CONSUMER REFERRAL FORM FOR TEMPUS UNLIMITED, INC.

Referral Date: ______________________ **TEMPUS Assigned Consumer #:** ______________

Consumer:

Name: ______________________ DOB: ______________________

Email: ______________________ Cell: ______________________

Home Address: ____

Mailing Address: ____

SS#: ______________ Gender: M ☐ F ☐

MassHealth MMIS # ______________________

SCO/OC/PACE ID# ______________________

CDC ID #: ______________ Veterans ID #: ______________________

Is Consumer a minor: ☐ Yes ☐ No Primary Language: ______________________

Parent(s) of Minor Child: Name: ______________ Relationship: ______________

Name: ______________ Relationship: ______________

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**: ☐ SerenityCare ☐ EBNHC ☐ UESP ☐ ElementCare ☐ Summit/Fallon ☐ CHA ☐ Harbor Health

☐ CDC

☐ VDC ☐ MA ☐ RI

☐ ABI/MFP Waiver: ☐ MFP-CL ☐ MFP-RS ☐ ABI-N ☐ ABI-RH

Surrogate: ☐ **AP:** ☐

Name: ______________________ DOB: ______________________

Email: ______________________ Phone: ______________________

Address: ____

Surrogate/AP's Relationship to Consumer: ______________________

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

Agency:

PCM/ASAP/MassAbility/DDS: ______________________

SkillsTrainer/Case Manager Name: ______________________

SkillsTrainer/Case Manager Email: ______________________

Phone: ______________ Ext: ______________ Fax: ______________

Acquired Brain Injury (ABI) / Moving Forward Plan (MFP) Waiver Participant Agreement:

Use of Fiscal Intermediary for Self-Directed Waiver Services

I participate in one of the following MassHealth waivers:

- Acquired Brain Injury Non-Residential Habilitation (ABI-N)
- Acquired Brain Injury with Residential Habilitation (ABI-RH)
- Moving Forward Plan Community Living (MFP-CL)
- Moving Forward Plan Residential Supports (MFP-RS)

I choose to use ABI or MFP self-directed waiver services.

About My Self-Directed Services

I understand that

- I employ my own direct care workers.
- MassHealth contracts with a fiscal intermediary (FI) who helps me with employer-required tasks.
- When I fill out, sign, and return this form to the FI, I give the FI the authority to do certain employer-required tasks for me.
- I must sign forms that allow the FI to act for me. The FI or my ABI/MFP waiver case manager or service coordinator will give me these forms. I understand that my direct care worker will be paid after I complete and return the forms to the FI. I may no longer be able to participate in ABI/MFP self-directed waiver services if I do not complete and return these forms.

I understand that

- I must have authorization for ABI/MFP self-directed waiver services in my plan of care. My ABI/MFP waiver case manager or service coordinator helps me find services that meet my needs.
- My direct care workers' weekly timesheets must not have more units than the number authorized by my ABI/MFP waiver case manager or service coordinator for each self-directed service.
- I am responsible for paying my direct care workers on my own
  - if I do not have authorization from my ABI/MFP waiver case manager or service coordinator, or
  - if I do not have enough units left on my waiver authorization on the days my direct care workers worked.
- I am responsible for paying my direct care workers on my own
  - if I am not eligible for MassHealth or am not enrolled in an ABI or MFP waiver on the days the direct care workers worked, or
  - if I have the direct care worker do work that is not covered or allowed by the waiver.
- MassHealth and the FI cannot pay my direct care workers if they are on
  - the List of Excluded Individuals/Entities maintained by the U.S. Department of Health and Human Services Office of Inspector General,
  - the MassHealth list of excluded providers, or
  - any other similar exclusion list.

The FI or my ABI/MFP waiver case manager or service coordinator can provide me with more information about this.

Payment to My DCWs

I understand that

- The amount of money paid to my direct care workers who provide waiver *Personal Care* is agreed on by the Personal Care Attendant Quality Homecare Workforce Council and the Service Employees International Union (SEIU Local 1199). The direct care workers must complete a New Hire Orientation and will receive payment for completing a New Hire Orientation. If the direct care worker does not take a New Hire Orientation, it may change their pay. I understand that direct care workers must complete a New Hire Orientation once. If my direct care worker has already completed a New Hire Orientation because they are a PCA or work for another participant-employer, they do not need to take it again and will not be paid for taking it a second time.
- The amount of money paid to my direct care workers who provide waiver A*dult Companion, Chore, Homemaker, Individual Support and Community Habilitation, and Peer Support* is set by the Executive Office of Health and Human Services.
- As the direct care worker's employer, I must
  - pay federal and state employer taxes,
  - buy workers' compensation insurance,
  - withhold taxes and fees, and
  - deduct union dues from my direct care worker's payments.

