Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

CONSUMER #:

Criminal Offender Record Information (CORI) Request Form

The MassHealth Money Follows the Person (MFP) waiver program's fiscal intermediaries have been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As a prospective employee of an MFP waiver participant to provide MFP self-directed waiver services, I understand that a criminal record check will be conducted of me by a MassHealth MFP waiver fiscal intermediary for conviction and pending criminal case information only. A criminal conviction or a pending criminal case will not necessarily disqualify me from working for the MFP waiver participant.

I hereby certify under the pains and penalties of perjury that the information on this form and any attachments that I have provided, has been reviewed and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. (Signature stamps and date stamps, or the signature of anyone other than the provider or applicant, are not acceptable.)

_____

Signature of provider or applicant

Last name, first name, middle name
(Please print.)

Maiden name or alias (if applicable)	Place of birth
Date of birth	Social security number (Required)

Mother's maiden name

Current address

Former address

Gender: ☐ M ☐ F	Height	Weight	Eye color

State driver's license number

Note: Please attach a copy of your driver's licence so that MassHealth can validate the information you provided above.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ► ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Formulario **W-4(SP)**

Department of the Treasury
Internal Revenue Service

Certificado de Retenciones del Empleado

► **Complete el Formulario W-4(SP) para que su empleador pueda retener la cantidad correcta del impuesto federal sobre los ingresos de su paga.**

► **Entregue el Formulario W-4(SP) a su empleador.**

► **La cantidad de la retención de impuestos está sujeta a revisión por el *IRS*.**

OMB No. 1545-0074

2022

Paso 1: Anote su información personal

(a) Su primer nombre e inicial del segundo	Apellido	**(b) Su número de Seguro Social**
Dirección (número de casa y calle o ruta rural)		► **¿Coincide su nombre completo y su número de Seguro Social con la información en su tarjeta?** De no ser así, para asegurarse de que se le acrediten sus ganancias, comuníquese con la Administración del Seguro Social (*SSA*, por sus siglas en inglés) al 800-772-1213 o acceda a *www.ssa.gov/espanol*.
Ciudad o pueblo, estado y código postal (*ZIP*)		

(c) ☐ **Soltero** o **Casado que presenta una declaración por separado**
☐ **Casado que presenta una declaración conjunta** o **Viudo que reúne los requisitos**
☐ **Cabeza de familia** (Marque solamente si no está casado y paga más de la mitad del costo de mantener una vivienda para usted y una persona calificada).

MARQUE UNA CASILLA

Complete los Pasos 2 a 4 SOLAMENTE si le aplican a usted; de lo contrario, siga al Paso 5. Vea la página **2** para obtener más información sobre cada paso, saber quién puede reclamar la exención de la retención, saber cuándo utilizar el estimador de retención de impuestos en *www.irs.gov/W4AppSP* y conocer acerca de su privacidad.

Paso 2: Personas con múltiples empleos o con cónyuges que trabajan

Complete este paso si (1) tiene más de un trabajo a la vez o (2) está casado y presenta una declaración conjunta y su cónyuge también trabaja. La cantidad correcta de retención depende de los ingresos obtenidos de todos los empleos.

Tome **sólo una** de las siguientes opciones:

(a) Utilice el estimador de retención de impuestos en *www.irs.gov/W4AppSP* para calcular su retención con la mayor precisión en este paso (y en los Pasos 3 a 4); **o**

(b) Utilice la **Hoja de Trabajo para Múltiples Empleos** en la página **3** y anote el resultado en el Paso 4(c) para calcular una retención aproximada; **o**

(c) Marque este recuadro si sólo hay dos empleos en total. Haga lo mismo en el Formulario W-4(SP) para el otro empleo. Esta opción es precisa para empleos con una paga similar; de lo contrario, se le pueden retener más impuestos de lo necesario . . . . . ► ☐

CONSEJO: Para un resultado preciso, entregue un Formulario W-4(SP) de 2022 en todos los otros empleos. Si usted (o su cónyuge) tiene ingresos del trabajo por cuenta propia, incluidos los ingresos como contratista independiente, utilice el estimador.

