autodirijo los servicios de atención personal, los salarios pagados a los Trabajadores de atención directa que proporcionan servicios de atención personal se establecen por medio de un convenio colectivo de trabajo entre el Consejo de Ayudantes de atención individual para una fuerza laboral de cuidado en el hogar de calidad (el Consejo) y el Sindicato Internacional de Empleados de Servicios (SEIU Local 1199). Si estoy recibiendo servicios autodirigidos de exención, como un acompañante adulto, para tareas, tareas domésticas, apoyo individual y habilitación comunitaria, o apoyo de compañeros, entiendo que los salarios para estos servicios se establecen por medio de la Oficina Ejecutiva de Salud y Servicios Humanos.
- Como empleador de mis Trabajadores de atención directa, debo realizar tareas requeridas del empleador, como pagar impuestos estatales y federales requeridos del empleador, comprar seguro de compensación de los trabajadores, y retener impuestos y tarifas de los pagos de mi trabajador de atención directa. Entiendo que las cuotas al sindicato son necesarias para servicios de atención personal.
- Entiendo que MassHealth ha contratado empresas conocidas como intermediarios fiscales ("FI", por sus siglas en inglés), que asisten a los participantes de la exención como yo a realizar tareas requeridas del empleador.
- Entiendo que el intermediario fiscal escogido por el administrador de casos de la exención de MFP será mi FI.

(continúa en la sección de la derecha de la página 2)

(continued from left half of page 1)

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 Direct Care Workers if the paperwork is not completed and submitted to my FI in accordance with his/her/their instructions;
- notifying my FI any time I hire or fire a Direct Care Worker, any time that I move, and any time one of my Direct Care Workers moves;
- notifying my FI and my MFP Waiver Case Manager when I am admitted to a nursing facility or other inpatient facility. I understand that MassHealth and the FI cannot pay for waiver activity time performed by my Direct Care Worker when I am in a nursing facility or other inpatient facility, and that any payments made while I am in a such a facility are considered fraud and will be reported to the state's Bureau of Special Investigations (BSI) for investigation, and that these may result in termination of my self-directed waiver services, as well as other potential penalties;
- informing my Direct Care Workers of the option of receiving their payments electronically through direct deposit in their bank accounts or through a debit-card service offered by my FI. My FI can provide the forms needed for my Direct Care Workers to request payment electronically;
- making sure that each week my Direct Care Workers sign and correctly fill out their activity forms (time sheets);
- making sure each of my Direct Care Workers' activity forms accurately reflects the days and hours they worked for me;
- sending my Direct Care Workers' completed activity forms to my FI, following my FI's instructions and in the timeframe provided by my FI.

I understand that:

- MassHealth and the FI cannot pay my Direct Care Worker if he or she is on the List of Excluded Individuals/Entities maintained by the U.S. Department of Health and Human Services Office of Inspector General. My FI or my MFP Waiver Case Manager can provide me with more information about this.
- I must have authorization for MFP self-directed waiver services from my MFP Waiver Case Manager and have sufficient units authorized on my waiver authorization before my FI can pay my Direct Care Workers.
- My weekly Direct Care Workers' waiver activity form must not have more units than the number

(continued on left half of page 3)

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

- Entiendo que al completar y firmar este formulario y devolverlo a mi FI, debo informarle a mi FI que le delego la autoridad para realizar estas tareas requeridas del empleador en mi nombre.

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 Trabajadores de atención directa si el papeleo no se completa y se remite a mi FI de acuerdo con sus instrucciones;
- notificar a mi FI cada vez que contrate o despida a un Trabajador de atención directa, siempre que yo me mude y siempre que cualquiera de mis Trabajadores de atención directa se mude;
- notificar a mi FI y a mi administrador de casos de la exención de MFP 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 Trabajador de atención directa cuando yo esté 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 (BSI, por sus siglas en inglés) para su investigación, pudiendo dar como resultado la terminación de los servicios autodirigidos de exención al igual que otras multas posibles;
- informar a mis Trabajadores de atención directa sobre la opción de recibir sus pagos electrónicamente por medio de depósito directo en su cuenta bancaria o por medio de un servicio de tarjeta de débito ofrecida por mi FI. Mi FI puede proporcionar los formularios necesarios para que mi Trabajador de atención directa solicite el pago electrónico;
- asegurar que mis Trabajadores de atención directa firmen y completen correctamente cada semana sus formularios de actividades (hojas de asistencia);
- asegurar que los formularios de actividades de mis Trabajador de atención directa reflejen con precisión los días y las horas que trabajaron para mí;
- enviar los formularios de actividades completados de mis Trabajadores de atención directa a mi FI, de acuerdo con sus instrucciones, en el período de tiempo proporcionado por mi FI.