  The FI will help me with this.

The Fiscal Intermediary's Responsibilities

I understand that the FI will

- Receive and process my direct care workers' timesheets.
- Make payroll payments to my direct care workers for me.
- Make correct withholdings from my direct care workers' paychecks.
- Send all money withheld from my direct care workers' paychecks to the proper agencies.
- Pay my federal, state, and local employment taxes for me.
- Pay my unemployment insurance taxes for me.
- Buy workers' compensation insurance in my name to cover my direct care workers.
- Get employer identification numbers (EINs).
- Fill out, file, and save copies of required employment forms.
- Send me summaries of my payrolls and my tax filings.
- Send me summaries (payroll cover sheets) that describe the number of hours allowed for me for each self-directed waiver service on my waiver approval, the number of hours I have used for each service, and the number of hours that remain on my waiver approval.
  - I understand I can share this information with my direct care worker so that we both know if there are enough hours remaining on my waiver approval for them to work and get paid.

My Responsibilities as the Employer of my Direct Care Workers

I understand that the FI will do certain employer-required tasks, but that I must

- Complete all paperwork required by the FI. I understand that the FI will not be able to pay my direct care workers if the paperwork is not completed and submitted to the FI following their instructions.
- Tell the FI any time I hire or fire a direct care worker, any time that I move, and any time one of my direct care workers moves.

- Tell the FI and my ABI/MFP waiver case manager or service coordinator when I am admitted to a hospital, nursing facility, or other inpatient facility.
  - I understand that MassHealth and the FI cannot pay for my direct care workers when I am in a hospital, nursing facility, or other inpatient facility. I also understand that any payments made while I am in a such a facility may be the subject of some action taken by MassHealth, which may include termination of my self-directed waiver services or other penalties, and may result in reporting to the state's Bureau of Special Investigations (BSI) or the Attorney General's Office Medicaid Fraud Division (MFD), or both, for fraud investigation.
- Tell my direct care workers that they will get their payments electronically through direct deposit in their bank accounts or through a debit-card service offered by the FI. The FI can provide the forms needed for my direct care workers to process payment electronically.
- Make sure that each week my direct care workers sign and fill out their timesheets.
- Make sure that each of my direct care worker's timesheets show the correct days and hours they worked and the correct service they provided.
- Send my direct care workers' completed timesheets to the FI, following the FI's instructions and in the timeframe provided by the FI.
- Use the Electronic Visit Verification (EVV) system in place of a paper or other timesheet to approve and submit the date and time my direct care worker provides certain services, unless I and my direct care worker qualify for an EVV exemption. I understand that my direct care workers must use the EVV system to verify the time they provide certain services, as specified by MassHealth.

Printed name of waiver participant ________________________________

Waiver participant's signature ____________________________________

OR

Printed name of legal guardian ___________________________________

Legal guardian's signature _______________________________________

Date ____________________

Acuerdo del beneficiario de la exención por Lesión Cerebral Adquirida (ABI) y del Plan Seguir Adelante (MFP):

Uso del intermediario fiscal para los servicios autodirigidos de la exención

Soy beneficiario de una de las siguientes exenciones de MassHealth:

- Lesión cerebral adquirida: Habilitación no residencial (ABI-N)
- Lesión cerebral adquirida: Habilitación residencial (ABI-RH)
- Plan Seguir Adelante: Vida en la comunidad (MFP-CL)
- Plan Seguir Adelante: Apoyos residenciales (MFP-RS)

Elijo usar los servicios autodirigidos de la exención ABI o MFP.