Complete los Pasos 3 a 4(b) en el Formulario W-4(SP) para sólo UNO de sus empleos. Deje esas líneas en blanco para los otros empleos. (Su cálculo de la retención será más preciso si completa los Pasos 3 a 4(b) en el Formulario W-4(SP) para el empleo que le paga el salario más alto).

Paso 3: Reclamación de dependientes

Si su ingreso total va a ser $200,000 o menos ($400,000 o menos si es casado que presenta una declaración conjunta):

Multiplique la cantidad de hijos calificados menores de 17 años por $2,000 . . . . . ► $ _____

Multiplique el número de otros dependientes por $500 . . ► $ _____

Sume las cantidades anteriores y anote el total aquí . . . . . **3** $

Paso 4 (opcional): Otros ajustes

(a) Otros ingresos (no incluya los ingresos de ningún empleo). Si desea que se le retengan impuestos por otros ingresos que espera este año que no tendrán retenciones, anote aquí la cantidad de los otros ingresos. Esto puede incluir intereses, dividendos e ingresos por jubilación . . . . . **4(a)** $

(b) Deducciones. Si espera reclamar deducciones diferentes a la deducción estándar y desea reducir su retención, utilice la **Hoja de Trabajo para Deducciones** en la página **3** y anote el resultado aquí . . . . . **4(b)** $

(c) Retención adicional. Anote todo impuesto adicional que desee que se le retenga en **cada período de pago** . . . . . **4(c)** $

Paso 5: Firme aquí

Bajo pena de perjurio, declaro haber examinado este certificado y que, a mi leal saber y entender, es verídico, correcto y completo.

► _____ **Firma del empleado** (Este formulario no es válido a menos que usted lo firme). ► _____ **Fecha**

Para uso exclusivo del empleador

Nombre y dirección del empleador	Primera fecha de empleo	Número de identificación del empleador (*EIN*)

OPTIONAL

FORM M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 11/19

Print full name ..... Social Security no. .....

Print home address..... City..... State..... Zip .....

Employee:

File this form with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:

Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2" .....
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C..... .....
3. Write the number of your qualified dependents. See Instruction D..... .....
4. Add the number of exemptions which you have claimed above and write the total..... ☐
5. Additional withholding per pay period under agreement with employer $_____

A. ☐ Check if you will file as head of household on your tax return.

B. ☐ Check if you are blind. C. ☐ Check if spouse is blind and not subject to withholding.

D. ☐ Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed $8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date..... Signed .....

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. The more exemptions you claim on this certificate, the less tax withheld from your employer. If you claim more exemptions than you are entitled to, civil and criminal penalties may be imposed. However, you may claim a smaller number of exemptions without penalty. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income. Underwithholding may result in owing additional taxes to the Commonwealth at the end of the year.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you decreases. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholdingg exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a spouse, write "4" in line 2. Entering "4" makes a withholding system adjustment for the $4,400 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

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

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes): **CHECK ONE BOX**

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States *(See instructions)*
- ☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- ☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
  Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Direct Care Worker
Signature Form

Name of fiscal intermediary (FI) **TEMPUS UNLIMITED, INC.**

- **All DCWs hired by a waiver participant must fill out and sign this form and give it to their employer (the Waiver Participant).**
- **The DCW's employer (the Waiver Participant) must submit this form to the FI, along with all other paperwork required by the FI and MassHealth.**
- **The FI cannot pay a DCW until all required paperwork is received and complete.**
- **MassHealth and the FI cannot pay a DCW to work**
  - **when the Waiver Participant is in an inpatient facility, such as a hospital or nursing facility; or**
  - **when the amount of time that has been authorized per week by the Waiver Participant's case manager has been exhausted or is insufficient.**
- **The DCW must read the rest of this form and sign below before receiving payment from the FI.**

