TO: Participants of the MFP Program

FROM: Fiscal Intermediary Department

RE: Employment Packages

Welcome to the Tempus Unlimited, Inc. Fiscal Intermediary (FI) program. Enclosed please find all the pre-populated forms you will need to sign, date and return to us in order to start your participation in the FI Program. The following is a list of the forms and a brief description of their use:

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

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

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

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

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

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

Fiscal Intermediary Procedure for Submitting Complaints and Grievances: This policy explains how you would proceed in filing a grievance if you were ever unhappy with the services Tempus Unlimited, Inc. provides.

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

Consent to the Use and Disclosure of Protected Health Information: By completing and signing this form, the Participant acknowledges consent/non-consent regarding the release of PHI and permission to leave detailed voicemails on home/cell phone. The Participant. Legal Guardian or POA completes and signs this form.

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

My Ombudsman Program: My Ombudsman is now able to assist any MassHealth member with questions or challenges accessing MassHealth covered benefits or services. The My Ombudsman program is an independent, free service for all MassHealth members as well as members' families, caregivers, and advocates. Many My Ombudsman staff are or have been MassHealth members, and have personal experience with disability. Additional information is available on the Tempus website.

Criminal Record Check (CORI): A name-based criminal record check (CORI) returns information on available Massachusetts arraignments. This type of criminal record check is done by submitting the name and date of birth for a person. That information is then searched against Massachusetts court records to determine if there is a possible record for that person. This type of criminal record check contains only Massachusetts information and is not fingerprint supported. **A CORI check is required for all DCW's.**

To request a CORI check for your Direct Care Worker (DCW), you can either create an online account at Request an Online CORI check (you must have a valid Massachusetts Driver's License or ID), or complete the CORI Request Form on the Tempus website and submit to the address at the top of the form ATTN: CORI Unit.

Sexual Offender Register Information (SORI): An online database to access information about Level 2 and Level 3 offenders. For information on how to conduct and interpret a SORI check, please visit our website.

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

Emergency Notification System (RAVE): We will use the system to notify you of office closings, important updates and other information that we need to provide quickly. Registration is not required however; an opt-out letter is mailed for those that prefer to not receive these notifications.

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

If you have any questions, please contact Tempus Unlimited, Inc. at Toll-Free at 1-877-479-7577 Monday through Friday between the hours of 7:30AM and 4:30PM. One of our Consumer Relations Specialists will be happy to assist you.

TEMPUS UNLIMITED, INC.
Opportunities for Independence

Fiscal Intermediary
Procedure for submitting Complaints and Grievances

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

I. If a consumer or surrogate is unhappy with the service, or with a representative of the FI, they can call (toll-free at 877-479-7577), fax, (800-359-2884) , email to: MAFMS@tempusunlmited.org, include the word "Complaint" in the subject line, or mail your letter to the Consumer Relations Supervisor at Tempus Unlimited, Inc., 600 Technology Center Drive, Stoughton, MA 02072. The Consumer Relations Supervisor will review the circumstances regarding the complaint and attempt to resolve the issue within 24 hours of receiving the request. The consumer will be informed of the resolution using the same method as the complainant (telephone, fax, or mail).

II. If a consumer is not satisfied with the action taken by the Consumer Relations Supervisor, and they feel strongly that their complaint is the result of a violation of law, or regulation, or egregious error or service, they can send an email to: Grievance@tempusunlimited.org, or mail to 600 Technology Center Drive, Stoughton, MA. 02072, ATTN: Compliance Department. The Compliance Office will review the circumstances regarding the grievance and will attempt to resolve the issue within 24 hours of receiving the request. The consumer will be informed of the resolution using the same method as the complainant (telephone, fax, or mail).

III. If a consumer is not satisfied with the action taken by the Compliance Department, the grievance will be forwarded to the CEO/FI Director via email and/or consumer should submit their grievance by US Mail to Chief Executive Officer/Fiscal Intermediary Director, 600 Technology Center, Stoughton, MA 02072. The CEO/FI Director will conduct an investigation of the circumstances through telephone interviews, personal interviews and/or reviews of written or printed documents relating to the issues.

