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

Criminal Offender Record Information (CORI) Request Form

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

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

DCW SIGNATURE

Signature of provider or applicant

Last name, first name, middle name
(Please print.) LAST NAME, FIRST NAME MIDDLE NAME

Maiden name or alias (if applicable) MAIDEN NAME OR ALIAS

Place of birth PLACE OF BIRTH

Date of birth DATE OF BIRTH

Social security number (Required) SOCIAL SECURITY #

Mother's maiden name
MOTHER'S MAIDEN NAME

Current address
CURRENT ADDRESS

Former address
FORMER ADDRESS

Gender: ☐ M ☐ F

Height HEIGHT

Weight WEIGHT

Eye color EYE COLOR

State driver's license number
STATE DRIVER'S LICENSE #

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
PCA/WORKER FIRST NAME MIDDLE INITIAL	PCA/WORKER LAST NAME	000-00-0000

Address: PCA/ WORKER ADDRESS

City or town, state, and ZIP code: PCA/WORKER CITY, STATE AND ZIP CODE

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

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

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.g* r if you: are completing this form after the beginning of ar in your marital status, number of jobs for you (and/or y deductions, or credits. Have your most recent p g of next year, use the estimator again to recheck your w

SAMPLE

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: Other Adjustments

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

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

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

PCA/WORKER SIGNATURE — **Employee's signature** (This form is not valid unless you sign it.)

TODAY'S DATE — **Date**

Employers Only

Employer's name and address

PRINT CONSUMER/EMPLOYER NAME CON#

First date of employment

Employer identification number (EIN)

Formulario **W-4**

Department of the Treasury
Internal Revenue Service

Certificado de Retenciones del Empleado

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

Entregue el Formulario W-4 a su empleador.

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

OMB No. 1545-0074

2026

Paso 1: Anote Su Información Personal

(a) Su primer nombre e inicial del segundo nombre	Apellido	(b) Su número de Seguro Social
NOMBRE Y INICIAL DEL SEGUNDO NOMBRE	**APELLIDO DEL PCA/WORKER**	000-00-0000

Dirección: DIRECCION DEL PCA / WORKER

Ciudad o pueblo, estado y código postal (*ZIP*): CIUDAD, ESTAFA Y COIDO POSTAL DEL PCA / WORKER

¿Coincide su nombre con el nombre en su tarjeta de Seguro Social? De no ser así, para asegurarse de que se le acrediten sus ganancias, comuníquese con la Administración del Seguro Social (*SSA*) al 800-772-1213 o acceda a *www.ssa.gov/es*.

(c) ☐ **Soltero** o **Casado que presenta una declaración por separado**

☐ **Casado que presenta una declaración conjunta** o **Cónyuge sobreviviente que reúne los requisitos**

MARQUE UNA CASILLA

☐ **Cabeza de familia** (Marque solamente si no está casado y paga más de la mitad del costo de mantener una vivienda para usted y una persona calificada).

Precaución: Para reclamar ciertos créditos o deducciones en su declaración de impuestos, usted (y/o su cónyuge, si es casado que presenta una declaración conjunta) tiene que tener un número de Seguro Social válido para trabajar. Vea la página **2** para más información.

CONSEJO: Considere usar el estimador de retención de impuestos en *www.irs.gov/W4AppSP* para calcular su retención con mayor precisión para el resto del año si: está completando este formulario después del comienzo del año; espera trabajar sólo parte del año; o tiene cambios durante el año en su estado civil, número de trabajos para usted (y/o su cónyuge, si es casado que presenta una declaración conjunta), dependientes, otros ingresos (no provenientes de trabajos), deducciones o créditos. Tenga disponible(s) su(s) talón(es) de cheque(s) más reciente(s) de este año cuando use el estimador. A comienzos del próximo año, use el estimador para volver a comprobar su retención.

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

Paso 2: Personas con Múltiples Empleos o con Cónyuges que Trabajan

Complete este pas… …senta una declaración conjunta y su cónyuge también t… …sos obtenidos de todos los empleos.

Tome **sólo una** de…

(a) Use el estimad… …mayor precisión en este paso (y en los Pasos **3** a **4**). Si usted o su cónyuge tiene ingresos del trabajo por cuenta propia, use esta opción; **o**

(b) Use la **Hoja de Trabajo para Múltiples Empleos** en la página **3** y anote el resultado en el Paso **4(c)** a continuación; **o**

(c) Si sólo hay dos empleos en total, puede marcar este recuadro. Haga lo mismo en el Formulario W-4 para el otro empleo. Esta opción es, por lo general, más precisa que el Paso **2(b)** si el pago del empleo con la paga más baja es mayor que la mitad del pago del empleo con la paga más alta. De lo contrario, el Paso **2(b)** es la opción más precisa . ☐

MUESTRA

Complete los Pasos 3 a 4(b) en el Formulario W-4 para sólo UNO de sus empleos. Deje esos pasos en blanco para los otros empleos. (Su retención será más precisa si completa los Pasos **3** a **4(b)** en el Formulario W-4 para el empleo con la paga más alta).

Paso 3: Reclamación de Dependiente y Otros Créditos

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

(a) Multiplique el número de hijos calificados menores de 17 años de edad por $2,200 . . . . . **3(a)** $

(b) Multiplique el número de otros dependientes por $500 . . . **3(b)** $

Sume las cantidades de los Pasos **3(a)** y **3(b)**, más la cantidad de otros créditos. Anote el total aquí . . . . . **3** $

Paso 4: Otros Ajustes

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

(b) Deducciones. Use la **Hoja de Trabajo para Deducciones** en la página **4** para determinar la cantidad de las deducciones que puede reclamar, lo cual reducirá su retención. (Si omite esta línea, su retención se basará en la deducción estándar). Anote el resultado aquí **4(b)** $

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

PARA RECLAMAR EXENCION DE RENTENTION, ESCRIBA EXENTO AQUI →

Exento de la retención

Reclamo exención de la retención para 2026 y certifico que cumplo con **ambas** condiciones para la exención para 2026. Vea **Exención de la retención** en la página **2**. Entiendo que necesitaré completar un nuevo Formulario W-4 para 2027 . . ☐

Paso 5: Firme Aquí

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

Firma del empleado — FECHA

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

Para Uso Exclusivo del Empleador

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

SAMPLE

Massachusetts Department of Revenue

Form M-4

Massachusetts Employee's Withholding Exemption Certificate

Print full name	Social Security number
PCA/Worker Name	PCA/Worker SSN

Home address
PCA/Worker Address

City/Town	State	Zip
PCA/Worker City	State	**PCA/Worker Zip Code**

Employee: File this form with your employer. Otherwise, Massachusetts income taxes will be withheld from your wages without exemptions.

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

How to Claim Your Withholding Exemptions

1 Your personal exemption. Enter "1" or, if you are age 65 or over or will be before next year, enter "2" **1**

2 If married and if exemption for spouse is allowed, enter "4" in line 2. If your spouse is age 65 or over or will be before next year and if otherwise qualified, enter "5." See Instruction C below **2**

3 Enter the number of qualified dependents. See Instruction D below **3**

4 Total number of withholding exemptions. Add lines 1 through 3 . . . . . **4**

5 Additional withholding per pay period under agreement with your employer **5**

A. ○ Fill in you will file as head of household.

B. ○ Fill in you are blind.

C. ○ Fill in your spouse if blind and not subject to withholding.

CHOOSE ONE

D. ○ Fill in you are a full-time student engaged in seasonal, part-time, or temporary employment whose estimated annual income will not exceed $8,000. **Employer:** Do **not** withhold if D is filled in.