I agree to accept the position of direct care worker (DCW) for _____
Waiver Participant's name

I understand that my employer is the Waiver Participant. My employer is responsible for hiring, firing, training and scheduling DCWs. My employer may select another person (a surrogate) to help manage his or her self-directed services. I must notify my employer and the surrogate (if any), of any changes in my circumstances that would affect my ability to perform my duties as a DCW. I must complete and provide accurate Waiver Activity Forms (time sheets) to my employer or the FI as soon as I can. The FI will process payroll for my employer. My employer is responsible for giving the check to me (unless I requested that my check be deposited directly into my bank account). I must provide proof of my identity to my employer to complete the Employment Eligibility Verification form (Form I-9), which the Department of Homeland Security requires all employees to complete. (The FI will give my employer this form.)

I understand that the MassHealth Waiver program pays for self-directed services provided by a DCW only when the DCW provides services to an eligible Waiver Participant who has obtained waiver authorization from his or her case manager for self-directed services. Self-directed services must be provided in accordance with the Waiver Participant's authorization, service agreement, and MassHealth regulations at 130 CMR 630.400.

In providing DCW services to my employer (the Waiver Participant) I agree to the following:

- If my employer has an advance directive concerning the provision of care in the event he or she becomes incapacitated, I agree to respect the terms of the advance directive, unless, as a matter of conscience, I cannot implement an advance directive. I agree not to condition the provision of care or otherwise discriminate against my employer based on whether or not the individual has executed an advance directive. I understand that I am not required to provide care that conflicts with an advanced directive.
- I agree to keep any records that are necessary to show the extent of the services I provide to my employer.
- I agree to furnish, upon request, copies of records in my possession and any information regarding payments I claimed for furnishing DCW services to my employer, to the Medicaid agency, the Secretary of the U.S. Department of Health and Human Services, or the State Medicaid fraud control unit.

I understand that I cannot be paid as a DCW if I am a spouse, surrogate, or legally responsible relative of the Waiver Participant.

I agree to comply with the disclosure requirements contained in 42 CFR Part 455, Subpart B as follows:

- Persuant to 42 CFR 455.104(a)(3), I am identifying below any other MassHealth provider entity in which I have ownership or control. (If none, please write "None"): _____
- If requested by MassHealth, I agree to provide information about business transactions in accordance with 42 CFR 455.105.
- In accordance with state statute M.G.L. c.118E, § 36, and federal requirement, 42 CFR 455.106, by signing this form, I am stating that I have not been convicted of a criminal offense related to my involvement in any program under Medicare, Medicaid, or the title XX services program.

I understand that my employer is required to offer me the option of having my DCW payments direct deposited into my bank account, or into a debit card service offered by the FI. If I do not elect my DCW payments to be direct deposited, I understand the FI will issue a check in my name and send it to my employer or give it to me.

Check here if you would like the FI to direct deposit your DCW payments. ☐

The following describes my relationship to my employer (the Waiver Participant). **(Please check one.)**

☐ adult child (18 yrs. or older) of waiver participant	☐ daughter-in-law of waiver participant
☐ son-in-law of waiver participant	☐ parent of adult (18 yrs. or older) waiver participant
☐ other relative (describe) _____	☐ non-relative (describe) _____

I certify under pains and penalties of perjury that the information on this signature form, and any accompanying statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete to the best of my knowledge. I also certify that I understand my duties, rights, and responsibilities as a DCW and that all the information I have provided to my employer (the Waiver Participant), to the fiscal intermediary, to the case management agency, or to MassHealth is true and accurate to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

X _____	_____	_____
DCW Signature	Print DCW name	Date

TEMPUS UNLIMITED, INC.
Opportunities for Independence

DIRECT DEPOSIT APPLICATION

DCW's Name: _____

Participant #: _____ **Participant's Name:** _____

Account Information

Name on Bank Account: _____

(PER MASSHEALTH - Direct Deposit Accounts must be in the name of the DCW only, the account cannot be a joint account shared by the DCW and the Participant or the Surrogate.)