IV. Within ten days of receiving the written grievance, the CEO/FI Director will issue a decision in writing to the consumer using the same method as the complainant (email or mail).

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

Notice of Privacy Practices **August 2024**

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

This notice is provided on behalf of Tempus Unlimited, Inc. herein named the Agency.

PURPOSE: This notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out payment for Fiscal Intermediary program services, required by the contract entered into between the Massachusetts Executive Office of Health and Human Services and Tempus Unlimited, Inc. Protected Health Information is information that may identify the Consumer and that relates to the consumer's past, present or future physical or mental health, and may include name, address, phone numbers and other identifying information.

We are required by law to give you this notice and to maintain the privacy and security of your protected health information.

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

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

If you believe your Privacy Rights have been violated, you may make a complaint to us or to the US Secretary of Health and Human Services at: http://www.hhs.gov/. To file a complaint with us, you may send a letter describing the violation to Tempus Unlimited, Inc. Compliance Department, 600 Technology Center Drive, Stoughton, MA 02072. You also may email a complaint to Grievance@TempusUnlimited.org.

There will be no retaliation for filing a complaint.

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

Your Privacy Rights:

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

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

Our Responsibilities:

We are required by law, to maintain the privacy and security of your protected health information and to abide by the terms of this Notice. We will let you know promptly if an incident occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can. If you tell us we can, you may change your mind at any time. We will request that you submit that request in writing. We will offer an accommodation to document your request if needed.

Examples of Uses and Disclosures

We will use your Protected Health information to provide services.

- Public Health: We may give your Protected Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and is required by law.
- Communicable Disease: We may disclose your Protected Health information to a person who may have been exposed to a communicable disease or may be otherwise at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.
- Law Enforcement: We must disclose your Protected Health Information for law enforcement purposes as required by law (e.g. a court order, subpoena, discovery request or other lawful process).
- As Required by Law: We must disclose your protected health Information when required by federal, state or local law.
- Health Oversight: We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight Agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.
- Abuse or Neglect: we must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect.
- Legal Proceedings: We may disclose your protected Health information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process.
- Required Uses and Disclosures: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.
- To Avoid Harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
- For Specific Government Functions: In certain situations, we may disclose Protected Health Information of veterans. We may disclose your Protected Health Information for national security activities required by law.

Aviso sobre las prácticas de privacidad Agosto 2024

Este aviso describe como la Información de Salud Protegida sobre usted puede ser utilizada y divulgada y la manera en la que usted puede adquirir acceso a esta información. Por favor revise este aviso cuidadosamente.

Este aviso es provisto por parte de Tempus Unlimited, Inc., aquí nombrado como la Agencia.

PROPÓSITO: Este aviso sobre las prácticas de privacidad describe cómo podemos utilizar y divulgar su información médica protegida para llevar a cabo tratamientos, pagos u operaciones de atención médica y para otros fines permitidos o requeridos por la ley. La información médica protegida es información que puede identificar al consumidor y que está relacionada con la salud física o mental del consumidor, ya sea pasada, presente o futura y podría incluir el nombre, la dirección, los números telefónicos y otra información identificativa.

Se nos requiere por ley darle este aviso a usted y mantener la privacidad y la seguridad de su información médica protegida.

Debemos cumplir con este Aviso, pero nos reservamos el derecho de cambiar las prácticas de privacidad descritas en él. Se puede obtener una versión actualizada de este Aviso en la página de web de la agencia, www.tempusunlimited.org, y estará publicado en nuestras oficinas. También puede solicitar una copia actualizada enviando una solicitud por escrito al Departamento de Cumplimiento de la Agencia, 600 Technology Center Drive, Stoughton, MA 02072.

Entendemos que la información médica sobre usted y sobre su salud es personal y confidencial y estamos comprometidos a proteger la confidencialidad de su información de salud protegida. Hemos creado un registro sobre el cuidado y los servicios que usted recibe a través de la agencia. Necesitamos este registro para poder proveer servicios y para poder cumplir con ciertos requisitos legales. Este Aviso le informará sobre las formas en que podemos utilizar y divulgar su información. También le describimos sus derechos y ciertas obligaciones que tenemos para utilizar y divulgar su información médica protegida.