(continúa en la sección de la derecha de la página 3)

(continued from left half of page 2)

authorized by my MFP Waiver Case Manager for each self-directed service.

- I will be responsible for paying my Direct Care Workers if I do not have authorization from my MFP Waiver Case Manager or if I do not have sufficient units left on my waiver authorization on the days my Direct Care Workers worked.
- I may lose my eligibility for MFP self-directed waiver services if I do not complete and return the required paperwork to my FI as instructed.
- If I have Direct Care Workers work for me and I am not MassHealth-eligible or enrolled in the an MFP waiver on the days they worked, that MassHealth and the FI are not responsible for paying my Direct Care Workers and I will need to pay them on my own.
- I must sign certain forms that will allow the FI to act on my behalf. I understand that my Direct Care Workers 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:

- receive and process my Direct Care Workers' waiver activity forms; write out my payroll checks for me in the name of each Direct Care Worker that worked for me, unless my direct care worker has elected to be paid electronically;
- make correct withholdings from my Direct Care Workers' paychecks;
- make deductions for union dues and fees for personal care services, 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 Direct Care Workers' 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 Direct Care Workers;
- send me the completed paychecks of my Direct Care Workers every two weeks for me to distribute for direct deposit or pay my Direct Care Workers through a debit card, if they choose 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;

(continued on left half of page 4)

(proviene de la sección de la derecha de la página 2)

Entiendo que:

- MassHealth y el FI no pueden pagarle a mi Trabajador de atención directa si dicha persona está en la Lista de individuos/entidades excluidas que mantiene la Oficina del inspector general del Departamento de Salud y Servicios Humanos de los EE.UU. Mi FI o mi administrador de casos de la exención de MFP puede proporcionarme más información sobre esto.
- Debo tener autorización previa para recibir servicios autodirigidos de exención de MFP de mi administrador de casos de la exención de MFP y tener suficientes unidades autorizadas en mi autorización de la exención antes de que mi FI pueda pagarle a mis Trabajadores de atención directa.
- Mi formulario semanal de actividad de la exención del Trabajador de atención directa no puede tener más unidades que el número autorizado por mi administrador de casos de la exención de MFP para cada servicio autodirigido.
- Seré responsable de pagar a mis Trabajadores de atención directa si no tuviera autorización de mi administrador de casos de la exención de MFP o si no tuviera unidades suficientes en mi autorización de la exención en los días en que trabajó mi Trabajador de atención directa.
- Puedo perder mi elegibilidad para los servicios autodirigidos de exención de MFP si no completo y devuelvo el papeleo requerido a mi FI tal como se indica.
- Entiendo que si tengo Trabajadores de atención directa que trabajen para mí y no soy elegible o estoy inscrito en MassHealth en la exención de MFP en los días en que trabaje mi Trabajador de atención directa, MassHealth y mi FI no serán responsables por pagarle a mis Trabajadores de atención directa y necesitaré pagarles por mi cuenta.
- Entiendo que debo firmar ciertos formularios que le permitirán al FI actuar en mi nombre. Entiendo que mis Trabajadores de atención directa 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 la exención de mis Trabajadores de atención directa; escribirá por mí los cheques de nómina a nombre de cada uno de los Trabajadores de atención directa que hayan trabajado para mí; a menos que mi Trabajador de atención directa haya elegido recibir pagos electrónicamente;

(continúa en la sección de la derecha de la página 4)

(continued from left half of page 4)

- send me summaries of my payrolls and my tax filings; and
- send me summaries (payroll cover sheets) that describe the number of hours authorized for me for each self-directed waiver service on my waiver authorization, the number of hours I have used for each service, and the number of hours that remain on my waiver authorization. I understand I can share this information with my Direct Care Worker so that my Direct Care Worker and I know if sufficient hours remain on my waiver authorization for him or her work and get paid.