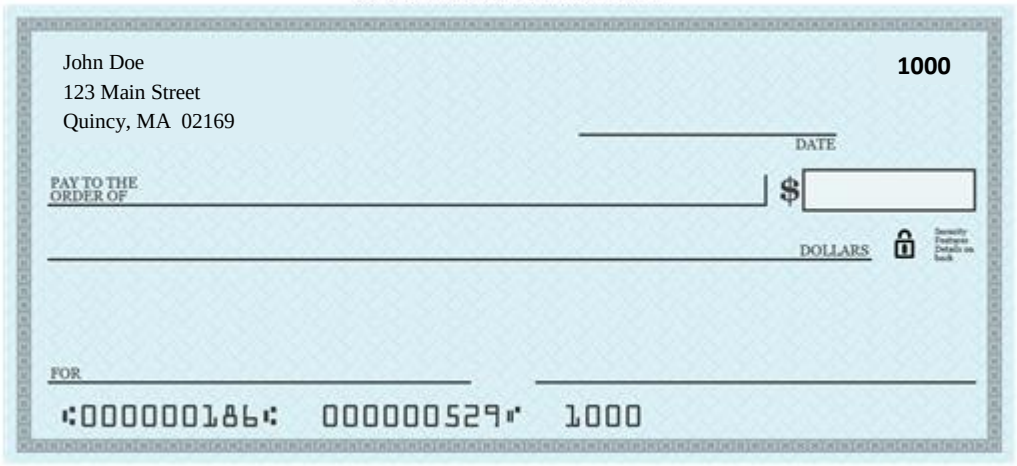
Bank Name: _____

Bank Routing #: _____ **Bank Account #:** _____

This is a ◯ **Checking Account** ◯ **Savings Account**

For a checking account please attach a voided check or a copy of a check (Starter checks must contain a preprinted DCW name and account number). For a savings account please attach a document from the bank indicating the DCW's name, the routing number and account number (cannot be handwritten). Do not attach a deposit slip. We will not process this application without a voided check, a copy of a check, or a document from your bank indicating the routing number and account number.

ATTACH CHECK HERE:



I hereby authorize Tempus Unlimited, Inc. (hereinafter "Company") to deposit any amounts owed to me by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize the Bank to accept and to credit any credit entries indicated by the Company to my account. In the event that the Company deposits funds erroneously into my account, I authorize the Company to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until the Company and the Bank have received written notice from me of its termination in such time and in such manner as to afford the Company and the Bank reasonable opportunity to act on it.

DCW's Signature: _____ **Date:** _____

TEMPUS UNLIMITED, INC.
Opportunities for Independence

APLICACIÓN PARA DEPOSITO DIRECTO

Nombre de DCW: _____

Numero de Partícipe: _____ **Nombre de Partícipe:** _____

Información de Cuenta

Nombre de persona en la cuenta de Banco: _____

POR MassHealth - Cuentas de depósito directo deben de estar solamente a nombre del DCW, la cuenta no puede ser una cuenta conjunta compartida por el DCW y el partícipe o el delegado.

Nombre de Banco: _____

 # de Ruta: _____ **# de Cuenta:** _____

Estos es uña ◯ **cuenta de chequera** ◯ **cuenta de ahorros**

Para una cuenta corriente, por favor sujete un cheque nulo o una copia del cheque **(Cheques de inicio tienen que tener el nombre del DSW y el número de cuenta preimpreso)**. Para una cuenta de ahorros, por favor sujete un documento de su banco que indique el número de ruta y el número de cuenta **(no puede ser escrito a mano)**. Por favor de no sujetar una hoja de depósito. **(No procesaremos esta aplicación sin un cheque nulo, una copia del cheque o un documento de su banco indicando el número de ruta y el número de cuenta.)**

