**Cons #: CON #**

# CONSUMER DIRECTED CARE AGREEMENT BETWEEN EMPLOYER & ( Name of ASAP )

This agreement made this_____day of_____, 20__, by and between **EMPLOYER NAME** (Employer) and provides as follows:

1. Employer has been determined to be eligible for certain home care services administered by ( **Name of ASAP** ) as set forth in this Agreement.

2. Employer has voluntarily chosen to participate in Consumer Directed Care offered by ( **Name of ASAP** ) which provides for employer to utilize home care funds to select, train and employ CDC worker(s) in accordance with the terms of this Agreement.

3. The duration of this agreement ("the agreement period") is from **Start Date** to **End Date**. Any extensions to the agreement period must be evidenced by a writing duly authorized by ( **Name of ASAP** ).

4. ( **Name of ASAP** ) reserves the right to:

   a. Terminate the agreement if the Employer fails to comply with any of the requirements of this Agreement and the Consumer Directed Care guidelines;

   b. Require the Employer to change from Consumer Directed Care to a traditional home care program utilizing agency employees;

   c. Terminate home care services if the Surrogate becomes unavailable, or ( **Name of ASAP** ) requires Employer to replace the Surrogate and another Surrogate cannot be identified within 30 days of the notification for the need for such replacement;

   d. Require the Employer to obtain a Surrogate if ( **Name of ASAP** ) determines that the Employer is not able to manage Consumer Directed Care independently. ( **Name of ASAP** ) will terminate the Consumer Directed Care option if the Employer does not obtain a Surrogate within 30 days of the date of ( **Name of ASAP** ) assessment;

   e. Require the Employer to replace a Surrogate if the Surrogate is not performing Consumer Directed Care tasks in accordance with this Agreement.

5. During the contract period, ( **Name of ASAP** ) agrees to authorize **# of hours per month** hours per month for the benefit of Employer to hire CDC worker(s) who shall perform home care services for the benefit of the Employer. Any cost incurred by the Employer for hours worked in excess of those authorized by ( **Name of ASAP** ) is the sole responsibility of the

Employer. Employer shall be solely responsible for the hiring, training, retention and firing of such home care employee(s).

**Must be Completed**

***(for Tempus Unlimited, Inc. payroll processing: Client is authorized***

**# of hrs per week** ***hours per week)***

6. ( **Name of ASAP** ) obligation to authorize and provide the expenditure of funds under this Agreement is subject to the availability of funding made available to ( **Name of ASAP** ) and the Executive Office of Elder Affairs.

7. As a condition for receiving Consumer Directed Care Services, Employer shall:

   a. fully and accurately complete and deliver to ( **Name of ASAP** ) all documentation as directed by ( **Name of ASAP** );

   b. complete and sign all employment forms required by

   c. complete and sign any activity forms and submit them to Tempus Unlimited, Inc. in accordance with the instructions provided and the timeframe specified by ( **Name of ASAP** );

   d. ensure that information submitted on any activity form and/or timesheet for each pay period correctly identifies who provided home care services and the correct hours and dates that the home care services were provided;

   e. hire, fire, schedule and CDC worker(s) for no more than the authorized hours and at the rates of pay as set forth in this Agreement;

   f. cooperate with ( **Name of ASAP** ) during assessments, evaluations and re-evaluations;

   g. notify ( **Name of ASAP** ) of date of termination of the employer's CDC worker(s) and/or any changes in workers;

   h. notify ( **Name of ASAP** ) of the Employer change of address;

   i. notify ( **Name of ASAP** ) when there is a change in the Employer's medical condition or living situation that may require an adjustment in the number of day/evening hours per week or type of service to be provided;

   j. work with ( **Name of ASAP** ) to resolve any issues or complaints;

   k. provide ( **Name of ASAP** ) upon request and at least annually, with documentation requested by ( **Name of ASAP** ) to verify compliance with employer obligations and proper use of Consumer Directed Care funds. Such documentation may include, but is not limited to, copies of W-2s issued to CDC worker(s), proof of payment of federal and state taxes, proof of payment of unemployment insurance taxes, and proof of purchase of worker's compensation insurance for CDC worker(s);

l. pay CDC worker(s) the wages set forth herein, with the appropriate taxes withheld;

m. comply with all applicable state and federal labor laws, including, but not limited to, federal and state child labor laws.

8. Employer hereby acknowledges that the CDC workers he or she hires to perform home care services are not employees, agents, representatives and/or servants of ( **Name of ASAP** ).

9. Employer holds harmless ( **Name of ASAP** ) and their agents, representatives, servants, directors, employees, attorneys, officers and anyone else claiming by or through ( **Name of ASAP** ) against any and all claims, charges, promises, agreements, controversies, demands, liabilities, obligations, suits, judgments, actions, causes of action, rights, damages, costs, losses, debts, and expenses (including attorneys' fees and costs), of any nature whatsoever, in law and in equity, ("potential claim") resulting from the acts, omissions, breach, default or other conduct of the Employer, his or her employees, agents, and others acting on his or her behalf, in connection with the performance of any work by or for the Employer arising out of this Agreement and the Employer hereby agrees to indemnify ( **Name of ASAP** ) and defend and bear all cost to defend any and all such potential claims against ( **Name of ASAP** ).