General Information

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

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

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

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

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

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

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

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

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

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

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

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

Signature	Date
PCA/Worker Signature	Today's Date

Rev. 3/24

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)
PCA/WORKER LAST NAME	PCA/WORKER FIRST NAME	Middle Initial	Other Last names (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
PCA/WORKER ADDRESS	APT#	PCA/WORKER CITY OR TOWN	STATE	ZIP CODE

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
PCA/WORKER DOB	PCA/WORKER SSN#	PCA/WORKER EMAIL ADDRESS	PCA/WORKER PHONE #

I am aware that federal law provides for imprisonment and/or fi
CHOOSE ONE
us
connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the follow **SAMPLE** status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of th
- ☐ 2. A noncitizen r
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. An alien authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)
PCA/WORKER SIGNATURE	TODAY'S DATE

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A		OR	List B	AND	List C
Document Title 1	**If you do use a document from List A from the next page , you MUST use a document from List B AND a document from List C**		**See List B on next page**		**See List C on next page**
Issuing Authority					
Document Number (if					
Expiration Date (if any					
Document Title 2 (if					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

PCA/WORKER 1ST DAY OF EMPLOYMENT

☐ Check here if you used an alternative procedure authorized by D

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

First Day of Employment (mm/dd/yyyy): **00/00/0000**

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
CONSUMER/EMPLOYER OR SURROGATE/AP NAME	SIGNATURE OF CONSUMER/EMPLOYER/SURROGATE/AP	TODAY'S DATE

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
	CONSUMER/EMPLOYER CITY STATE ZIP CODE

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

SAMPLE

Supplement B,
...n and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**
Last Name From Section 1	**First Name From Section 1**	**Middle Initial From Section 1**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)
DOCUMENT TYPE	**DOCUMENT #**	**EXPIRATION DATE**

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

SAMPLE

Supplement A, ...nd/or Translator Certification for Section 1

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**
Last Name from Section 1	**First Name From Section 1**	**Middle Initial From Section 1**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Signature of Preparer or Translator			**Today's Date**
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
PCA/WORKER Last Name	**PCA/WORKER First Name**		**Middle Initial**
Address *(Street Number and Name)*	City or Town	State	ZIP Code
PCA/WORKER Address	**PCA/WORKER City or Town**	**STATE**	**ZIP CODE**

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Instructions for Form I-9, Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 05/31/2027

Anti-Discrimination Notice: Employers must allow all employees to choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information entered in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or **Supplement B, Reverification and Rehire**. Employees do NOT need to prove their citizenship, immigration status, or national origin when establishing their employment authorization for Form I-9 or E-Verify. Requesting such proof or any specific document from employees based on their citizenship, immigration status, or national origin, may be illegal. Similarly, discriminating against employees in hiring, firing, recruitment, or referral for a fee, based on citizenship, immigration status, or national origin may be illegal. Employers should not reject acceptable documentation due to a future expiration date. For more information on how to avoid discrimination or how to report it, contact the Immigrant and Employee Rights Section in the Department of Justice's Civil Rights Division at **www.justice.gov/ier**.

Purpose of Form I-9

Employers and employees must complete their respective sections of Form I-9. The form is used to document verification of the identity and employment authorization of each new employee (both U.S. citizen and alien) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document the verification of the identity and employment authorization of each new employee (both U.S. citizen and alien) hired after November 27, 2011.

Definitions

Employee: A person who performs labor or services in the United States for an employer in return for wages or other remuneration. The term “employee” does not include individuals who do not receive any form of remuneration (e.g., volunteers), independent contractors, or those engaged in certain casual domestic employment.

Employer: A person or entity, including an agent or anyone acting directly or indirectly in the interest thereof, who engages the services or labor of an employee to be performed in the United States for wages or other remuneration. This includes recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Authorized Representative: Any person an employer designates to complete and sign Form I-9 on the employer's behalf. Employers are liable for any statutory and regulatory violations made in connection with the form or the verification process, including any violations committed by any individual designated to act on the employer's behalf.

Preparer and/or Translator: Any individual who helps the employee complete or translates **Section 1** for the employee.

General Instructions

Filing Fee. See Form G-1055, available at **www.uscis.gov/forms**, for specific information about the fees applicable to this form.

Form I-9 consists of:

- **Section 1**: Employee Information and Attestation
- **Section 2**: Employer Review and Verification
- Lists of Acceptable Documents
- Supplement A, Preparer and/or Translator Certification for Section 1
- Supplement B, Reverification and Rehire (formerly Section 3)

EMPLOYEES

Employees must complete and sign **Section 1** of Form I-9 no later than the first day of employment (i.e., the date the employee begins performing labor or services in the United States in return for wages or other remuneration). Employees may complete **Section 1** before the first day of employment, but cannot complete the form before acceptance of an offer of employment.

EMPLOYERS

Employers in the United States, except Puerto Rico, must complete the English-language version of Form I-9. Only employers located in Puerto Rico may complete the Spanish-language version of Form I-9 instead of the English-language version. Any employer may use the Spanish-language form and instructions as a translation tool.

All employers must:

- Make the instructions for Form I-9 and Lists of Acceptable Documents available to the employee when completing the Form I-9 and when requesting that the employee present documentation to complete Supplement B, Reverification and Rehire. See page 5 for more information.
- Ensure that the employee completes **Section 1**.
- Complete **Section 2** within three business days after the employee's first day of employment. If you hire an individual for less than three business days, complete **Section 2** no later than the first day of employment.
- Complete Supplement B, Reverification and Rehire when applicable.
- Leave a field blank if it does not apply and allow employees to leave fields blank in **Section 1**, where appropriate.
- Retain completed forms. You are not required to retain or store the page(s) containing the Lists of Acceptable Documents or the instructions for Form I-9. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Additional guidance about how to complete Form I-9 may be found in the **Handbook for Employers: Guidance for Completing Form I-9 (M-274) and on I-9 Central.**

Section 1: Employee Information and Attestation

Step 1: Employee completes Section 1 no later than the first day of employment.

- All employees must provide their current legal name, complete address, and date of birth. If other fields do not apply, leave them blank.
- When completing the name fields, enter your current legal name and any last names you previously used, including any hyphens or punctuation. If you only have one name, enter it in the Last Name field and then enter "Unknown" in the First Name field.
- Providing your 9-digit Social Security number in the Social Security number field is voluntary, unless your employer participates in E-Verify. See page 5 for instructions related to E-Verify. Do not enter an Individual Taxpayer Identification Number (ITIN) as your Social Security number.

Step 2: Attest to your citizenship or immigration status.

You must select one box to attest to your citizenship or immigration status.

1. **A citizen of the United States.**
2. **A noncitizen national of the United States:** An individual born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
3. **A lawful permanent resident:** An individual who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant.