Acerca de mis servicios autodirigidos

Entiendo que

- Soy el empleador de mis propios asistentes de atención directa.
- MassHealth contrata a un intermediario fiscal (FI), el cual me ayuda con las tareas relacionadas con ser empleador.
- Cuando complete y firme este formulario y se lo envíe al FI, le doy autoridad para realizar por mí ciertas tareas relacionadas con ser empleador.
- Debo firmar formularios que le permitan al FI actuar en mi nombre. Estos formularios me los dará el FI o mi administrador de casos o coordinador de servicios de la exención ABI/MFP. Entiendo que mi asistente de atención directa recibirá su pago después de que yo complete los formularios y se los envíe al FI. Es posible que no pueda volver a participar de los servicios autodirigidos de la exención ABI/MFP si no completo y envío estos formularios.

Entiendo que

- Debo tener autorización para los servicios autodirigidos de la exención ABI/MFP en mi plan de atención. Mi administrador de casos o coordinador de servicios de la exención ABI/MFP me ayuda a encontrar servicios que satisfagan mis necesidades.
- Las planillas semanales de horas trabajadas de mis asistentes de atención directa no deben tener más unidades que el número autorizado por mi administrador de casos o coordinador de servicios de la exención ABI/MFP para cada servicio autodirigido.
- Soy responsable de pagar por mi cuenta a mis asistentes de atención directa
  - si no tengo autorización de mi administrador de casos o coordinador de servicios de la exención ABI/MFP, o
  - si no me quedan muchas unidades en la autorización de mi exención en los días en que trabajaron mis asistentes de atención directa.
- Soy responsable de pagar por mi cuenta a mis asistentes de atención directa
  - si no soy elegible para recibir MassHealth o si no estoy inscrito en las exenciones ABI o MFP en los días en que trabajaron los asistentes de atención directa, o
  - si pido al asistente de atención directa que realice tareas que no están cubiertas ni permitidas por la exención.
- MassHealth y el FI no pueden pagarles a mis asistentes de atención directa si están en
  - la Lista de personas o entidades excluidas que mantiene la Oficina del Inspector General del Departamento de Salud y Servicios Humanos de EE. UU.
  - la lista de MassHealth de proveedores excluidos, o
  - cualquier otra lista de exclusión similar.

El FI o mi administrador de casos o coordinador de servicios de la exención ABI/MFP puede brindarme más información sobre esto.

Pagar a mis DCW (asistentes de atención directa)

Entiendo que

- La suma de dinero que se paga a mis asistentes de atención directa que prestan servicios de *cuidados personales* de exención se acuerda entre el Consejo para la Calidad de la Fuerza Laboral de los Ayudantes de Atención Individual y el Sindicato Internacional de Empleados de Servicios (SEIU Local 1199). Los asistentes de atención directa deben completar una *Orientación para el Nuevo PCA* y recibirán un pago por hacerlo. Si el asistente de atención directa no realiza una *Orientación para el Nuevo PCA*, su paga puede cambiar. Entiendo que los asistentes de atención directa deben completar una *Orientación para el Nuevo PCA* una vez. Si mi asistente de atención directa ya ha completado una *Orientación para el Nuevo PCA* porque es un PCA o porque trabaja para otro empleador beneficiario, no tiene que volverla a hacer y no se le pagará por hacerla una segunda vez.
- La suma de dinero que se paga a mis asistentes de atención directa que prestan servicios de exención de *acompañante para adultos, quehaceres, ayudante de quehaceres domésticos, apoyo individual y habilitación comunitaria,* y *apoyo de pares* está establecida por la Oficina Ejecutiva de Salud y Servicios Humanos.
- Como empleador de los asistentes de atención directa, debo
  - pagar los impuestos federales y estatales del empleador,
  - comprar un seguro de compensación por riesgo laboral,
  - retener impuestos y tasas, y
  - deducir las cuotas del sindicato de los pagos de mis asistentes de atención directa.

  EL FI me ayudará con esto.