Si usted cree que sus derechos de privacidad han sido violados, usted puede someter una queja a nosotros o al Secretario de la Salud y Servicios Humanos de Estados Unidos en la página de web http://www.hhs.gov/. Para someter una queja ante nosotros, puede enviar una carta a la agencia describiendo la violación al Departamento de Cumplimiento 600 Technology Center Drive, Stoughton, MA 02072. También puede someter una queja a través de correo electrónico dirigido a Grievance@TempusUnlimited.org..

No habrá represalias por someter una queja.

QUIENES SEGUIRÁN ESTE AVISO: Este aviso describe las prácticas de la agencia, los profesionales de la salud, los empleados, los voluntarios y otras personas que trabajan en cualquiera de los programas de Tempus Unlimited, Inc. en los que usted posiblemente participe.

Sus derechos de privacidad:

Usted tiene los siguientes derechos en relación a su información de salud protegida y puede:

- Obtener una copia impresa actualizada de este Aviso.
- Inspeccionar u obtener una copia de los documentos creados por la agencia. Su solicitud para obtener una copia de estos documentos tiene que ser sometida por escrito o en un formato que nos permita verificar al solicitante como el consumidor o guardián u otra persona designada.
- Solicitar que modifiquemos su información médica protegida (PHI, por sus siglas en inglés) si usted cree que la información está incompleta o incorrecta.

- Obtener un registro de ciertas divulgaciones de información médica protegida.
- Obtendremos su permiso por escrito para que los usos y divulgaciones de su información de salud protegida se le envíe a través de medios alternativos o en localizaciones alternativas.
- Obtendremos su permiso por escrito para que los usos y divulgaciones de su información de salud protegida que no sea cubierta por el aviso o permitido a través de la ley. Usted puede cancelar este permiso excepto en la medida en que el uso o la divulgación ya haya ocurrido. Este pedido para ser cancelado tiene que ser sometido por escrito o en un formato que nos permita verificar al solicitante como el consumidor o guardián u otra persona designada.

Nuestras responsabilidades:

Se nos requiere por ley mantener la privacidad y la seguridad de su información médica protegida y cumplir con los términos de este aviso. Le dejaremos saber prontamente si ocurre algún incidente que pueda haber comprometido la privacidad o seguridad de su información. Debemos de seguir los deberes y prácticas de privacidad que se describen en este aviso y darle una copia a usted. No usaremos ni compartiremos su información de otra manera que no sea la descrita aquí a menos que usted nos diga que podemos. Si nos dice que podemos, puede cambiar de opinión en cualquier momento. Le solicitaremos que envíe esa solicitud por escrito. Ofreceremos una adaptación para documentar su solicitud si es necesario.

Ejemplos de usos y divulgaciones:

Utilizaremos su información médica protegida para brindar servicios.

- Salud pública: Podemos compartir su información médica protegida con agencias de salud pública que están encargadas de prevenir o controlar enfermedades, lesiones o discapacidades y que sea requerido por la ley.
- Enfermedad contagiosa: Podemos divulgar su información médica protegida a alguna persona que pueda haber estado expuesta a alguna enfermedad contagiosa o que pueda estar en riesgo de contraer o propagar la enfermedad o condición, como alguna enfermedad que requiera aislamiento, si así lo autoriza la ley.
- Ejecución de la ley: Debemos divulgar su información médica protegida para fines de la ejecución de la ley, según sea requerido por la ley (e.g. una orden judicial, citación, solicitud de proposición u otro proceso legal)
- Según lo exija la ley: Debemos divulgar su información médica protegida cuando así lo exija la ley federal, estatal o local.
- Supervisión de la salud: Debemos divulgar su información de salud protegida a una agencia de supervisión de la salud para las actividades autorizadas por la ley, tales como investigaciones e inspecciones. Las agencias de supervisión son aquellas que supervisan el sistema de salud, los programas de beneficios del gobierno como Medicaid, y otros programas regulatorios gubernamentales.
- Abuso o negligencia: Debemos divulgar su información médica protegida a las autoridades gubernamentales que están autorizadas por la ley para recibir informes sobre sospechas de abuso o de negligencia.
- Procedimientos legales: Podemos divulgar su información médica protegida en durante el curso de cualquier procedimiento judicial o administrativo o en respuesta a una orden judicial, citación, solicitud de proposición u otro proceso legal.
- Requerimiento de usos y divulgaciones: Debemos hacer divulgaciones cuando así lo requiera el Secretario del Departamento de Salud y Servicios Humanos para investigar o determinar nuestro cumplimiento con las Regulaciones de Privacidad de HIPAA.
- Para evitar daños: Podemos utilizar y divulgar información sobre usted cuando sea necesario para prevenir una amenaza grave a su salud o seguridad o la salud o seguridad del público o de otra persona.
- Para funciones gubernamentales específicas: Podemos divulgar información médica protegida de veteranos en ciertas situaciones. Podemos divulgar su información médica protegida para actividades de seguridad nacional requeridas por la ley.