ATTACH CHECK HERE:

Autorizo por este medio a mi empleador (más adelante "compañía") a depositar cualquier cantidad debida yo iniciando entradas de crédito a mi cuenta en la institución financiera. (Más adelante "banco") indicado en esta forma. Además, autorizo el banco a aceptar y a acreditar cualquier entrada de crédito indicada por la compañía a mi cuenta. En caso que la compañía deposite fondos erróneamente en mi cuenta, autorizo a la compañía al cargar cuenta por una cantidad que no exceda la cantidad original del crédito erróneo. Esta autorización es de permanecer a toda fuerza y efecto completo hasta que la compañía y el banco hayan recibido el aviso escrito de mí de su terminación en tal hora y de tal manera que le produzca a la compañía y al banco oportunidad razonable para actuar sobre ella.

Firma de DCW: _____ **Fecha:** _____

Focus Card

Enrollment Form

To receive your PCA payments on a U.S. Bank Focus Card, fill out this form and return it to the Fiscal Intermediary. Your card will be mailed to the address provided in 7-10 business days.

First Name:

Last Name:

Address:

City: State: Zip Code:

Phone Number[1]:

Social Security Number:

Date of Birth:

Email Address (optional)[2]:

Important Information About Procedures For Opening A New Account

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: when you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

I hereby authorize the Fiscal Intermediary to initiate credit entries (deposits) and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my Focus Card. This authorization will remain in effect until cancelled by me with written notification to the Fiscal Intermediary.

I acknowledge receipt of the Pre-Acquisition Disclosure and the Fee Schedule, as evidenced by my signature below.

Signature: Date:

Information below this line will be used by the Fiscal Intermediary only.

To assist the Fiscal Intermediary in processing your pay, please provide information about the individual to whom you provide Services (your "Client"):

Client Name:

Client No.:

Client Address

Street:

Apt/Suite:

City: Zip:

[1] By providing us with a telephone number for a cellular phone or other wireless device, including a number that you later convert to a cellular number, you are expressly consenting to receiving communications— including but not limited to prerecorded or artificial voice message calls, text messages, and calls made by an automatic telephone dialing system—from us and our affiliates and agents at that number. This express consent applies to each such telephone number that you provide to us now or in the future and permits such calls for non-marketing purposes. Calls and messages may incur access fees from your cellular provider. [2] An email address is required for all requests. We use email to communicate information about your request. Confidential, personal or financial information will never be sent or requested in an email from U.S. Bank.

Tarjeta Focus

¡Inscríbase hoy!

Formulario de Inscripción

Para recibir sus pagos PCA en una Tarjeta U.S. Bank Focus, llene este formulario y envíelo al Intermediario Fiscal. Su tarjeta será enviada por correo a la dirección proporcionada dentro de 7 a 10 días hábiles.

Nombre:

Apellido:

Dirección física:

Ciudad: Estado: Código postal:

Número de teléfono[1]:

Número de Seguro Social:

Fecha de nacimiento:

Dirección de correo electrónico (opcional)[2]:

Información importante sobre procedimientos para abrir una cuenta nueva

Para ayudar al gobierno a luchar contra el financiamiento del terrorismo y contra actividades de lavado de dinero, la ley Federal exige que todas las instituciones financieras obtengan, verifiquen y registren información que identifique a toda persona que abra una cuenta. Esto significa que cuando abra una cuenta, se le pedirá su nombre, dirección, fecha de nacimiento y cualquier otra información que nos permita identificarle. Es posible que también le pidamos mostrar su licencia de conducir u otros documentos de identificación.

Por la presente, autorizo al Intermediario Fiscal a iniciar entradas de crédito (depósitos) y, si es necesario, a iniciar entradas de débito y ajustes por cada entrada de crédito errónea en mi Tarjeta Focus. Esta autorización se mantendrá en efecto hasta que yo la cancele mediante una notificación por escrito al Intermediario Fiscal.