Responsabilidades del intermediario fiscal (FI)

Entiendo que el FI

- Recibirá y procesará las planillas de horas trabajadas de mis asistentes de atención directa.
- Hará pagos de nómina a mis asistentes de dirección directa en mi nombre.
- Hará las retenciones correctas de los cheques de pago de mis asistentes de atención directa.
- Enviará a las agencias correspondientes el dinero retenido de los cheques de pago de mis asistentes de atención directa.
- Pagará por mí los impuestos sobre la nómina federales, estatales y locales.
- Pagará por mí las tasas del seguro de desempleo.
- Comprará en mi nombre el seguro de compensación por riesgo laboral para cubrir a mis asistentes de atención directa.
- Obtendrá números de identificación del empleador (EIN).
- Completará, presentará y guardará copias de los formularios de empleo requeridos.
- Me enviará resúmenes de mis nóminas y mis presentaciones de impuestos.
- Me enviará resúmenes (carátulas de la nómina) que describan el número de horas que se me autorizan para cada servicio autodirigido de exención en la aprobación de mi exención, el número de horas que he usado para cada servicio y el número de horas que quedan en la aprobación de mi exención.
  - Entiendo que puedo compartir esta información con mi asistente de atención directa para que ambos sepamos si quedan suficientes horas en la aprobación de mi exención para que trabaje y reciba un pago.

Mis responsabilidades como empleador de mis asistentes de atención directa

Entiendo que el FI realizará ciertas tareas relacionadas con ser empleador, pero que yo debo

- Completar toda la documentación solicitada por el FI. Entiendo que el FI no podrá pagar a mis asistentes de atención directa si no completé la documentación y no se la envié siguiendo sus instrucciones.
- Notificar al FI cada vez que contrate o despida a un asistente de atención directa, cada vez que me mude y cada vez que mis asistentes de atención directa se muden.
- Notificar al FI y a mi administrador de casos o coordinador de servicios de la exención ABI/MFP cuando sea admitido en un hospital, un centro de enfermería u otro centro hospitalario.
  - Entiendo que MassHealth y el FI no pueden pagar a mis asistentes de atención directa cuando yo esté en un hospital, un centro de enfermería u otro centro hospitalario. También entiendo que cualquier pago hecho mientras yo esté en dichos establecimientos puede verse sujeto a alguna decisión tomada por MassHealth, que puede incluir la cancelación de mis servicios autodirigidos de exención u otras sanciones, y puede causar la notificación a la Agencia de Investigaciones Especiales (BSI) o la División de Fraude contra Medicaid de la Oficina del Fiscal General (MFD), o ambas, para investigar casos de fraude.
- Notificar a mis asistentes de atención directa que recibirán sus pagos de manera electrónica mediante un depósito directo en su cuenta bancaria o mediante un servicio de tarjeta de débito ofrecido por el FI. El FI puede proporcionar los formularios necesarios para que mis asistentes de atención directa procesen los pagos electrónicamente.
- Asegurarme de que, cada semana, mis asistentes de atención directa firmen y completen sus planillas de horas trabajadas.
- Asegurarme de que cada planilla de horas trabajadas de mis asistentes de atención directa muestre los días y horas correctos que han trabajado y el servicio prestado correcto.
- Enviar al FI las planillas de horas trabajadas de mis asistentes de atención directa, siguiendo las instrucciones del FI y en el plazo provisto por el FI.
- Usar el sistema de Verificación Electrónica de Visitas (EVV) en lugar de un papel u otras planillas de horas trabajadas para aprobar y enviar la fecha y las horas en que mi asistente de asistencia directa presta ciertos servicios, a menos que mi asistente y yo califiquemos para una exención de EVV. Entiendo que mis asistentes de atención directa deben usar el sistema de EVV para verificar el tiempo en el que prestan ciertos servicios, tal como lo especifica MassHealth.

Nombre en letra de imprenta del beneficiario de la exención ________________________________

Firma del beneficiario de la exención ______________________________________

O

Nombre en imprenta del tutor legal ____

Firma del tutor legal ____

Fecha ____________________

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

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.)

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

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

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 to be filed) ________
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ________
- ☑ Other (specify) HCSR
- ☐ Estate (SSN of decedent) ________
- ☐ Plan administrator (TIN) ________
- ☐ Trust (TIN of grantor) ________
- ☐ Military/National Guard
- ☐ State/local government
- ☐ Farmers' cooperative
- ☐ 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.

- ☐ Health care & social assistance
- ☐ Wholesale-agent/broker
- ☐ Construction
- ☐ Rental & leasing
- ☐ Transportation & warehousing
- ☐ Accommodation & food service
- ☐ Wholesale-other
- ☐ Retail
- ☐ Real estate
- ☐ Manufacturing
- ☐ Finance & insurance
- ☑ Other (specify) HCSR

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

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☐ No
If "Yes," write previous EIN here

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	Designee's telephone number (include area code)
INTAKE SUPERVISOR	877-479-7577
Address and ZIP code	Designee's fax number (include area code)
600 TECHNOLOGY CENTER DRIVE, STOUGHTON, MA 02702	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.