10. ( **Name of ASAP** ) agrees to provide Case Management Services and Fiscal Intermediary Services to Employer, provided Employer is not in breach of this Agreement.

11. This Agreement shall not be amended or modified unless such amendment or modification is in writing and signed by the both parties. If any part of this Agreement shall in any form or matter deemed to be invalid, illegal or unenforceable, the remaining portions of this Agreement not so affected shall continue to operate and be of full force and effect.

| **Print Employer Name** | **Employer Signature** | **DATE** |
|---|---|---|
| Name of Employer | Signature of Employer | Date |
| **Print Case Manager Name** | **Case Manager Signature** | **DATE** |
| Name of Case Manager | Signature of Case Manager | Date |
| **Print Agency Supervisor** | **Supervisor Signature** | **DATE** |
| Name of Agency Supervisor | Signature of Supervisor | Date |
| **Print Surrogate Name (if applicable)** | **Surrogate Signature** | **DATE** |
| Name of Surrogate | Signature of Surrogate | Date |

Form **SS-4** (Rev. December 2023)
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.)**
**See separate instructions for each line. Keep a copy for your records.**
**Go to *www.irs.gov/FormSS4* for instructions and the latest information.**

OMB No. 1545-0003

**EIN**

**Type or print clearly.**

**1** Legal name of entity (or individual) for whom the EIN is being requested
EMPLOYER'S NAME HCSR

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

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

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

**5a** Street address (if different) (Don't enter a P.O. box.)
EMPLOYER'S PHYSICAL ADDRESS

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

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

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

**7a** Name of responsible party
EMPLOYER'S NAME

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

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

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

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

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

☐ Sole proprietor (SSN)
☐ Partnership
☐ Corporation (enter form number t
☐ Personal service corporation
☐ Church or church-controlled orga
☐ Other nonprofit organization (specify)
☑ Other (specify) HCSR

SAMPLE

☐ State/local government
☐ Federal government
☐ REMIC
☐ Indian tribal governments/enterprises
Group Exemption Number (GEN) if any

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

State

Foreign country

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

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

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

**12** Closing month of accounting year DECEMBER

**14** Reserved for future use

**13** Highest number of employees expected in the next 12 months (enter -0- if none).

| Agricultural | Household | Other |
|---|---|---|
| 0 | 0 | 0 |

**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) EMPLOYER'S NAME: HOUSEHOLD EMPLOYER

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

Signature EMPLOYER'S SIGNATURE OR SIGNATURE & SOCIAL SECURITY NUMBER OF PARENT OR LEGAL GUARDIAN, IF MINOR CHILD

Date TODAY'S DATE

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

**For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.** Cat. No. 16055N Form **SS-4** (Rev. 12-2023)

EMPLOYER'S DATE OF BIRTH 000-000-0000 CONSUMER NUMBER 000000

# 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), 10–13, 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), and 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 Number

**4.** No. of locations

## Principal Place of Business

**5.** Owner, partnership or legal corporate name: EMPLOYER'S NAME
Name (cont'd.): c/o TEMPUS UNLIMITED INC

**6.** Number and street: 600 TECHNOLOGY CENTER DR

**7.** City or town: STOUGHTON

**8.** State: MA

**9.** Zip: 02072—4708

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

SAMPLE

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

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

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

**13.** Describe nature of business: PERSONAL CARE

**14.** Business activity code: 8050

**15.** Check applicable box: ☐ Profit ☐ Non-profit

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

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

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

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

Close date: Mo / Day / Yr

## Background Information

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

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

## Exempt Organizations

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

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

## Location of business

Federal Identification number _____

**22.** Trade name: EMPLOYER'S NAME

Trade name (cont'd.)

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

**24.** City or town

**25.** State **26.** Zip

**27.** (Area code) Telephone number: (EMP) SPH—ONE #

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

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

### Convention Center Financing District

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

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

### Filing Frequencies

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

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

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

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

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

## Tax Type Information

### Withholding

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

**APPROX. DATE OF FIRST PAYROLL**

**35.** Number of employees in Massachusetts:

**APPROX. # OF EMPLOYEES TO BE PAID EACH PAYROLL**

### Sales/Use Tax on Goods

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

### Sales/Use Tax on Telecommunications Services

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

### Meals Tax on Food and All Beverages

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

**39.** Check if food/beverage vending machine: ☐

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

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

**42.** Seating capacity:

### Room Occupancy

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

**44.** Locality code

**45.** Number of rooms:

### Use Tax Purchaser

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

### Convention Center Financing Surcharges

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

b. Boston Vehicular Rental Transaction Surcharge. Mo Day Yr

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

### Cigar and Smoking Tobacco Excise

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

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

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

| Your signature | Title | Date |
|---|---|---|
| **EMPLOYER'S SIGNATURE** | **OWNER** | **TODAY'S DATE** |

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

(Rev. December 2023) 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're 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 isn't effective until we approve your request. See the instructions for more information.