Confirmo haber recibido la Divulgación Previa a la Adquisición y la Lista de Cargos, para lo cual mi firma a continuación sirve de evidencia.

Firma: Fecha:

La información debajo de esta línea será usada solo por el Intermediario Fiscal.

Para ayudar al Intermediario Fiscal a procesar su pago, provea información acerca del individuo a quien usted proporcionó Servicios (su "Cliente"):

Nombre del cliente:

Cliente número:

Dirección del cliente

Calle:

Apto./Suite:

Ciudad: Código postal:

Los servicios pueden estar disponibles solamente en inglés.

[1] Al proporcionarnos un número de teléfono de un celular u otro dispositivo inalámbrico, incluido un número que más adelante cambie a un número de teléfono celular, usted nos da su consentimiento expreso para recibir comunicaciones a ese número tanto de nuestra parte como de nuestros afiliados y agentes, lo que incluye, por ejemplo, llamadas de mensajes de voz artificiales o pregrabados, mensajes de texto y llamadas realizadas mediante un sistema de marcación telefónica automática. Este consentimiento expreso se aplica a todo número de teléfono de este tipo que nos proporcione ahora o en el futuro y permite que estas llamadas sirvan para propósitos que no sean de marketing. Es posible que las llamadas y mensajes incurran en cargos de acceso por parte de su proveedor de telefonía celular. [2] Se requiere una dirección de correo electrónico para todas las solicitudes. Utilizamos correos electrónicos para comunicar información sobre su solicitud. Nunca se enviará ni solicitará información confidencial, personal o financiera a través de un correo electrónico de U.S. Bank.

Electronic Timesheets Agreement

I. About The Electronic Timesheets Module

a. The Electronic Timesheets Module is a web-based interface through which Consumers, Surrogates, Personal Care Attendants (PCAs)/Workers, and Fiscal Intermediary staff can respectively view relevant timesheet information.

b. Consumers, Surrogates and PCAs/Workers will be able to use the system to both submit and approve timesheets electronically for payment by the Fiscal Intermediary.

c. A Consumer is not required to have a Surrogate in order to use the system. However, in cases where a Consumer does have a Surrogate and the Consumer approves the Surrogate to have access to the Electronic Timesheets Submission Interface, both the Consumer and his/her Surrogate will have identical abilities to enter and approve timesheets for payment.

II. Terms and Conditions

By signing below, you are agreeing to the following Terms and Conditions:

a. The Consumer and/or Surrogate (if applicable) and the PCA/Worker ***each have a valid, separate e-mail address*** *to* which they have frequent access. ***Consumer, Surrogate, PCA or Worker cannot use the same e-mail address.***

b. The Consumer and/or Surrogate (if applicable) and the PCA/Worker ***each agree to maintain a valid separate e-mail address*** during the term of this agreement and to notify Tempus Unlimited, Inc. of any changes to their e-mail addresses.

c. The Consumer, his/her Surrogate (if applicable) and the PCA/Worker agree to use the Electronic Timesheets Submission Interface as a method of submitting timesheets.

   i. Signing this Agreement does not require you to only use the Electronic Timesheets Submission Interface. Other methods of submitting time, such as faxing or mailing, are still acceptable.

d. A timesheet may only be submitted electronically if the Consumer and/or Surrogate (if applicable) and the PCA/Worker have executed this Agreement.

e. An individual Electronic Timesheets Agreement is required for each Consumer and PCA/Worker relationship that chooses to use the Electronic Timesheets Submission Interface.

   i. This is true even if the Consumer or PCA/Worker is already using the Electronic Timesheets Submission Interface in another Consumer and PCA/Worker relationship.

III. Termination of the Agreement

a. The Consumer, his/her Surrogate (if applicable) or the PCA/Worker may terminate this agreement at any time by submitting such request in writing to Tempus Unlimited, Inc.