Applicant's telephone number (include area code)

Name and title (type or print clearly)

Applicant's fax number (include area code)

Signature Date

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

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), 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:

4. No. of locations:

Principal Place of Business

5. Owner, partnership or legal corporate name:

Name (cont'd.): C/O TEMPUS UNLIMITED INC

6. Number and street: 600 TECHNOLOGYCENTER 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

Trade name (cont'd.)

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

24. City or town

25. State

26. Zip

27. (Area code) Telephone number

( ) —

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

35. Number of employees in Massachusetts:

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
	OWNER	

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

(Rev. December 2024) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

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)

- [x] 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)

3 Trade name (if any)

4 Address

Number Street Suite or room number

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, 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

Print your name here

Print your title here HCSR

Date

Best daytime phone

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 – 3770178

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, they are true, correct, and complete.

Sign your name here

Print your name here

Print your title here Intake Coordinator

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)

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 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 authorizations. 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 on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain . . . . ► ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 5 instructions.

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.

Signature | Date

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	Social Security number(s)
Mailing address	Federal Identification number
City/Town	State Zip
Phone number	Email address

Representative Information

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 type(s) and filing period(s) [specify the tax type(s) and year(s) or filing period(s) (date of death if estate tax)]:

Name of individual and firm	Address	Email address/phone number
MICHAEL HEINEMAN	600 Technology Center Drive 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
	EMPLOYER	

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	[signature]	Michael Heineman	

Form M-2848 Instructions

General Information

To protect the confidentiality of tax records, Massachusetts law generally prohibits the Department of Revenue (DOR) from disclosing information contained in tax returns or other documents filed with it to persons other than the taxpayer or the taxpayer's representative. For your protection, the Department requires that you file a Power of Attorney (POA) before it will release tax information to your representative. The POA also allows your representative to act on your behalf to the extent you indicate. Use Form M-2848, Power of Attorney and Declaration of Representative, for this purpose if you choose. You may file a POA without using Form M-2848, but it must contain the same information as Form M-2848 would.

You may use Form M-2848 to appoint one or more individuals to represent you in tax matters before the DOR. You may use Form M-2848 for any matters affecting any tax imposed by the Commonwealth, and the power granted is limited to these tax matters.

For certain corporate excise matters under MGL ch 63. By executing this agreement an officer of a principal reporting corporation filing under MGL ch 63, § 32B represents that the principal reporting corporation is authorized to execute this agreement as agent for all corporations that participated in, or were required to participate in, such filing for any component of the corporate excise reported or required to be reported under any section of MGL ch 63 by any such corporation whether relating to the income measure, non-income measure, or a minimum excise tax liability under the corporate excise.

A principal reporting corporation acts on behalf of all corporations that participated in, or were required to participate in, a filing under MGL ch 63, § 32B, as stated in the preceding paragraph. Consequently, in the case of such a filing by a principal reporting corporation, the references in this agreement to "taxpayer(s)" shall include all such corporations.

Filing the Power of Attorney. You must file the original, a photocopy or facsimile transmission (fax) of the POA with each DOR office in which your representative is to represent you. You do not have to file another copy with other DOR offices or counsel who later have the matter under consideration unless you are specifically asked to provide an additional copy.

Revoking a Power of Attorney. If you previously filed a POA and you want to revoke it, you may use Form M-2848 to change your representatives or alter the powers granted to them. File the form with the office of DOR in which you filed the earlier power. The new POA will revoke the earlier one for the same matters and tax periods unless you specifically state otherwise.

If you want to revoke a POA without executing a new one, send a signed statement to each office of DOR in which you filed the earlier POA you are now revoking. List in this statement the name and address of each representative whose authority is being revoked.