   Conditional residents should select this status. Asylees and refugees should NOT select this status; they should instead select "An alien authorized to work." If you select "lawful permanent resident," enter your 7- to 9-digit USCIS Number (A-Number) in the space provided.

4. **An alien authorized to work:** An individual who has authorization to work but is not a U.S. citizen, noncitizen national, or lawful permanent resident.

   If you select this box, enter the date that your employment authorization expires, if any, in the space provided. In most cases, your employment authorization expiration date is found on the documentation evidencing your employment authorization. If your employment authorization documentation has been automatically extended by the issuing authority, enter the expiration date of the automatic extension in this space.

   - Refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, and other aliens authorized to work whose employment authorization does not have an expiration date, should enter N/A in the Expiration Date field.

   Employees who select "an alien authorized to work" must enter **one** of the following to complete **Section 1**:

   (1) USCIS Number/A-Number (7 to 9 digits);

   (2) Form I-94 Admission Number (11 digits); or

   (3) Foreign Passport Number and the Country of Issuance

   Your employer may not ask for documentation to verify the information you entered in **Section 1**.

Step 3: Sign and enter the date you signed Section 1. Do NOT back-date this field.

Step 4: Preparer and/or translator completes a Preparer and/or Translator Certification, if applicable.

If a preparer and/or translator assists an employee in completing Section 1, that person must complete a Certification area on Supplement A, Preparer and/or Translator Certification for Section 1, located on Page 3 of Form I-9. There is no limit to the number of preparers and/or translators an employee may use. Each preparer and/or translator must complete and sign a separate Certification area. Employers must ensure that they retain any additional pages with the employee's completed Form I-9. If the employee does not use a preparer or translator, employers are not required to provide or retain Supplement A.

Step 5: Present Form I-9 Documentation

Within three business days after your first day of employment, you, the employee, must present to your employer original, acceptable, and unexpired documentation that establishes your identity and employment authorization. For example, if you begin employment on Monday, you must present documentation on or before the Thursday of that week. However, if you were hired to work for less than three business days, you must present documentation no later than the first day of employment.

Choose which documentation to present to your employer from the Lists of Acceptable Documents. An employer cannot specify which documentation you may present from the Lists of Acceptable Documents. You may present either: 1.) one selection from List A or 2.) a combination of one selection from List B and one selection from List C. In certain cases, you may also present an acceptable receipt for List A, B, or C documents. For more information on receipts, refer to the M-274.

- List A documentations show both identity and employment authorization. Some documentation must be presented together to be considered acceptable List A documentation. If you present acceptable List A documentation, you should not be asked to present List B and List C documentation.

- List B documentation shows identity only and List C documentation shows employment authorization only. If you present acceptable List B and List C documentation, you should not be asked to present List A documentation. Guidance is available in the M-274 if you are under the age of 18 or have a disability (special placement) and cannot provide List B documentation.

Your employer must physically examine the documentation you present to complete Form I-9, or examine them consistent with an alternative procedure authorized by the Secretary of DHS. If your documentation reasonably appears to be genuine and to relate to you, your employer must accept the documentation. If your documentation does not reasonably appear to be genuine or to relate to you, your employer must reject it and provide you with an opportunity to present other documentation. Your employer may choose to make copies of your documentation, but must return the original(s) to you. Your employer may not ask for documentation to verify the information you entered in **Section 1**.

Section 2: Employer Review and Verification

Before completing **Section 2**, you, the employer, should review **Section 1**. If you find any errors or missing information in **Section 1.**, the employee must correct the error, and then initial and date the correction.

You may designate an authorized representative to act on your behalf to complete **Section 2**.

You or your authorized representative must complete **Section 2** by physically examining evidence of the employee's identity and employment authorization within three business days after the employee's first day of employment. For example, if an employee begins employment on Monday, you must review the employee's documentation and complete **Section 2** on or before the Thursday of that week. However, if the individual will work for less than three business days, **Section 2** must be completed no later than the first day of employment.

Step 1: Enter information from the documentation the employee presents.

You, the employer or authorized representative, must either physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, the original, acceptable, and unexpired documentation the employee presents from the Lists of Acceptable Documents to complete the applicable document fields in **Section 2**. You cannot specify which documentation an employee may present from these Lists of Acceptable Documents. A document is acceptable if it reasonably appears to be genuine and to relate to the person presenting it. Photocopies, except for certified copies of birth certificates, are not acceptable for Form I-9. Employees must present one selection from List A or a combination of one selection from List B and one selection from List C.

You may use common abbreviations for states, document titles, or issuing authorities, such as: "DL" for driver's license, and "SSA" for Social Security Administration. Refer to the M-274 for abbreviation suggestions.

List A documentation shows both identity and employment authorization.

- Enter the required information from the List A documentation in the first set of document entry fields in the List A column. Some List A documentation consists of a combination of documents that must be presented together to be considered acceptable List A documentation. If the employee presents a combination of documents for List A, use the second and third sets of document entry fields in the List A column. Use the Additional Information space, as necessary, for additional documents. When entering document information in this space, ensure you record all available document information, such as the document title, issuing authority, document number and expiration date.
- If an employee presents acceptable List A documentation, do not ask the employee to present List B and List C documentation.

List B documentation shows identity only, and List C documentation shows employment authorization only.

- If an employee presents acceptable List B and List C documentation, enter the required information from the documentation under each corresponding column and do not ask the employee to present List A documentation.
- If an employee under the age of 18 or with disabilities (special placement) cannot provide List B documentation, see the M-274 for guidance.

In certain cases, the employee may present an acceptable receipt for List A, B, or C documentation. For more information on receipts, refer to the Lists of Acceptable Documents and the M-274.

Photocopies

- You may make photocopies of the documentation examined but must return the original documentation to the employee.
- You must retain any photocopies you make with Form I-9 in case of an inspection by DHS, the Department of Labor, or the Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section.

Step 2: Enter additional information, if necessary.

Use the Additional Information field to record any additional information required to complete **Section 2**, or any updates that are necessary once **Section 2** is complete. Initial and date each additional notation. See the M-274 for more information. Such notations include, but are not limited to:

- Those required by DHS, such as extensions of employment authorization or a document's expiration date.
- Replacement document information if a receipt was previously presented.
- Additional documentation that may be presented by certain nonimmigrant employees.

You may also enter optional information, such as termination dates, form retention dates, and E-Verify case numbers, if applicable.

Step 3: Select the box in the Additional Information area if you used an alternate procedure for document examination authorized by the Secretary of DHS.

You must select this box if you used an alternative procedure authorized by DHS to examine the documents. You may refer to the M-274 for guidance on implementing alternative procedures for document examination approved by the Secretary of DHS.

Step 4: Complete the employer certification.

Employers or their authorized representatives, if applicable, must complete all applicable fields in this area, and sign and date where indicated.

Reverification and Rehire

To reverify an employee's work authorization or document an employee's rehire, use Supplement B, Reverification and Rehire (formerly Section 3). Employers need only complete and retain the supplement page when employment authorization reverification is required. Employers may choose to document a rehire on the supplement as well. Enter the employee's name at the top of each supplement page you use. In the New Name field, record any change the employee reports at the time of reverification or rehire. Use a new section of the supplement for each instance of a reverification or rehire, sign and date that section when completed, and attach it to the employee's completed Form I-9. Use additional supplement pages as necessary. Use the Additional Information fields if the employee's documentation presented for reverification requires future updates.