Change Form and Supply Request

Tempus Unlimited, Inc. 600 Technology Center Drive Stoughton MA 02072 Phone (877)479-7577 Fax (800)359-2884 Email MAFMS@tempusunlimited.org

This Change Form is submitted to change information for **(check one):** ☐ Consumer/Participant ☐ PCA/Worker ☐ Surrogate

Consumer/Participant #

Consumer/Participant Name

Last 4 Digits of SSN

PCA/Worker Name

Type of Change (Required)

- ☐ Consumer/Participant Address
- ☐ PCA/Worker Address
- ☐ Surrogate Address

Change Requested By (Required)

- ☐ Consumer/Participant
- ☐ Surrogate
- ☐ PCA/Worker
- ☐ PCM/CM

If you have terminated a PCA/Worker, you must complete a PCA/Worker Employment Termination Form. You can obtain this form from our website https://tempusunlimited.org/ or by contacting us @ 1-877-479-7577. A Consumer Relations Specialist will be happy to assist.

First Name

Initial

Last Name

Address

City

State

ZIP Code

Phone Number - -

Cell Phone Number - -

Email Address

Name (Print)

Signature (only the signature of the requestor is required)

Date

Supply Request:

☐ Timesheets ☐ FI Paid Time Off Timesheets ☐ Payment Schedule ☐ New Hire Paperwork (NHP) ☐ Form W4 ☐ E-Timesheet Application

☐ Direct Deposit Application ☐ Debit Card Application ☐ Change Forms ☐ Other: _____

Change Form and Supply Request Instructions

Change Form

- Check who the change form is being submitted for (Consumer/Participant, PCA/Worker or Surrogate)

This Change Form is submitted to change information for **(check one):**	☐ Consumer/Participant	☐ PCA/Worker	☐ Surrogate

- Enter Consumer/Participant # and Participant/ Consumer Name
- Enter Last 4 of SSN and PCA/Worker Name (if applicable)
- Check Type of Change and Change Requested By

Type of Change (Required)	Change Requested By (Required)
☐ Consumer/Participant Address	☐ Consumer/Participant
☐ PCA/Worker Address	☐ Surrogate
☐ Surrogate Address	☐ PCA/Worker
	☐ PCM/CM

- Enter information to be updated
    - Address
    - City, State and Zip Code
    - Phone Number
    - Cell Number
    - Email Address
    - Appropriate Individual should Print Name, Sign and Date the form

Signatures

- Only the signature of the requestor is required
- Only the Consumer/Participant/Surrogate or PCM Staff can update Consumer Information
- Only the Surrogate can update Surrogate Information
- Only the PCA/Worker can update PCA Information

Supply Request

- Check the forms you would like to be mailed to you (you can check more than one box).

Completed forms can be sent via Mail, Fax or Email (see top of page one). All requests will be processed in the order they are received

PCA/Worker Direct Deposit Change Form

For changing existing Direct Deposit Information on file ONLY.
Please use the Direct Deposit Application if you do not currently have Direct Deposit.