Consumer Printed Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Consumer #: ☐☐☐☐☐☐

Consumer E-mail: ☐☐

Consumer Signature: _____ Date:_____

Surrogate Printed Name: ☐☐

Surrogate E-mail: ☐☐

Surrogate Signature:_____ Date: _____

PCA/Worker Printed Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Last 4 digits of SS#: ☐☐☐☐

PCA/Worker E-mail: ☐☐

PCA/Worker Signature: _____ Date: _____

Módulo de Nóminas Electrónicas

I. **<u>Sobre el Módulo de Nóminas Electrónicas</u>**

a. El Modulo de Nóminas Electrónicas es un interfaz basado en web a través del cual los Consumidores, Delegados, Asistentes de Cuidado Personal (PCA)/Trabajadores y el personal del Intermediario Fiscal pueden ver respectivamente información de las nóminas.

b. Consumidores, Delegados y PCA/Trabajadores podrán utilizar el sistema tanto para presentar como para aprobar nóminas electrónicamente para el pago por el Intermediario Fiscal.

c. No le es requerido al Consumidor tener un Delegado para poder utilizar el sistema. Pero en casos cuando el consumidor si tiene un Delegado y el consumidor aprueba al Delegado para que tenga acceso al Interfaz de Presentación de Nóminas Electrónicas , tanto el Consumidor como su Delegado tendrán capacidades idénticas de entrar y aprobar nóminas para el pago..

II. **<u>Términos y Condiciones</u>**

Al firmar más adelante, usted está de acuerdo con los términos y condiciones:

a. El Consumidor y/o el Delegado (si corresponde) y el PCA/Trabajador acuerdan en ***cada uno mantener una dirección de correo electrónico válida y separada*** al cual tienen acceso frecuente. ***<u>El consumidor, sustituto, PCA o trabajador no pueden usar la misma dirección de correo electrónico</u>*****.**

b. Tanto el Consumidor y/o el Delegado como el PCA/Trabajador ***acuerdan en mantener una dirección de correo electrónico válida y separada*** durante el periodo de este acuerdo y de notificarle a Tempus Unlimited, Inc. de cualquier cambio a sus direcciones de correo electrónico.

c. El Consumidor y su Delegado (si corresponde) y el PCA/Trabajador acuerdan en utilizar el Interface de Presentación de Nóminas Electrónicas como método de presentar nóminas.

i. Firma de este acuerdo no requiere que se utilice únicamente el Interface de Presentación de Nóminas Electrónicas. Otros métodos de presentar nóminas, tales como enviar por fax o por correo, todavía son aceptables.

d. Una nómina solo puede ser presentada electrónicamente si el Consumidor y/o el Delegado (si corresponde) y el PCA/Trabajador han ejecutado este acuerdo.

e. Un Acuerdo Individual de Nóminas Electrónicas es requerido para cada relación de Consumidor y PCA/Trabajador que decida utilizar el Interfaz de Presentación de Nóminas Electrónicas.

i. Esto es cierto incluso si el Consumidor o el PCA/Trabajador ya está utilizando el Interfaz de Presentación de Nóminas Electrónicas en otra relación de Consumidor y PCA/Trabajador.

III. Terminación del Acuerdo

a. El Consumidor, su Delegado (si corresponde) o el PCA/Trabajador puede terminar este acuerdo en cualquier momento presentando tal pedido por escrito a Tempus Unlimited, Inc.

Nombre Impreso del Consumidor: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Número de Consumidor #: ☐☐☐☐☐☐

E-mail del Consumidor: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Firma del Consumidor: ______________________________ Fecha: ____________________

Nombre Impreso del Delegado: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

E-mail del Delegado: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Firma del Delegado: ______________________________ Fecha: ____________________

Nombre Impreso del PCA/Trabajador: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Últimos 4 dígitos del número de SS: ☐☐☐☐

E-mail del PCA/Trabajador: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Firma del PCA/Trabajador: ______________________________ Fecha: ____________________