Reverifications

When reverification is required, you must reverify the employee by the earlier of the employment authorization expiration date stated in Section 1 (if any), or the expiration date of the List A or List C employment authorization documentation recorded in Section 2. Employers should complete any subsequent reverifications, if required, by the expiration date of the List A or List C documentation entered during the employee's most recent reverification.

For reverification, employees must present acceptable documentation from either List A or List C showing their continuing authorization to work in the United States. You must allow employees to choose which acceptable documentation to present for reverification. Employees are not required to show the same type of document they presented previously. Enter the documentation information in the appropriate fields provided.

You should not reverify the employment authorization of U.S. citizens and noncitizen nationals, or lawful permanent residents (including conditional residents) who presented a Permanent Resident Card (Form I-551) or other employment authorization documentation that is not subject to reverification (such as an unrestricted Social Security card). Reverification does not apply to List B documentation. Reverification may not apply to certain aliens. See the M-274 for more information about when reverification may not be required.

Rehires

If you rehire an employee within three years from the date the employee's Form I-9 was first completed, you may complete the supplement and attach it to the employee's previously completed Form I-9. If the employee remains employment-authorized, as indicated on the previously completed Form I-9, record the date of rehire and any name changes. If the employee's employment authorization or List A or C documents have expired, you must reverify the employee as described above.

Alternatively, you may complete a new Form I-9 for rehired employees. You must complete a new Form I-9 for any employee you rehired more than three years after you originally completed a Form I-9 for that employee.

Employee and Employer Instructions Related E-Verify

E-Verify uses Form I-9 information to confirm employees' employment eligibility. For more information, go to **www.e-verify.gov** or contact us at **www.e-verify.gov/contact-us**.

For employees of employers who participate in E-Verify:

- You must provide your Social Security number in the Social Security number field in **Section 1**.
  - If you have applied for, but have not yet received, your Social Security number, you should leave the field blank until you receive the number. Update this field once you receive it, and initial and date the notation.
  - If you can present acceptable identity and employment authorization documentation to complete Form I-9, you may begin working while waiting to receive your Social Security number.
- Providing your email address and telephone number in **Section 1** will allow you to receive notifications associated with your E-Verify case.
- If you present a List B document to your employer, it must contain a photograph.

For E-Verify employers:

- Ensure employees enter their Social Security number in **Section 1**.
- You must only accept List B documentation that contains a photograph. This applies to individuals under the age of 18 and individuals with disabilities.
- You must retain photocopies of certain documentation.

USCIS Forms and Information

Employers may photocopy or print blank Forms I-9. To ensure you are using the latest version of this form and corresponding instructions, visit the USCIS website at **www.uscis.gov/i-9**. You may order paper forms at **www.uscis.gov/forms/forms-by-mail** or by contacting the USCIS Contact Center at **1-800-375-5283** or **1-800-767-1833** (TTY).

For additional guidance about Form I-9, employers and employees should refer to the **Handbook for Employers: Guidance for Completing Form I-9 (M-274)** or USCIS' Form I-9 website at **www.uscis.gov/i-9-central**.

You can obtain information about Form I-9 by e-mailing USCIS at **I-9Central@uscis.dhs.gov**. Employers may call **1-888-464-4218** or **1-877-875-6028** (TTY). Employees may call the USCIS employee hotline at **1-888-897-7781** or **1-877-875-6028** (TTY).

Retaining Completed Forms I-9

An employer must retain Form I-9, including any supplement pages, on which the employee and employer (or authorized representative) entered data, as well as any photocopies made of the documentation the employee presented, for as long as the employee works for the employer. When employment ends, the employer must retain the individual's Form I-9 and all attachments for one year from the date employment ends, or three years after the first day of employment, whichever is later. In the case of recruiters or referrers for a fee (only applicable to those that are agricultural associations, agricultural employers, or farm labor contractors), the retention period is three years after the first day of employment.

Completed Forms I-9 and all accompanying documents should be stored in a safe and secure location. Employers should ensure that the information employees provide on Form I-9 is used only as stated in the DHS Privacy Notice below.

Form I-9 may be generated, signed, and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR section 274a.2. Employers creating, modifying, or storing Form I-9 electronically are encouraged to review these and any other relevant standards for electronic signature, and the indexing, security, and documentation of electronic Form I-9 data.

Penalties

Employers may be subject to penalties if Form I-9 is not properly completed or for employment discrimination occurring during the employment eligibility verification process. See 8 U.S.C. section 1324a and section 1324b, 8 CFR section 274a.10 and 28 CFR Part 44. Individuals may also be prosecuted for knowingly and willfully entering false information, or for presenting fraudulent documentation, to complete Form I-9.

Employees: By signing **Section 1** of this form, employees attest under penalty of perjury (28 U.S.C. section 1746) that the information they provided, along with the citizenship or immigration status they select, and all information and documentation they provide to their employer, is true and correct, and they are aware that they may face penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or using false documentation when completing this form. Further, falsely attesting to U.S. citizenship may subject employees to penalties or removal proceedings, and may adversely affect an employee's ability to seek future immigration benefits.

Employers: By signing **Sections 2** and **3**, as applicable, employers attest under penalty of perjury (28 U.S.C. section 1746) that they have physically examined the documentation presented by the employee, that the documentation reasonably appears to be genuine and to relate to the employee named, that to the best of their knowledge the employee is authorized to work in the United States, that the information they enter in **Section 2** is complete, true, and correct to the best of their knowledge, and that they are aware that they may face civil or criminal penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing Form I-9.

DHS Privacy Notice

AUTHORITIES: The information requested on this form, and the associated documents, are collected under the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 U.S.C. 1324a).

PURPOSE: The primary purpose for providing the requested information on this form is for employers to verify your identity and employment authorization. Consistent with the requirements of the Immigration Reform and Control Act of 1986, employers use the Form I-9 to document the verification of the identity and employment authorization for new employees to prevent the unlawful hiring, or recruiting or referring for a fee, of individuals who are not authorized to work in the United States. This form is completed by both the employer and the employee and is ultimately retained by the employer.

DISCLOSURE: The information employees provide is voluntary. However, failure to provide the requested information, including your Social Security number (if applicable), and any requested evidence, may result in termination of employment. Failure of the employer to ensure proper completion of this form may result in the imposition of civil or criminal penalties against the employer. In addition, knowingly employing individuals who are not authorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an individual to work in the United States. The employer must retain this completed form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section. USCIS does not store Form I-9 data obtained from external employers or retrieve the information by a personal identifier. DHS may share the information you provide on this form and any additional requested evidence with authorized organizations. DHS follows approved routine uses described in the associated published system of records notice [DHS/USCIS-011 E-Verify, June 18, 2019, 84 FR 28326] and the privacy impact assessments [DHS/USCIS/PIA-036(b) Form I-9 Employment Eligibility Verification Update]. A complete list of the routine uses can be found in the system of records notice associated with this form at **http://www.dhs.gov/system-records-notices-sorns**. DHS may also share this information, as appropriate, for law enforcement purposes or in the interest of national security.