(continued on left half of page 5)

(proviene de la sección de la derecha de la página 4)

- efectuará las retenciones correspondientes de los cheques de sueldo de mis Trabajadores de atención directa;
- hará deducciones para las cuotas y aranceles del sindicato para servicios de atención personal, de acuerdo con el convenio colectivo entre el Consejo de Ayudantes de atención individual para una fuerza laboral de cuidado en el hogar de calidad y el Sindicato (SEIU Local 1199); y enviará estos importes al sindicato;
- enviará todo el dinero retenido de los cheques de sueldo de mis Trabajadores de atención directa 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 en mi nombre para mis Trabajadores de atención directa;
- me enviará los cheques de pago completados cada dos semanas para que los distribuya a mis Trabajadores de atención directa, deposite directamente los cheques de pago en las cuentas bancarias de mis Trabajadores de atención directa, o pague por medio de una tarjeta de débito, si escogen recibir pagos electrónicamente;
- realizará otras tareas requeridas del 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 autorizado para mí de cada servicio autodirigido de exención en mi autorización de exención, el número de horas que he usado para cada servicio, y el número de horas que restan en mi autorización de exención. Entiendo que puedo compartir esta información con mi Trabajador de atención directa para que ambos sepamos si hay suficientes horas restantes en mi autorización de exención y para que trabaje y se le pague.

(continúa en la sección de la derecha de la página 5)

(continued on left half of page 4)

Here is my printed name

Print Participant Name

Here is my signature

Participant's Signature

OR

Here is my legal guardian's signature

Legal Guardians Signature

Today's date

Today's Date

Commonwealth of Massachusetts
MassHealth

(proviene de la sección de la derecha de la página 4)

Mi nombre en letra de molde

Mi nombre en letra de molde______

Mi firma

Mi firma

O

La firma de mi Tutor legal

La firma de mi Tutor legal

Fecha de hoy

Fecha de hoy

Estado de Massachusetts
MassHealth

Form **SS-4** (Rev. December 2019) 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
EMPLOYER NAME

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) (Don't enter a P.O. box.)
EMPLOYER'S PHYSICAL ADDRESS

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

5b City, state, and ZIP code (if foreign, see instructions)
EMPLOYER'S CITY, STATE AND ZIP CODE

6 County and state where principal business is located
EMPLOYER'S STATE AND COUNTY

7a Name of responsible party
EMPLOYER'S NAME

7b SSN, ITIN, or EIN
EMPLOYER'S SSN 000-00-0000

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 t
☐ Personal service corporation
☐ Church or church-controlled orga
☐ Other nonprofit organization (specify) ►
☑ Other (specify) ► **HCSR**

SAMPLE

☐ State/local government
☐ Federal government
☐ REMIC
☐ 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) ► **HCSR**
☐ 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 $5,000 or less in total wages.) If you don't 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.
☐ Health care & social assistance ☐ Wholesale-agent/broker
☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) ► **HCSR**

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

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ■ No
If "Yes," write previous EIN here ► **UNLESS EMPLOYER HAS EIN HE/SHE MUST CHECK THIS BOX**

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 **INTAKE SUPERVISOR**
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) ► **EMPLOYER'S NAME: HOUSEHOLD EMPLOYER**

Applicant's telephone number (include area code) **EMPLOYER PHONE #**

Signature ► **EMPLOYER'S SIGNATURE OR SIGNATURE & SOCIAL SECURITY NUMBER OF PARENT OR LEGAL GUARDIAN, IF MINOR CHILD** Date ► **TODAY'S DATE**

Applicant's fax number (include area code) **EMPLOYER FAX #**

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

Do I Need an EIN?