Consumer Number: _____ Consumer Name: _____

PCA/Worker Name: _____ PCA/Worker Phone #:_____

Previous Bank Information

Name on Bank Account: _____

Bank Name: _____ Account Type: Savings ◯ Checking ◯

Bank Routing #: _____ Bank Account #: _____
(9 digits)

New Bank Information

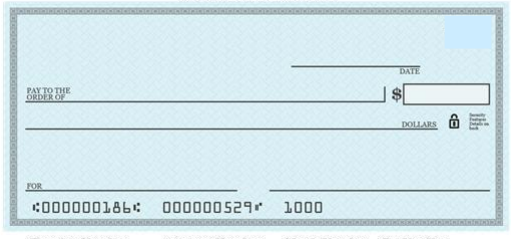
Name on Bank Account: _____
(PER MASSHEALTH – Direct Deposit Accounts must be in the name of the employee only, the account cannot be a joint account shared by the PCA/Worker and the Consumer or the Surrogate).

Bank Name: _____ Account Type: Savings ◯ Checking ◯

Bank Routing #: _____ Bank Account #: _____
(9 digits)

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

ATTACH CHECK HERE:



Routing Number Account Number Check Number – Do Not Use

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

PCA/Worker Signature: _____ Date: _____

600 Technology Center Drive, Stoughton, MA 02072
Toll-Free Phone #: 1-877-479-7577
www.tempusunlimited.org
Toll-Free Fax #: 1-800-359-2884
REV. 8/6/2024

WHO MAY NOT BE A WORKER

EFF. 3/1/06

The Parent of a Minor Child, Including Adoptive and Foster Parents

Spouse

Surrogate

Any Legally Responsible Relative

600 Technology Center Drive, Stoughton, MA 02072
Toll Free Phone #: 1-877-479-7577
Rev. 04/2017

www.tempusunlimited.org
Toll Free Fax #: 1-800-359-2884

Dear Consumer,

The Department of Industrial Accidents (DIA) has revised the Notice to Employees poster and has established new notice requirements.

We have provided the revised poster on the back of this notice for your convenience.

As an employer, you must:

- Fill out the Notice to Employees
- Post in a visible location utilized and accessible to all employees.
    - If no such location exists, the poster must be distributed to employees electronically or by mailing a copy.
- The posted must be updated, reposted, and redistributed whenever any of the information changes.

The revised poster is also available on the DIA website using the link or QR code below, in the following languages:

- English
- Arabic
- Cape Verdean
- Chinese
- Khmer
- Haitian Creole
- Portuguese
- Spanish
- Vietnamese

https://www.mass.gov/info-details/notice-to-employees-poster

Thank You,

Tempus Unlimited, Inc.

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-877-479-7577 | Email: MAFMS@tempusunlimited.org

NOTICE TO EMPLOYEES

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

IF YOU ARE INJURED ON THE JOB:

- **Immediately notify your employer that you have been injured.**

Employer HR/Workers' Compensation Contact Phone Number

- **Tell the medical provider that you have been injured at work and give the information below:**

Insurance Carrier	Address	Phone Number
Atlantic Charter Insurance Company	PCA, 25 New Chardon Street, Boston, MA 02114	(617) 488-6500

Employer Address

- **If the employer fails to report the injury to the insurer, the employee may file an Employee's Claim (Form 110).**
- **Additional information regarding your rights and eligibility for benefits pursuant the Workers' Compensation law may be obtained by contacting the Department of Industrial Accidents at 617.727.4900 or visiting www.mass.gov/dia.**

IF MEDICAL TREATMENT IS NEEDED:

Injured workers may select their own medical provider. Medical treatment costs that are reasonable, necessary, and related to the work injury will be paid by the above-named insurer.

If medical facility information is provided below, the above-named insurer has a preferred provider arrangement and the insurer has arranged for your initial treatment at:

Medical Facility: Address:

_____ _____

Phone Number:

_____

EMPLOYER: THIS NOTICE MUST BE FILLED OUT AND POSTED WHERE EMPLOYEES CAN READ IT PURSUANT M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). EMPLOYERS MAY NOT RETALIATE, DISCRIMINATE (IN ACCORDANCE WITH ANY APPLICABLE STATE OR FEDERAL LAWS WHICH INCLUDES IMMIGRATION STATUS), OR PROVIDE FALSE INFORMATION ABOUT THE WORKERS' COMPENSATION PROCESS TO THEIR EMPLOYEES. THIS NOTICE MUST BE UPDATED, POSTED AND REDISTRIBUTED WHEN THERE ARE CHANGES TO THE INFORMATION.