Direct Care Worker Provider Agreement for Self-Direction in the Acquired Brain Injury (ABI) / Moving Forward Plan (MFP) Waivers

This agreement is for a direct care worker (DCW) who is hired by a waiver participant. Please read, sign, and return this form to your employer (the waiver participant).

SAMPLE

Instructions and Important Information

- Your employer (the waiver participant) must submit this form to the fiscal intermediary (FI), along with other paperwork required by the FI and MassHealth.
- The FI cannot pay you until all required paperwork is received and complete.
- MassHealth and the FI cannot pay you to work when:
  - the waiver participant is in an inpatient facility, such as a hospital or nursing facility; or
  - the amount of time that was authorized per week by the waiver participant's case manager has been exhausted or is insufficient.

You must read, sign, and return this agreement before receiving payment as part of the waiver program.

Provider Agreement

By signing below, I agree to the following:

1. I understand that, as a DCW and provider of MassHealth covered services, I must comply with the provider eligibility requirements at 130 CMR 630.404 and the scope of services at 130 CMR 630.000: *Home- and Community-Based Services Waiver* as applicable to the waiver services I provide.
2. **I understand that my employer is the waiver participant. My employer is NOT MassHealth or the fiscal intermediary (FI).** My employer is responsible for hiring, firing, training, and scheduling me and other DCWs. My employer may choose another person (a surrogate) to help manage their self-directed services. I must notify my employer and the surrogate (if one exists), of any changes in my circumstances that would affect my ability to perform my duties as a DCW.
3. I understand that I must provide proof of my identity to my employer to complete the Employment Eligibility Verification form (Form I-9), which the Department of Homeland Security requires all employees to complete. (The FI will give my employer this form.)
4. I understand that I must complete and provide accurate Waiver Activity Forms (timesheets) to my employer or the FI as soon as I can, including through the use of Electronic Visit Verification (EVV) system for the delivery of services, as specified by MassHealth.
5. I understand that the FI will process payroll on behalf of my employer (the waiver participant). I understand that I must enroll in direct deposit, but may also enroll in payroll debit card, unless I have applied for and received an approval to get payment by paper check. If I get paid by paper check, I acknowledge that the FI will issue a check in my name and send it to my employer (the waiver participant).

6. I understand it is my responsibility to immediately notify the FI and my employer (the waiver participant) if any of my contact information changes, such as my name, address, email, phone number, or other information. I must immediately provide my updated contact information to my employer (the waiver participant) and the FI any time this information changes.
7. I understand that the MassHealth Waiver program pays for self-directed services provided by a direct care worker only when the DCW provides services to an eligible waiver participant who has obtained waiver authorization from their case manager for self-directed services. Self-directed services must be provided in accordance with the waiver participant's authorization, service agreement, and MassHealth regulations at 130 CMR 630.400.
8. I understand that my employer (the waiver participant) will tell me what tasks they need me to provide for them, according to their waiver authorization.
9. I understand that I cannot be paid as a DCW if I am a spouse, surrogate, or legally responsible relative of the waiver participant.
10. I understand that the FI is required to follow all federal and state rules regarding tax withholding, and the FI cannot change such rules. I understand that certain relationships between me and my employer (the waiver participant) may affect my tax exemption status. I understand that any tax exemption status resulting from my relationship with my employer is mandatory, based on applicable federal and state tax rules.
11. I understand that DCWs who provide waiver personal care to waiver participants in the Moving Forward Plan – Community Living (MFP-CL) Waiver are part of the Personal Care Attendant Collective Bargaining Unit, represented by the Personal Care Attendant Union.
12. I understand that if I provide waiver personal care to MFP-CL waiver participants, I must complete the New Hire Orientation if I haven't taken it before as a DCW or PCA and that I will receive payment for attending the New Hire Orientation. I understand that if I do not take the New Hire Orientation, it may affect my rate of pay for providing waiver personal care to MFP-CL waiver participants.

In providing DCW services to my employer (the waiver participant), I agree to the following:

13. If my employer has an advance directive concerning the provision of care in the event they become incapacitated, I agree to respect the terms of the advance directive, unless, as a matter of conscience, I cannot implement an advance directive. I agree not condition the provision of care or otherwise discriminate against my employer based on whether or not the individual has executed an advance directive. I understand that I am not required to provide care that conflicts with an advanced directive.
14. I agree to keep any records that are necessary to show the extent of the services I provide to my employer (the waiver participant), including activity forms (also called "timesheets").
15. I agree to provide, upon request, copies of records in my possession and any information regarding payments I claimed for DCW services to my employer, to the Medicaid agency, the Secretary of the U.S. Department of Health and Human Services, or the State Medicaid fraud control unit.

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

16. Under 42 CFR 455.104(a)(3), I am identifying below any other MassHealth provider entity in which I have ownership or control. A MassHealth provider entity could include any provider type enrolled with MassHealth, including a home health agency, an adult foster care agency, or any other provider type. Please complete this information on Page 3, below.
17. If requested by MassHealth, I agree to provide information about business transactions following 42 CFR 455.105.
18. Under state statute M.G.L. c.118E, § 36, and federal requirement, 42 CFR 455.106, by signing this form, I am stating that I have not been convicted of a criminal offense related to my involvement in any program under Medicare, Medicaid, or the Title XX services program.
19. I understand that certain relationships between me and my employer (the waiver participant) may affect my tax exemption status. I understand that any tax exemption status resulting from my relationship with my employer is mandatory, based on applicable federal and state tax rules. I understand that the FI is required to follow all federal and state rules regarding tax withholding, and the FI cannot change these rules.

Provider Information and Attestation

Please check one option.

The following describes my relationship to my employer (the waiver participant). Please check ONLY one.

- ☐ I am not related to my waiver participant-employer.
- ☐ I am the adult child (18 yrs. or older) of my waiver participant-employer.
- ☐ I am the daughter-in-law or son-in-law of my waiver participant-employer.
- ☐ I am the parent of my adult (18 yrs. or older) waiver participant-employer.
- ☐ I am related to my waiver participant-employer in a different way (please explain):

PLEASE EXPLAIN

Please check one option:

Under 42 CFR 455.104(a)(3), I am identifying below any other MassHealth provider entity in which I have ownership or control. A "MassHealth provider entity could include any provider type enrolled with MassHealth, including a home health agency, an adult foster care agency, or any other provider type. Please check one:

- ☐ I DO NOT have ownership or control of any other MassHealth provider entity.
- ☐ I DO have ownership or control of any other MassHealth provider entity.

The information for such entity/entities is as follows:

ENTITY INFORMATION

Please check the box below to show understanding about the New Hire Orientation requirement:

- ☐ I understand that if I provide waiver personal care to MFP-CL waiver participants, I must complete a New Hire Orientation if I have not already taken it as a DCW or PCA and that I will receive payment for attending New Hire Orientation. I understand that if I do not take New Hire Orientation, it may affect my rate of pay.

