CONSUMER REFERRAL FORM FOR TEMPUS UNLIMITED, INC.

Referral Date: 7-29-2022 **TEMPUS Assigned Consumer #:** 012345

Consumer:

Name: 100 Main Street, Anytown, MA 012 Email: janedoe@email.com

Phone: 555-555-5555 Cell: 444-444-4444

Home Address: 1 Main Street

Mailing Address: 1 Main Street

SS#: 000-00-0000 DOB: 01-01-2001 Gender: M ☑ F ☐

MassHealth MMIS # MM12345678

SCO/OC/PACE ID# 1234567890

CDC/VIP SIMS# 0123456789 Care Program:

Is Consumer a minor: ☑ Yes ☐ No Primary Language: English

Parent(s) of Minor Child: Name: John Doe Relationship: Father

Name: Jane Doe Relationship: Mother

Previous PCA services / Consumer owned business? ☐ Yes ☑ No If Yes, EIN:

Program Enrolled:

☐ FFS:

☐ SCO: **SCO Agency**: ☐ Tufts ☐ CCA ☐ SWH ☐ UHC ☐ Fallon ☐ BMC

☐ One Care: **One Care Agency**: ☐ CCA ☐ Tufts ☐ UHC

☑ PACE: **PACE Agency**: ☑ Serenity Care ☐ East Boston NNHC ☐ Uphams Corner ☐ ElementCare ☐ Summit/Fallon

☐ CDC/VIP

☐ MFP

Surrogate: ☑ **AP:** ☐

Name: James Doe Email: jamesdoe@email.com

Phone: 555-555-5555

Address: 100 Main Street, Anytown, MA 01234

Surrogate/AP's Relationship to Consumer: Uncle

Welcome Package Should be mailed to: ☐ Consumer ☑ Surrogate/AP

Agency:

PCM/ASAP: Northeast Arc 2678 Hard Copy Mailed to Tempus: Y ☑ N ☐

Skills Trainer/Case Manager Name: Jane Smith

Skills Trainer/Case Manager Email: janesmith@email.com

Phone: 111-222-3333 Ext: 111 Fax: 555-111-2222

MassHealth

Consumer Agreement for PCA Fiscal Intermediary Services

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

(continued on left half of page 2)

Acuerdo del consumidor para servicios de intermediario fiscal de PCA

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

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

(continued from left half of page 1)

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

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

(continued on left half of page 3)

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

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

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

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

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

(continued on left half of page 4)

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

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

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(continued from left half of page 3)

Here is my printed name

Consumer Name

Here is my signature

Consumer Signature

OR

Here is my legal guardian's signature

Legal Guardian's Signature (if applicable)

Today's date

Today's Date

Commonwealth of Massachusetts
MassHealth

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

Mi nombre en letra de molde

Mi Nombre En Letra De Molde

Mi firma

Mi Firma

O

La firma de mi Tutor legal

La Firma De Mi Tutor Legal (si es aplicable)

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
CONSUMER'S 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.)
CONSUMER'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)
CONSUMER'S CITY, STATE AND ZIP CODE

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

7a Name of responsible party
CONSUMER'S NAME

7b SSN, ITIN, or EIN
CONSUMER'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**

☐ State/local government
☐ Federal government
☐ Indian tribal governments/enterprises
☐ REMIC
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.

☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Accommodation & food service ☐ Wholesale-agent/broker ☐ 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) ▶ **CONSUMER'S NAME: HOUSEHOLD EMPLOYER**

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

Signature ▶ **CONSUMER'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)
CONSUMER FAX #

CONSUMER'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: CONSUMER'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

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: C O N S U M E R' S N A M E

Trade name (cont'd.)

23. Number and street **(PO box is not acceptable)**: C O N S U M E R' S A D D R E S S

24. City or town

25. State **26.** Zip

27. (Area code) Telephone number: (C O N) 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
CONSUMER'S SIGNATURE	**OWNER**	**TODAY'S DATE**

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

SAMPLE

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

OMB No. 1545-0748

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

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

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

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

For IRS use:

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

(Check one)

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

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

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

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

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

3 Trade name (if any)

4 Address — Consumer's Number and Street Address

Number Street Suite or room number

Consumer'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** — Consumer or Legal Guardian Signature

Print your name here — Consumer's Name

Print your title here — HCSR

Date / / **Today's Date**

Best daytime phone — Consumer 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) 04 – 3770718

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

8 Trade name (if any)

9 Address 600 Technology Center Drive

Number Street Suite or room number

Stoughton | MA | 02072

City State ZIP code

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

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

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

X **Sign your name here** Intake Coordinator Signature

Date Date

Print your name here Print Intake Coordinator Name

Print your title here Intake Coordinator

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	Taxpayer identification number(s)	
Consumer Name **Consumer Address**	**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**	CAF No. **0312-75867R** PTIN Telephone No. **877-479-7577** Fax No. **617-934-1191**
Check if to be sent copies of notices and communications ☑	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. **0312-75867R** PTIN Telephone No. **877-479-7577** Fax No. **617-934-1191**
Check if to be sent copies of notices and communications ☐	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 prior tax information authorization. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations you made for the matters listed on this line unless you check the line 5 box and **attach a copy** of the prior authorization(s) you want to remain in effect. . . . . ► ☐

To revoke a prior tax information authorization, see 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.**

CONSUMER OR LEGAL GUARDIAN SIGNATURE	**DATE**
Signature	Date
PRINT CONSUMER OR LEGAL GUARDIAN NAME	**HCSR**
Print Name	Title (if applicable)

Form M-2848
Power of Attorney and Declaration of Representative

Rev. 7/14

Massachusetts Department of Revenue

See separate instructions. Please print or type.

Part 1. Power of Attorney

A Name of taxpayer(s) or principal reporting corporation

CONSUMER'S NAME

Social Security number(s)

CONSUMER'S SSN#

Number and street, including apartment number or rural route

CONSUMER'S ADDRESS

Federal Identification number

FEDERAL IDENTIFICATION #

City/Town

CONSUMER'S CITY

State Zip

CONSUMER'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

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
CONSUMER'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

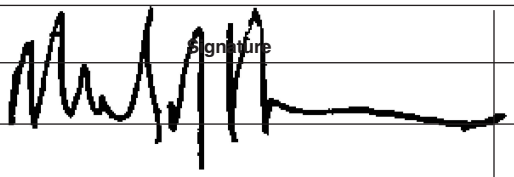
Part 2. Declaration of Representative.

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

TEMPUS UNLIMITED, INC.
Opportunities for Independence

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
REV 09/14/2021
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**