REVISED JUNE 2024

TEMPUS UNLIMITED, INC.
Opportunities for Independence

IMPORTANT INFORMATION ON TAXES

While on the MFP program, you may receive in the mail various forms from certain government agencies. For example: Massachusetts Division of Unemployment Assistance (DUA), the Internal Revenue Service (IRS) and the Massachusetts Department of Revenue (DOR), to name a few.

At no time, should there ever be any financial charges to a consumer personally, and we never expect you to remit any monies in response to these notices. If you receive anything stating money is owed, immediately fax or mail it to the Fiscal Intermediary office at the address on this stationery. We will take care of the situation.

Tempus Unlimited, Inc. pays your Unemployment Insurance, Social Security/Medicare and Worker's Compensation Insurance for your VIP program, and also pays quarterly withholding taxes to the IRS on your behalf. Any paperwork you may receive regarding filing quarterly taxes should be disregarded **unless there is a monetary demand for payment of quarterly taxes.** In that case, please forward said forms directly to this office and we will resolve the issue.

You may receive blank forms at the end of each quarter (March, June, September and December) on which to file quarterly taxes. Since **WE FILE THESE ELECTRONICALLY** for you, you may throw them out. Again, if you do get a notice from the IRS that these taxes have not been paid, showing a dollar amount due, please mail or fax to us and we will research and resolve the problem.

I hope this will help to ease your mind regarding various notifications you may receive. If you have any questions, feel free to call Tempus Unlimited, Inc. or your Skills Trainer at your agency.

EARNED SICK TIME

Notice of Employee Rights

Beginning July 1, 2015, Massachusetts employees have the right to earn and take sick leave from work.

WHO QUALIFIES?

All employees in Massachusetts can earn sick time.

This includes full-time, part-time, temporary, and seasonal employees.

HOW IS IT EARNED?

- Employees earn 1 hour of sick time for every 30 hours they work.
- Employees can earn and use up to **40 hours per year** if they work enough hours.
- Employees with unused earned sick time at the end of the year can **rollover up to 40 hours.**
- Employees **begin earning** sick time on their first day of work and **may begin using** earned sick time 90 days after starting work.

WILL IT BE PAID?

- If an employer has 11 or more employees, sick time must be paid.
- For employers with 10 or fewer employees, sick time may be unpaid.
- Paid sick time must be paid on the same schedule and at the same rate as regular wages.

WHEN CAN IT BE USED?

- An employee can use sick time when the employee or the employee's child, spouse, parent, or parent of a spouse is sick, has a medical appointment, or to address the effects of domestic violence.
- The smallest amount of sick time an employee can take is one hour.
- Sick time cannot be used as an excuse to be late for work without advance notice of a proper use.
- Use of sick time for other purposes is not allowed and may result in an employee being disciplined.

CAN AN EMPLOYER HAVE A DIFFERENT POLICY?

Yes. An employer can have their own sick leave or paid time off policy, so long as employees can use at least the same amount of time, for the same reasons, and with the same job-protections as under the Earned Sick Time Law.

RETALIATION

- Employees using earned sick time cannnot be fired or otherwise retaliated against for exercising or attempting to exercise rights under the law.
- Examples of retaliation include: denying use or delaying payment of earned sick time, firing an employee, taking away work hours, or giving the employee undesirable assignments.

NOTICE & VERIFICATION

- Employees must **notify** their employer before they use sick time, except in a emergency.
- Employers may require employees to **use a reasonable notification system** the employer creates.
- If an employee is out of work for 3 consecutive days **OR** uses sick time within 2 weeks of leaving their job, an employer may require documentation from a medical provider.

DO YOU HAVE QUESTIONS?