Please complete and attest to the following information:

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

I attest to all the above information, and agree to accept the position of direct care worker (DCW) for

PRINT NAME OF WAIVER PARTICIPANT

(Print name of waiver participant)

DCW signature DCW SIGNATURE DCW printed name DCW PRINTED NAME

DCW email address DCW EMAIL ADDRESS Date signed DATE SIGNED

Acuerdo de servicios del asistente de atención directa para la autodirección en las Exenciones por Lesión Cerebral Adquirida (ABI) o del Plan Seguir Adelante (MFP)

Este acuerdo es para el asistente de atención directa (DCW) contratado por un beneficiario de la exención. Por favor, lea y firme este formulario, y envíelo a su empleador (el beneficiario de la exención).

MUESTRA

Instrucciones e información importante

- Su empleador (el beneficiario de la exención) debe presentar este formulario al Intermediario Fiscal (FI), junto con los demás documentos requeridos por el FI y MassHealth.
- El FI no puede pagarle hasta que se reciba y se complete toda la documentación requerida.
- MassHealth y el FI no pueden pagarle por trabajar cuando:
  - el beneficiario de la exención esté internado en un centro de atención, como un hospital o un centro de enfermería; o
  - cuando se haya utilizado o sea insuficiente la cantidad de tiempo que autorizó por semana el administrador de casos del beneficiario de la exención.

Usted debe leer, firmar y enviar este acuerdo antes de recibir su sueldo como participante del programa de exención.

Acuerdo de servicios

Al firmar a continuación, acepto lo siguiente:

1. Entiendo que, como asistente de atención directa (DCW) y proveedor de los servicios cubiertos por MassHealth, debo cumplir con los requisitos de elegibilidad del proveedor estipulados en 130 CMR 630.404 y con el alcance de los servicios estipulados en 130 CMR 630.000: *Exención de Servicios Basados en el Hogar y la Comunidad (HCBS)* según corresponda a los servicios de la exención que presto.
2. **Entiendo que mi empleador es el beneficiario de la exención. Mi empleador NO es MassHealth ni el Intermediario Fiscal (FI).** Mi empleador es responsable de contratarme, despedirme, capacitarme y programar mis servicios, y también aplicable a otros DCW. Mi empleador puede elegir a otra persona (un representante) para que lo ayude a administrar sus servicios autodirigidos. Debo notificar a mi empleador y al representante (si lo hubiera) de cualquier cambio en mi situación que afectaría mi capacidad de realizar mis labores como DCW.
3. Entiendo que debo proporcionar comprobantes de mi identidad a mi empleador para completar el formulario de Verificación de Elegibilidad de Empleo (Formulario I-9), que el Departamento de Seguridad Nacional (DHS) requiere que completen todos los empleados. (El FI debe entregar este formulario al empleador.)
4. Entiendo que debo completar y proporcionar Formularios de actividades de la Exención (planillas de horas trabajadas) a mi empleador o al FI lo antes que pueda, incluido mediante el use del sistema de Verificación Electrónica de Visitas (EVV) para la prestación de servicios, tal como lo especifica MassHealth.

5. Entiendo que el FI procesará la nómina en nombre de mi empleador (el beneficiario de la exención). Entiendo que debo inscribirme en depósito directo, pero que también puedo inscribirme en una tarjeta de débito de nómina, a menos que haya solicitado y recibido la aprobación para obtener mi pago con un cheque impreso. Si me pagan con un cheque impreso, reconozco que el FI emitirá un cheque a mi nombre y lo enviará a mi empleador (el beneficiario de la exención).
6. Entiendo que es mi obligación notificar inmediatamente al FI y a mi empleador (el beneficiario de la exención) si hubiera cambios en mi información de contacto, como mi nombre, dirección, correo electrónico, número de teléfono y cualquier otra información. Debo proporcionar inmediatamente mi información de contacto actualizada a mi empleador (el beneficiario de la exención) y al FI cada vez que cambie dicha información.
7. Entiendo que el programa de exenciones de MassHealth paga por los servicios autodirigidos prestados por un asistente de atención directa (DCW) solo cuando el DCW preste servicios a un beneficiario de la exención elegible que haya obtenido la autorización para la exención de parte de su administrador de casos para servicios autodirigidos. Los servicios autodirigidos deben ser prestados de acuerdo con la autorización del beneficiario de la exención, el acuerdo de servicios y el reglamento de MassHealth estipulado en 130 CMR 630.400.
8. Entiendo que mi empleador (el beneficiario de la exención) me dirá qué tareas necesita que le brinde, de acuerdo con la autorización de la exención.
9. Entiendo que no me pueden pagar como DCW si soy el cónyuge, el representante o el familiar legalmente responsable del beneficiario de la exención.
10. Entiendo que se exige que el FI cumpla con todos los requisitos federales y estatales respecto a la retención de impuestos, y que el FI no puede cambiar dichos requisitos. Entiendo que determinadas relaciones entre mi empleador (el beneficiario de la exención) y yo podrían afectar mi estado de exención de impuestos. Entiendo que cualquier estado de exención de impuestos que derive de mi relación con mi empleador es obligatorio, conforme a los correspondientes requisitos impositivos federales y estatales.
11. Entiendo que los DCW que prestan servicios de cuidados personales de exención a los beneficiarios de la exención de Vida en la comunidad del Plan Seguir Adelante (MFP-CL) forman parte de la Unidad de Negociación Colectiva de los Asistentes de Cuidados Personales, representados por el Sindicato de Asistentes de Cuidados Personales.
12. Entiendo que si presto servicios de cuidados personales de exención a los beneficiarios de la exención MFP-CL, debo tomar la Orientación para el Nuevo PCA si no la he completado anteriormente como DCW o PCA, y que recibiré pago por asistir a la Orientación para el Nuevo PCA. Entiendo que si no completo la Orientación para el Nuevo PCA, esto puede afectar mi tarifa de pago por prestar servicios de cuidados personales de exención a los beneficiarios de la exención MFP-CL.

Al prestar servicios de DCW a mi empleador (el beneficiario de la exención), acepto lo siguiente:

13. Si mi empleador tuviera una instrucción anticipada respecto a la prestación de cuidados en caso de que quedara incapacitado, acepto respetar los términos de dicha instrucción anticipada, a menos que, por una cuestión de conciencia, no la pueda poner en práctica. Acepto no condicionar la prestación de cuidados ni discriminar a mi empleador si la persona haya o no puesto en práctica una instrucción anticipada. Entiendo que no se me exige que preste servicios de cuidados que contradigan una instrucción anticipada.

14. Acepto mantener todos los registros que sean necesarios para demostrar el alcance de los servicios que presto a mi empleador (el beneficiario de la exención), entre ellos los formularios de actividades (también llamados “planillas de horas trabajadas”).

15. Acepto proporcionar a la agencia de Medicaid, el Secretario del Departamento de Salud y Servicios Humanos de EE. UU. o la Unidad de Control de Fraude contra Medicaid del Estado, si se me solicita, copia de los registros que estén en mi poder y de toda la información referida a los pagos que reclamé por los servicios de DCW prestados a mi empleador.