How to Complete Form M-2848

Part 1. Power of Attorney
Taxpayer's name, identification number and address.

a. For individuals. Enter your name, social security number, address, phone number and email address in the space provided. If joint returns are involved, and you and your spouse are designating the same representative(s), also enter your spouse's name and social security number and your spouse's address (if different).

b. For a corporation, partnership or association. Enter the name, federal identification number and business address. If the POA for a partnership will be used in a tax matter in which the name and social security number of each partner have not previously been sent to DOR, list the name and social security number of each partner in the available space at the end of the form or on an attached sheet.

c. For a principal reporting corporation. Enter the name, federal identification number and business address of the principal reporting corporation.

d. For a trust. Enter the name, title and address of the fiduciary, and the name and federal identification number of the trust.

e. For an estate. Enter the name, title and address of the decedent's personal representative, and the name and identification number of the estate. The identification number for an estate is the decedent's social security number and include the federal identification number if the estate has one.

Appointee(s), tax types, years or filing periods. Enter the name, firm, address, email and phone number of the individual(s) you appoint. Your representative must be a person who may be a part of an organization, firm, or partnership.

In the columns provided, clearly identify the tax type(s) and the year(s) or filing period(s) for which the power is granted. You may list any number of years or filing periods and tax type(s) on the same POA. If the matter relates to estate tax, enter the date of the taxpayer's death instead of the year or period.

If the POA will be used in connection with a penalty that is not related to a particular tax type, such as personal income or corporate, enter the section of the General Laws which authorizes the penalty in the "tax type(s)" column.

Powers granted by Form M-2848. Your signature on Form M-2848 authorizes the individual(s) you designate, or their whole firm if you fill in the oval, (your representative or "attorney-in-fact") generally to perform any act you can perform. This includes executing waivers and offers of waivers of restrictions on assessment or collections of deficiencies; waivers of notice of disallowance of a claim for credit or refund; and executing consents extending the legally allowed period for assessment or collection of taxes. The authority does not include the power to receive refund checks.

To disallow your representative to be able to perform any of these or other specific acts, or to allow your representative the power to delegate authority or substitute another representative beyond the individual(s) or firm you listed, insert specific language in the blank space provided.

Where you want copies to be sent. You may also have copies of all notices and all other written communications sent to your representative. Check box 1 if you want copies of all notices or all communications sent to the first appointee named at the top of the form. Check box 2 if you want copies sent to one of your other appointees, and list name.

Signature of taxpayer(s). For individuals: If a joint return is involved and both spouses will be represented by the same individual(s), both must sign the POA unless one authorizes the other (in writing) to sign for both. In that case, attach a copy of the authorization. However, if the spouses are to be represented by different individuals, each may execute a POA.

For a partnership: All partners must sign unless one partner is authorized to act in the name of the partnership. A partner is authorized to act in the name of the partnership if under state law the partner has authority to bind the partnership.

For a corporation or association: An officer having authority to bind the entity must sign.

For a principal reporting corporation: An officer having authority to bind the principal reporting corporation of a combined group.

If you are signing the POA for a taxpayer who is not an individual, such as a corporation or trust, type or print your name on the line below the signature line at the bottom of the form.

Important Note Regarding Electronic Signatures and Filing

If either the taxpayer (in Part 1) or the representative (in Part 2) is typing their full name on this form as their signature, then they should save the completed form as a pdf on their computer and submit the pdf to DOR to POADOR@dor.state.ma.us, where the taxpayer or representative (or each separately) states the following:

"The attached Power-of-Attorney form, designating ______________________ to be the taxpayer's representative, includes the (choose applicable term) **taxpayer's** or **representative's** typed name that they intend to serve as their valid signature, and intends to transmit on this form to the Massachusetts DOR."

Part 2. Declaration of Representative

Your representative must complete Part 2.

1. They must declare their capacity as one of the following: an attorney, a CPA or public accountant, an Enrolled Agent, an officer or full-time employee of the taxpayer, immediate family of taxpayer, a fiduciary, or other (with a statement describing relationship).

2. For an attorney, CPA or public accountant, your representative must enter in the "jurisdiction" column the name of the state or U.S. possession or territory where they are licensed. For an Enrolled Agent, enter the enrollment card number.

3. The signature and printed name of the representative and the date signed.

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 **<u>I am adding the access</u>** of the following persons:

Name____Relationship____________________________

Name____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 **<u>I am revoking the access</u>** of the following persons:

Name____Relationship______________________________

Name____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____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 of Consumer/Surrogate Legal or Personal 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____Relación____________________________

Nombre____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_______________________________________Relación_____________________________

Nombre_______________________________________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:____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/Delegado Representante Legal o Personal	**Nombre impreso**	**Fecha**