Call the Fair Labor Division at 617-727-3465 **E-Mail** us at EarnedSickTime@state.ma.us

Visit www.mass.gov/ago/earnedsicktime

Commonwealth of Massachusetts
Office of the Attorney General

The Attorney General enforces the Earned Sick Time Law and regulations.
It is unlawful to violate any provision of the Earned Sick Time Law.
Violations of any provision of the Earned Sick time law, M.G.L. c. 149, §148C, or these regulations, 940 CMR 33.00 shall be subject to paragraphs (1), (2), (4), (6) and (7) of subsection (b) of M.G.L. c. 149, §27C(b) and to §150.
This notice is intended to inform.
Full text of the law and regulations are available at www.mass.gov/ago/earnedsicktime.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Office of Long Term Services and Supports
One Ashburton Place, 5th Floor
Boston, Massachusetts 02108

CHARLES D. BAKER
Governor

KARYN E. POLITO

AMANDA CASSEL KRAFT
Acting
Assistant Secretary for MassHealth

NOTICE: COVID-19 Vaccine Requirement for DCWs

October 4, 2021

Dear HCBS Waiver Participant,

On September 1, 2021, the Baker-Polito Administration announced a vaccine requirement for all staff at rest homes, assisted living residences (ALRs), hospice programs, and home care agency workers providing in-home, direct care services under a state contract or state program as part of a continued effort to protect older adults and more vulnerable populations against COVID-19. On September 8, 2021, the Massachusetts Department of Public Health (DPH) promulgated 105 CMR 159.000: *COVID-19 Vaccinations for Certain Staff Providing Home Care Services in Massachusetts,* which requires certain home care workers, including Direct Care Workers (DCWs) working in the MassHealth Home and Community-based Services (HCBS) Moving Forward Plan (MFP) Waivers Self-Directed Program, to receive the COVID-19 vaccine.

As a result, **all DCWs working in the MassHealth HCBS MFP Waivers Self-Directed Program are required to complete the full regimen of COVID-19 vaccine by October 31, 2021**, except for those DCWs who qualify for an exemption because:

1. The vaccine is medically contraindicated, meaning that administration of a COVID-19 vaccine to that individual would likely be detrimental to the individual's health, and the individual can provide documentation demonstrating their need for this exemption, and the individual is able to perform their essential job functions with a reasonable accommodation that is not an undue burden on you, their employer; or

2. The individual objects to vaccination on the basis of a sincerely held religious belief and the individual can provide documentation demonstrating their sincerely held religious belief and the individual is able to perform their essential job functions with a reasonable accommodation that is not an undue burden on you, their employer.

Please continue reading to learn more information about the vaccine requirement and what this means for you as an employer of DCWs under the MassHealth HCBS MFP Waivers Self-Directed Program.

Please continue reading on reverse side →

When is the deadline for my DCW to get a COVID-19 vaccine?

All DCWs are required to receive the full required regimen of vaccine doses, or document that they qualify for an exemption, by October 31, 2021. The full required regimen of COVID-19 vaccine doses means:

- Two doses of the Pfizer-BioNTech COVID-19 vaccine; or
- Two doses of the Moderna COVID-19 vaccine; or
- One dose of the Johnson & Johnson COVID-19 vaccine.

Does the vaccine requirement change my rights and responsibilities as a Waiver Participant Consumer-employer?

No, this vaccine requirement does not change your rights and responsibilities as the employer of your DCW(s). **As a Waiver Participant Consumer-employer, it is your choice whether to hire, terminate, or decline services from a DCW based on their individual vaccination status**.

Please speak with your Waiver Case Manager for more information about your responsibilities as a Waiver Participant Consumer-employer.

Can I ask my DCW about their vaccination status?

Yes. In order to make the best decisions about your safety and personal care, you may ask your DCW(s) to verify if they have been vaccinated and/or whether they qualify for an exemption. As the employer, you are entitled to ask your DCW(s) to complete the attached COVID-19 Vaccine Attestation Form, which has important information about the COVID-19 vaccine and your DCW(s)' vaccination status. For information regarding the vaccine requirement, please go to: https://www.mass.gov/info-details/massachusetts-law-about-vaccination-immunization.