Acepto cumplir con los requisitos de divulgación de información estipulados en 42 CFR Parte 455, Subparte B, según lo siguiente:

16. Conforme a 42 CFR 455.104(a)(3), indico, a continuación, otra entidad proveedora de servicios a MassHealth de la cual soy propietario o tengo el control. Una “entidad proveedora de servicios a MassHealth” podría incluir a todo tipo de proveedor inscrito en MassHealth, como una agencia de cuidados a domicilio (HHA), una agencia de cuidado temporal para adultos (AFC) u otro tipo de proveedor. Por favor, complete esta información en las páginas 3 y 4, a continuación.

17. Si MassHealth lo requiriera, acepto brindar información sobre transacciones comerciales de conformidad con 42 CFR 455.105.

18. Conforme al estatuto estatal M.G.L. c.118E, § 36 y a los requisitos federales estipulados en 42 CFR 455.106, al firmar este formulario, declaro que no he sido condenado por delitos penales relacionados con mi participación en ningún programa de Medicare, Medicaid o el programa de servicios del Título XX.

19. Entiendo que determinadas relaciones entre mi empleador (el beneficiario de la exención) y yo podrían afectar mi estado de exención de impuestos. Entiendo que todo estado de exención de impuestos que derive de mi relación con mi empleador es obligatorio, conforme a los correspondientes requisitos impositivos federales y estatales. Entiendo que se exige que el FI cumpla con todos los requisitos federales y estatales respecto a la retención de impuestos, y que el FI no puede cambiar estos requisitos.

Información y declaración del proveedor

Por favor, marque una opción:

La siguiente opción describe mi relación con mi empleador (el beneficiario de la exención). Por favor, marque SOLO una.

- ☐ No estoy relacionado con mi empleador-beneficiario de la exención.
- ☐ Soy el(la) hijo(a) adulto(a) (mayor de 18 años) de mi empleador-beneficiario de la exención.
- ☐ Soy la nuera o el yerno de mi empleador-beneficiario de la exención.
- ☐ Soy el padre o la madre de mi empleador-beneficiario de la exención adulto (mayor de 18 años).
- ☐ Estoy relacionado con mi empleador-beneficiario de la exención de una manera diferente (por favor, explíquelo):

POR FAVOR EXPLIQUELO

Por favor, marque una opción:

Conforme a 42 CFR 455.104(a)(3), indico, a continuación, otra entidad proveedora de servicios a MassHealth de la cual soy propietario o tengo el control. Una "entidad proveedora de servicios a MassHealth" podría incluir a todo tipo de proveedor inscrito en MassHealth, como una agencia de cuidados a domicilio (HHA), una agencia de cuidado temporal para adultos (AFC) u otro tipo de proveedor. Por favor, marque una opción:

- ☐ NO soy el propietario ni tengo el control de otra entidad proveedora de servicios a MassHealth.
- ☐ SÍ soy el propietario o tengo el control de otra entidad proveedora de servicios a MassHealth. La información sobre tal entidad o entidades es la siguiente:

ENTIDAD

Por favor, marque la siguiente casilla para demostrar su entendimiento acerca del requisito de la Orientación para el Nuevo PCA:

- ☐ Entiendo que si presto cuidados personales de exención a los beneficiarios de la exención MFP-CL, debo tomar la Orientación para el Nuevo PCA si no la he completado anteriormente como DCW o PCA, y que recibiré pago por asistir a la Orientación para el Nuevo PCA. Entiendo que si no completo la Orientación para el Nuevo PCA, esto puede afectar mi tarifa de pago.

Por favor, complete la siguiente información y declare:

Certifico bajo pena de perjurio que la información indicada en el presente formulario de firma, como toda otra declaración aquí incluida, ha sido revisada y firmada por mí, y es verdadera, precisa y completa según mi leal saber y entender. Certifico también que entiendo mis deberes, derechos y responsabilidades como DCW y que toda la información que he provisto a mi empleador (el beneficiario de la exención), al intermediario fiscal (FI), a la agencia de coordinación de casos o a MassHealth es verdadera y precisa según mi leal saber y entender. Entiendo que puedo estar sujeto a sanciones civiles o juicios penales por todo tipo de falsificación, omisión o encubrimiento de hechos materiales contenidos en el presente.

Declaro como cierta toda la información anterior y estoy de acuerdo en aceptar el puesto de asistente de atención directa (DCW) para NOMBRE EN LETRA IMPRENTA DEL BENEFICIARIO DE LA EXENCION
(Nombre en letra de imprenta del beneficiario de la exención)

Firma del DCW FIRMA DEL DCW Nombre en letra de imprenta del DCW NOMBER DCW

Correo electrónico del DCW CORREO ELECTRONICO DEL DCW Fecha de la firma FECHA

TEMPUS UNLIMITED, INC.
Opportunities for Independence
formerly Cerebral Palsy of Massachusetts, Inc.

DIRECT DEPOSIT APPLICATION

DCW's Name: DCW Name

Participant #: Paticipant # **Participant's Name:** Participant Name

Account Information

Name on Bank Account: Name on Bank Account

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

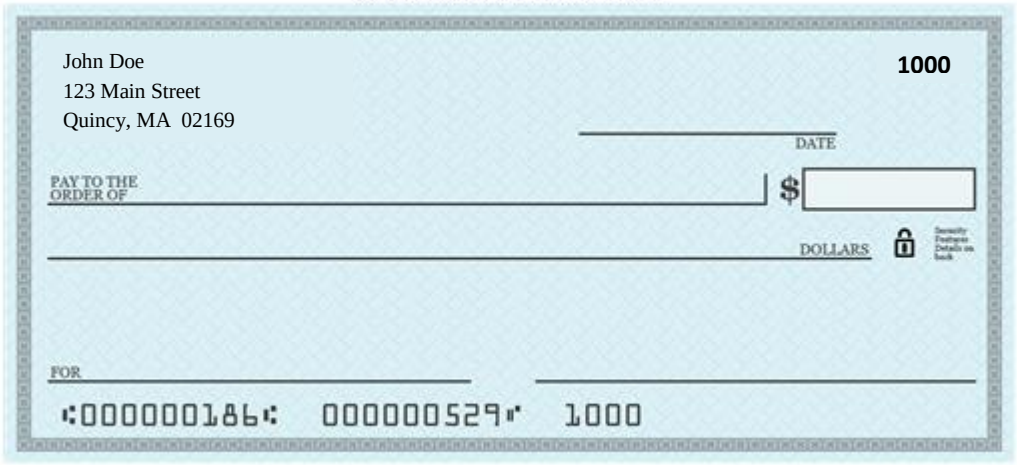
Bank Name: Your Bank Name

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

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

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

ATTACH CHECK HERE:



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.

DCW's Signature: DCW's Signature **Date:** Today's Date

600 Technology Center Drive, Stoughton, MA 02072
Toll-Free Phone #: 1-877-479-7577
www.tempusinc.org
Toll-Free Fax #: 1-800-359-2884

TEMPUS UNLIMITED, INC.
Opportunities for Independence
formerly Cerebral Palsy of Massachusetts, Inc.