File Form SS-4 if the applicant entity doesn't 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	doesn't 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	doesn't already have an EIN	complete lines 1, 2, 4a–6, 7a–b, 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, 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]	doesn't 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, 7a–b, 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 as applicable), 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 1–7b, 9a, 10–12, 13–17 (if applicable), and 18.
is a withholding agent for taxes on nonwage income paid to an alien (that is, 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, 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, 7a–b, 9a, 10, and 18.
is a single-member LLC (or similar single-member entity)	needs an EIN to file Form 8832, Entity 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	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 doesn't have employees.

[2] However, don't 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] Don't use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

[4] However, grantor trusts that don't 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 agent* in the instructions. **Note:** State or local agencies may need an EIN for other reasons, for example, hired employees.

[8] See *Disregarded entities* in 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: SOCIAL SECURITY #

4. No. of locations

Principal Place of Business

5. Owner, partnership or legal corporate name: EMPLOYER'S 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

SAMPLE

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): PERSONAL CARE

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

E M P L O Y E R'S NAME

Trade name (cont'd.)

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

E M P L O Y E R'S ADDRESS

24. City or town

25. State

26. Zip —

27. (Area code) Telephone number

(E M P) S P H — O N E #

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

APPROX. DATE OF FIRST PAYROLL

35. Number of employees in Massachusetts:

APPROX. # OF EMPLOYEES TO BE PAID EACH PAYROLL

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
EMPLOYER'S SIGNATURE	OWNER	TODAY'S DATE

SAMPLE

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

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

OMB No. 1545-0748

For IRS use:

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.

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): **Employer's Name**

3 Trade name (if any):

4 Address

Employer's Number and Street

Number Street Suite or room number

Employer's City | **MA** | **Zip Code**

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.

Sign your name here **Employer or Legal Guardian Signature**

Print your name here **Employer's Name**

Print your title here **HCSR**

Date / / **Today's Date**

Best daytime phone **Employer's Telephone #**

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) 0 4 – 3 7 7 0 7 1 8

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.

Sign your name here Intake Coordinator Signature

Print your name here

Print your title here **Intake Coordinator**

Date Date

Best daytime phone **1-877-479-7577**

Form **8821**

(Rev. January 2021)

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. See instructions.

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 6.

Taxpayer name and address

Employer Name
Employer Address

Taxpayer identification number(s)

TAX ID NUMBER

Daytime telephone number | Plan number (if applicable)

2 Designee(s). If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached** ► ☐

Name and address

TEMPUS UNLIMITED, INC.
600 TECHNOLOGY CENTER DRIVE
STOUGHTON, MA. 02072

Check if to be sent copies of notices and communications ☑

CAF No. **0312-75867R**
PTIN
Telephone No. **877-479-7577**
Fax No. **617-934-1191**
Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

Name and address

Check if to be sent copies of notices and communications ☐

CAF No. **0312-75867R**
PTIN
Telephone No. **877-479-7577**
Fax No. **617-934-1191**
Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax information. Each designee 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 EMPLOYMENT TAX	940,940R,940EZ,941,941R,941X,941 (C), 843, W-2,W-2(C), W-3,W-3 (C),SS-4.	QUARTERS 1,2,3,4 2022 - 2024	TAX LIABILITY
	147-C		VERIFICATION LETTER

4 Specific use not recorded on the 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 line 5 . . . . ► ☑

Authorization for SS-4 and 147C

5 Retention/revocation of pr[...]**d, skip this line. If the line 4 box isn't checked, the IRS will a**[...] file unless you check the line 5 box and **attach a copy** of th[...] . . . . ► ☐

To revoke a prior tax inform[...]e the line 5 instructions.

SAMPLE

6 Taxpayer signature. If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

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

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

EMPLOYER OR LEGAL GUARDIAN SIGNATURE | DATE

Signature | Date

PRINT EMPLOYER OR LEGAL GUARDIAN NAME | HCSR

Print Name | Title (if applicable)

Rev. 7/14

Massachusetts Department of Revenue

Form M-2848
Power of Attorney and Declaration of Representative

See separate instructions. Please print or type.