Should I ask my DCW for a copy of their vaccine card or medical information?

You may ask to *look at* your DCW(s)' vaccine card or an applicable doctor's letter explaining why they cannot receive a vaccine. It is strongly recommended that Waiver Participant Consumer-employers NOT keep copies of this information on file, but if a Consumer-employer chooses to do so, the Consumer-employer should ensure that any such documents are maintained in compliance with any applicable laws.

If you wish to keep a record of your DCW(s)' vaccination status, you may have them complete the attached COVID-19 Vaccine Attestation Form after viewing their verification documents.

What should I do if my DCW refuses to get a vaccine?

COVID-19 vaccination is the most effective method for preventing infection and serious illness from the virus. As the employer of your DCW(s), it is your decision whether to hire, schedule, or terminate someone who has not received a vaccine. You do not have to employ anyone who is not vaccinated unless they qualify for an exemption and can perform their essential job functions without undue burden on you, their employer.

The Massachusetts Executive Office of Health and Human Services (EOHHS) does not plan to monitor DCWs' vaccination statuses. Consumer-employers are responsible for monitoring their own employees' vaccination statuses.

COVID-19 Vaccine Attestation Form

MassHealth Home and Community-based Services MFP Waivers Self-Directed Program

This form will help your Waiver Participant Consumer-employer verify your vaccine status and make decisions about their safety and personal care. **Any Direct Care Worker who refuses to complete this form and/or comply with regulations promulgated, or regulations issued, by the Department of Public Health (DPH) pertaining to COVID-19 vaccination requirements may be subject to termination, as determined by their Waiver Participant Consumer-employer.**

By signing below, I acknowledge the following:

- I understand that Direct Care Workers (DCWs) working in the MassHealth Home and Community-based Services MFP Waivers Self-Directed Program are required to complete the full regimen of COVID-19 vaccine doses by October 31, 2021, per the Massachusetts Department of Public Health regulation 105 CMR 159.000: *COVID-19 Vaccinations for Certain Staff Providing Home Care Services in Massachusetts*;
- I have received information regarding the risks and benefits of receiving a COVID-19 vaccine, which includes information available at https://www.mass.gov/info-details/massachusetts-law-about-vaccination-immunization;
- I understand that under state and federal employment law, my Waiver Participant Consumer-employer has a legal right to require that I receive a COVID-19 vaccine as a condition of employment. **My Waiver Participant Consumer-employer can make hiring, termination, and scheduling decisions based on this requirement**;
- I can produce proof of my vaccination status or proof supporting a qualified exemption;
- I understand that if I qualify for an exemption or if I otherwise do not get the vaccine, I may be at greater risk of contracting COVID-19 and/or spreading it to others; and
- I understand that my Waiver Participant Consumer-employer may choose to terminate employment even if I qualify for an exemption if I cannot perform my essential job functions through a reasonable accommodation without creating an undue burden on my Waiver Participant Consumer-employer.

DCW Vaccine Status

By signing below, I attest to the following under the pains and penalties of perjury (please check one):

☐ I have completed the full regimen of COVID-19 vaccine doses. Specifically, I have received two doses of the Pfizer-BioNTech vaccine, or two doses of the Moderna vaccine, or one dose of the Johnson & Johnson vaccine.

☐ I am requesting a COVID-19 vaccine exemption based on one of the following (please check one):

- ☐ A licensed independent practitioner who has a practitioner/patient relationship with me has determined that administration of the COVID-19 vaccine is medically contraindicated, meaning the COVID-19 vaccine would likely be detrimental to my health, and I have documentation from said licensed independent practitioner demonstrating this determination; or
- ☐ I object to receiving a COVID-19 vaccine based on a sincerely held religious belief and I have documentation demonstrating this sincerely held religious belief.

☐ I am not currently vaccinated against COVID-19 and am not requesting (or do not qualify for) an exemption.

DCW Name	DCW Signature	Date Signed
Waiver Participant Consumer Name	Waiver Participant Consumer, Surrogate, or Legal Guardian Signature	Date Signed