APLICACIÓN PARA DEPOSITO DIRECTO

Nombre de DCW: Nombre de DCW

Numero de Partícipe: Numero de Participe **Nombre de Partícipe:** Nombre de Participe

Información de Cuenta

Nombre de persona en la cuenta de Banco: Nombre de persona en la cuenta de Banco

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

Nombre de Banco: Nombre de Banco

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

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

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

ATTACH CHECK HERE:

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

Firma de DCW: Firma de DCW **Fecha:** Feche

U.S. BANK FOCUS CARD

Enrollment Form

us bank

SAMPLE

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

First Name: PCA / WORKER FIRST NAME

Last Name: PCA / WORKER LAST NAME

Address: PCA / WORKER ADDRESS

City: CITY State: STATE Zip Code: Zip Code

Phone Number[1]: PCA / Worker Phone Number

Social Security Number: Date of Birth:

Email Address[2]: PCA / Worker Email Address

Important Information About Procedures For Opening A New Account

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

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

I acknowledge receipt of the Pre-Acquisition Disclosure, the Fee Schedule, the Cardholder Agreement and Pre-Enrollment Disclosures (for payroll programs if employed in Connecticut, Hawaii, Illinois, Minnesota, New Hampshire, New York, Pennsylvania, or Vermont), as evidenced by my signature below.

Signature: PCA / Worker Signature Date: **TODAY'S DATE**

Information below this line will be used by Tempus Unlimited only.

To assist Tempus Unlimited in processing your pay, please provide information about the individual to whom you provide Services (your "Consumer"):

Consumer Name: CONSUMER NAME

Consumer No.: Consumer #

Consumer Address

Street:

Apt/Suite: Consumer / Employer Apt / Suite

City: City State: State Zip: Zip Code

☐ By Checking this box and signing above, I authorize Tempus Unlimited, Inc. to mail all PCA/Worker Payment Vouchers for this Consumer to my current address on file. This authorization is to remain in full force and effect until Tempus Unlimited, Inc. has received written notice from me of its termination in such time and in such manner as to afford Tempus Unlimited, Inc. reasonable opportunity to act on it.

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

The Focus Card is issued by U.S. Bank National Association pursuant to a license from Visa U.S.A. Inc. ©2026 U.S. Bank. Member FDIC.

TARJETA U.S. BANK FOCUS

Formulario de Inscripción

MUESTRA

Para recibir tus pagos en una Tarjeta U.S. Bank Focus, completa este formulario y e
Tu tarjeta se enviará por correo postal dentro de 7 a 10 días hábiles a la direcc

Nombre: PCA / Trabajador Nombre

Apellido: PCA / Trabajador Apellido

Dirección: PCA / Tranajador Dirección

Ciudad: Ciudad Estado: Estado Código Postal: Código Postal

Número de Teléfono[1]: PCA / Trabajador Número de Seguro Social

Número de Seguro Social: Número de Seguro Social Fecha de Nacimiento: Fecha de Nacimiento

Dirección de Correo Electrónico[2]: Dirección de Correo Electrónico

Información Importante sobre Procedimientos para Abrir una Cuenta Nueva

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

Por la presente, autorizo a Tempus Unlimited a iniciar entradas de crédito (depósitos) y, si es necesario, a iniciar entradas de débito y ajustes por cualquier entrada de crédito errónea en mi Tarjeta Focus. Esta autorización se mantendrá vigente hasta que yo la cancele a través de una notificación por escrito a Tempus Unlimited.

Acuso recibo de la Divulgación Previa a la Adquisición, la Lista de Cargos, el Contrato para Titulares de Tarjetas y las Divulgaciones Previas a la Inscripción (para programas de nómina de empleados en Connecticut, Hawaii, Illinois, Minnesota, New Hampshire, New York, Pennsylvania o Vermont), según lo manifiesta mi firma a continuación.

Firma: PCA / Trabajador Firma Fecha: Fecha

La información debajo de esta línea será para uso exclusivo de Tempus Unlimited.

Para ayudar a Tempus Unlimited a procesar tu pago, provee información acerca del individuo a quien le proporcionas Servicios (tu "Consumidor"):

Nombre del Consumidor: Nombre del Consumidor

Número del Consumidor: Número del Consumidor

Dirección del Consumidor

Calle: Dirección del Consumidor

Apt./Suite: Apto / Suite

Ciudad: Ciudad Estado: Estado Código postal: Código postal

☐ Al marcar esta casilla y firmar arriba, autorizo a Tempus Unlimited, Inc. a enviar por correo todos los recibos de pago de PCA/Trabajador/a para este Consumidor/a a mi dirección actual que esta en archivo. Esta autorización permanecerá en pleno vigor y efecto hasta que Tempus Unlimited, Inc. haya recibido una notificación por escrito de mi parte sobre su rescisión, en el momento y de la manera que le permita a Tempus Unlimited, Inc. tener una oportunidad razonable para actuar al respecto.

Algunos materiales y servicios podrían estar disponibles solamente en inglés.

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

La Tarjeta Focus es emitida por U.S. Bank National Association, de conformidad con una licencia de Visa U.S.A. Inc. ©2026 U.S. Bank. Miembro FDIC.

Electronic Timesheets Agreement

I. About The Electronic Timesheets Module

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

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

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

II. Terms and Conditions

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

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

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

c. The Consumer, his/her Surrogate (i a method of submitting timesheets.

i. Signing this Agreement d of submitting time, such as faxing or mailing,

d. A timesheet may only be submitte ed this Agreement.

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

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

SAMPLE

III. Termination of the Agreement

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

Consumer Printed Name: MARY SMITH Consumer #: 000000

Consumer E-mail: MARYSMITH@YAHOO.COM

Consumer Signature: _____ PARTICIPANT SIGNATURE _____ Date: _____ DATE _____

Surrogate Printed Name: JOHN SMITH

Surrogate E-mail: JOHNSMITH@GMAIL.COM

Surrogate Signature: _____ SURROGATE SIGNATURE _____ Date: _____ DATE _____

PCA/Worker Printed Name: JANE DOE Last 4 digits of SS#: 0000

PCA/Worker E-mail: JANEDOE@YAHOO.COE

PCA/Worker Signature: _____ DCW SIGNATURE _____ Date: _____ DATE _____

Módulo de Nóminas Electrónicas

I. Sobre el Módulo de Nóminas Electrónicas

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

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

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

II. Términos y Condiciones

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

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

b. Tanto el Consumidor y/o el Delegado como el PCA/Trabajador ***acuerdan en mantener una dirección de correo electrónico válida y separada*** durante el periodo de este ac
correo electrónico

c. El Consumidor y s
método de presen
ominas Electrónicas como

i. Firma de
Otros métodos de presentar nóminas, tales como enviar por fax o por correo, todavía son aceptables.

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

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

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

III. Terminación del Acuerdo

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

MUESTRA

Nombre Impreso del Consumidor: MARY SMITH Número de Consumidor #: 000000

E-mail del Consumidor: MARYSMITH@YAHOO.COM

Firma del Consumidor: PARTICIPE FIRMA Fecha: FECHA

Nombre Impreso del Delegado: JOHN SMITH

E-mail del Delegado: JOHNSMITH@GMAIL.COM

Firma del Delegado: FIRMA DEL DELEGADO Fecha: FECHA

Nombre Impreso del PCA/Trabajador: JANE D0E Últimos 4 dígitos del número de SS: 0000

E-mail del PCA/Trabajador: JANEDDE@YAHOO.COM

Firma del PCA/Trabajador: DCW FIRMA Fecha: FECHE