- If you're 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're filing this form.

(Check one)

- [◉] You want to **appoint** an agent for tax reporting, depositing, and paying.
- [○] You want to **revoke** an existing appointment.

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

**1 Employer identification number (EIN)** [ ][ ] – [ ][ ][ ][ ][ ][ ][ ]

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

**3 Trade name** (if any) EMPLOYER NUMBER AND STREET

**4 Address**

Number Street Suite or room number

EMPLOYER CITY (City) | STATE (State) | ZIP CODE (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, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series) | ☑ | ☐ |
| Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series) | ☑ | ☐ |
| Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series) | ☐ | ☐ |
| Form 944, Employer's ANNUAL Federal Tax Return (all 944 series) | ☐ | ☐ |
| 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 can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

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

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

**Sign your name here** EMPLOYER OR LEGAL GUARDIAN SIGNATURE

Date DATE

Print your name here EMPLOYER NAME

Print your title here HCSR

Best daytime phone EMPLOYER PH #

**Now give this form to the agent to complete.**

**Part 3:** **Agent Information: If you'll 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 United, 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, they are true, correct, and complete.

**Sign your name here** INTAKE COORDINATOR SIGNATURE

Print your name here: Intake Coordinator Name

Print your title here: Intake Coordinator

Date: DATE

Best daytime phone: 1-877-479-7577

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

# Tax Information Authorization

► **Go to *www.irs.gov/Form8821* for instructions and the latest information.**
► **Don't sign this form unless all applicable lines have been completed.**
► **Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you. See instructions.**

OMB No. 1545-1165

**For IRS Use Only**
Received by:
Name
Telephone
Function
Date

**1 Taxpayer information.** Taxpayer must sign and date this form on line 6.

| Taxpayer name and address | Taxpayer identification number(s) | |
|---|---|---|
| **Employer Name**<br>**Employer 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.**<br>**600 TECHNOLOGY CENTER DRIVE**<br>**STOUGHTON, MA. 02072** | CAF No. **0312-75867R**<br>PTIN<br>Telephone No. **877-479-7577**<br>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**<br>PTIN<br>Telephone No. **877-479-7577**<br>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 2024 - 2026** | **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.**

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

Massachusetts Department of Revenue

# Form M-2848

# Power of Attorney and Declaration of Representative

## Part 1. Power of Attorney

Name of taxpayer(s) or principal reporting corporation
**CONSUMER NAME**

Social Security number(s)
**CONSUMER SSN #**

Mailing address
**CONSUMER ADDRESS**

Federal Identification number

City/Town
**CONSUMER CITY**

State
**STATE**

Zip
**ZIP CODE**

Phone number
**CONSUMER PHONE NUMBER**

Email address
**CONSUMER EMAIL ADDRESS**

**Representative Information**

Hereby appoint(s) the following individual(s) as atto assachusetts Department of Revenue for the following tax type(s) and filing peri eath if estate tax)]:



| Name of individual and firm | | address/phone number |
|---|---|---|
| **MICHAEL HEINEMAN** | **600 Technology Center Drive<br>Stoughton, MA. 02072** | **(877) 479-7577** |
| | | |
| | | |

Fill in oval if you wish to allow a DOR representative to communicate with any individual from firms listed above. ○

**Tax Type(s) & Filing Period(s) at Issue**

| Tax type(s) | Filing period(s) |
|---|---|
| **INCOME TAX WITHHOLDING, TA-1** | **ALL** |
| | |
| | |

**The representative is 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 receive refund checks.**

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

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** ◉ Appointee first named above, or

**2** ☐ Another appointee designated above. Name _____

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):

**Signature of taxpayer(s) or authorized individual of principal reporting entity.** See instructions. 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 entity.

| Signature (see instructions) | Title (if applicable) | Date |
|---|---|---|
| **CONSUMER SIGNATURE** | **EMPLOYER** | **DATE** |

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

| Signature (see instructions) | Title (if applicable) | 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;

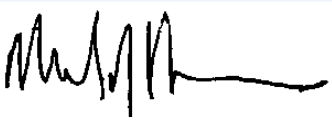
**5** a full-time employee of the taxpayer;

**6** a member of the taxpayer's immediate family (spouse, parent, child or sibling);

**7** a fiduciary for the taxpayer;

**8** other (describe relationship) _____

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** (see instructions) | **Print name** | **Date** |
|---|---|---|---|---|
| 1 | MA- BBO#556841 |  | Michael Heineman | |
| | | | | |
| | | | | |
| | | | | |

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**.

| **Con, Surr or Legal Rep Signature** | **Print Name** | **DATE** |
|---|---|---|
| **Signature of Consumer/Surrogate Legal Representative** | **Printed Name** | **Date** |

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

Por este medio le doy mi consentimiento a Tempus Unlimited, Inc. para utilizar y divulgar información protegida de salud (PHI) sobre mí para llevar a cabo 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 | Nombre Impreso | Fecha |
|---|---|---|
| **Firma del Consumidor/Delegado Representante Legal** | **Nombre impreso** | **Fecha** |