Part 1. Power of Attorney

A Name of taxpayer(s) or principal reporting corporation: **EMPLOYER'S NAME**

Social Security number(s): **EMPLOYER'S SSN#**

Number and street, including apartment number or rural route: **EMPLOYER'S ADDRESS**

Federal Identification number:

City/Town: **EMPLOYER'S CITY**

State / Zip: **EMPLOYER'S STATE AND ZIP CODE**

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
MICHAEL HEINEMAN	600 TECHNOLOGY CENTER DRIVE STOUGHTON, MA 02072	(877) 479-7577
	SAMPLE	

Type of tax (individual, corporate, etc.)	**Year(s) or period(s)** (date of death if estate tax)
INCOME TAX WITHHOLDING, TA-1	ALL

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
EMPLOYER'S SIGNATURE	EMPLOYER	TODAY'S 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

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**		

10/06/14

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) on my behalf to enable billing and reimbursement for services provided by the Tempus Unlimited Fiscal Intermediary program. I understand that Tempus Unlimited, Inc. staff may have access to the following types of PHI and may use this information to either approve or deny timesheets and/or to submit billing for reimbursement or for other program billing and reimbursement. Types of PHI that we may share could be a MassHealth ID, other payer Insurance IDs, admit and discharge paperwork for inpatient stays, and information of your stay at a long term care facility. We only use this information to provide documentation to MassHealth and other payers for reimbursement for FI services. We also use this information to ensure that timesheets are not submitted fraudulently and that we are billing MassHealth for actual work done by PCA or worker that you have authorized. We also use this information for staff training and for conducting quality assurance, (monitoring the need, appropriateness, and quality of services provided).

I have been given a Notice of Privacy Practices that fully explains the uses and disclosures that Tempus Unlimited, Inc. will make with my protected health information (PHI). 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 protected health information for payment, and health care operations, but that if I do not consent, Tempus Unlimited, Inc. may refuse to provide me Fiscal Intermediary 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 protected health information. **You have my permission** to release information to them or **I am adding the access** of the following persons:

Name **Name of Person** Relationship **Relationship**

Name **Name of Person** Relationship **Relationship**

I understand that I have the right to object to the use and/or disclosure of my protected 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 **Name of Person** Relationship **Relationship**

Name **Name of Person** Relationship **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 **Your Password (if applicable)** Effective Date: **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	Print Name	Today's Date
Signature of Consumer/Surrogate Legal or Personal Representative	**Printed Name**	**Date**

600 Technology Center Drive, Stoughton, MA 02072
Toll-Free Phone #: 1-877-479-7577
www.tempusunlimited.org
Toll-Free Fax #: 1-800-359-2884

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 fracturaciones y reembolso de los servicios proporcionados por el programa de Intermediario Fiscal de Tempus Unlimited, Inc. Entiendo que Tempus Unlimited, Inc. y sus empleados pueden utilizar esta información para aprobar o negar hojas de tiempo y/o someter fracturaciones para reembolso para la facturación y reembolso de otros programas. Tipos de PHI que podemos compartir podrían ser su número de identificación de MassHealth, otras identificaciones del seguro del pagador, documentación de admisión y alta para estadías de pacientes hospitalizados e información de su estadía en un centro de atención a largo plazo. Sólo utilizamos esta información para proporcionar documentación a MassHealth y a otros pagadores para el reembolso de los servicios del intermediario fiscal (FI por sus siglas en inglés). También utilizamos esta información para asegurarnos de que las hojas de tiempo trabajados no se envíen de manera fraudulenta y que estemos facturando a MassHealth por el trabajo realizado por el PCA o el trabajador a quien usted haya autorizado. También utilizamos esta información para la capacitación del personal y para realizar controles de calidad (monitoreando la necesidad, idoneidad y calidad de los servicios prestados).

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 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 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 Nombre______ Relación Relación______

Nombre Nombre______ Relación 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 Nombre______ Relación Relación______

Nombre Nombre______ Relación Relación______

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

Contraseña: Contraseña______ Fecha de vigencia: 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/DelegadoRepresentante Legal o Personal	Nombre Impreso	Fecha
Firma del Consumidor/Delegado Representante Legal o Personal	**Nombre impreso**	**Fecha**