Employer Packet (Forms to Complete)

Tempus Unlimited Fiscal Intermediary

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

- ❑ **Referral Form**: This form is completed by your agency at the time of referral. It provides the FI with your basic information, program details, and contact information for your case manager or skills trainer. Please review for accuracy.
- ❑ **Consumer Agreement**: The Consumer Agreement outlines the roles and responsibilities of the Consumer and the Fiscal Intermediary. The Consumer or Legal Guardian completes and signs this form.
- ❑ **SS-4 Application for Employer Identification Number (EIN)**: Each consumer is an employer in the FI program. You will need an Employer Identification Number (EIN) for Tempus FI to report tax withholding and other information to the Internal Revenue Service. This form is required by the Federal Government. The Consumer, Legal Guardian or POA completes and signs this form.
- ❑ **Form TA-1 Application for Original Registration**: This application is like the SS-4 above; however, it is required by the State of Massachusetts. The Consumer, Legal Guardian or POA completes and signs this form.
- ❑ **8821 Tax Information Authorization**: This form grants permission to Tempus FI to inspect and receive information about the tax forms indicated on line 3(b) and for the tax periods indicated on line 3(c) on form 8821. The Consumer, Legal Guardian or POA completes and signs this form.
- ❑ **2678 Employer Appointment of Agent**: This form grants permission to Tempus FI to file the appropriate forms and make tax payments to the Internal Revenue Service (IRS) as an agent of the Consumer. The Consumer, Legal Guardian or POA completes and signs this form.
- ❑ **M-2848 Power of Attorney and Declaration of Representative**: This form grants permission to Tempus FI to file the following forms on your behalf: The State Income Tax withholding and the TA-1 Application.
- ❑ **Consent to the Use and Disclosure of Protected Health Information**: By completing and signing this form, the Consumer acknowledges consent/non consent regarding the release of PHI and permission to leave detailed voicemails on home/cell phone. The Consumer, Surrogate or Legal Guardian completes and signs this form.

Please complete and return these forms as soon as possible. Once we have received your completed FI forms **and you receive a prior approval informing you of the number of hours you are authorized to use per week**, Tempus FI will mail a Welcome Packet including our FI Operations Handbook and forms for your Personal Care Attendants (PCAs) to complete their onboarding.

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

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

Consumer Referral (Completed by Agency)

Tempus Unlimited Fiscal Intermediary

Please complete with the Consumer, including all required information. Missing fields may cause a delay in processing.

Referral Date*	Tempus Consumer No

Consumer Information

Consumer First Name*	Consumer Middle Name	Consumer Last Name*	Gender*	Date of Birth*	SSN*

Consumer Email Address*	

Consumer Home Address* ***(P.O. Box is not acceptable)***

Street Address*					
Bldg/Unit/Apt					
City*		State*		Zip Code*	
Is the Consumer's mailing address the same as Consumer's home address?*				☐ Yes	☐ No

Consumer Mailing Address ***(P.O. Box is acceptable)***

Street Address*					
Bldg/Unit/Apt					
City*		State*		Zip Code*	

Consumer Primary Phone Type*		Cell Phone	Home Phone	Primary Language*
☐ Cell Phone	☐ Home Phone			

Has the Consumer previously received PCA services, or owned a business?*	☐ Yes	☐ No	If Yes, EIN:________________________

Is the Consumer a Minor?*	☐ Yes	☐ No

Parent(s) of Minor Child *(if applicable)*			
Name:		Relationship:	
Name:		Relationship:	

Does the Consumer have a Surrogate or Administrative Proxy (AP)?*	☐ Surrogate	☐ AP	☐ N/A
Tempus FI should mail the Consumer Welcome Package to:*	☐ Consumer	☐ Surrogate/AP	

Surrogate/Administrative Proxy (AP) Information *(if applicable)*

First Name	Last Name	Date of Birth	Relationship to Consumer	Phone Number	Phone Type
Surrogate/AP Email*					
Surrogate or Administrative Proxy's Address					
Street Address*					
Bldg/Unit/Apt					
City*		State*		Zip Code*	

Program/Payor Information

Program*	MassHealth ID	SCO/One Care/ PACE Plan	SCO/One Care/ PACE ID	SIMS ID (CDC)	Veterans ID (VDC)

Agency Information

Agency* *PCM/ASAP/MassAbility/DDS*	Skills Trainer/Case Manager's Name*	Skills Trainer/Case Manager's Email*
Phone Number*	Extension	Fax

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

Verify Form is Complete

Consumer Agreement for Personal Care Attendant Program (PCA) Fiscal Intermediary (FI) Services

MassHealth
THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

By signing this document, I acknowledge that I am a consumer of MassHealth-approved Personal Care Attendant Services (PCA Services) and understand that:

1. I am the employer of my PCA(s) and must hire my own PCA.
2. I may conduct a CORI and/or a SORI background check for my PCAs, and such requests will be processed by the fiscal intermediary (FI) on my behalf if I choose to do so.
3. My PCA must be at least sixteen (16) years of age.
4. MassHealth and the FI cannot pay my PCA if my PCA is on the List of Excluded Individuals and Entities (LEIE) maintained by the U.S. Department of Health and Human Services Office of Inspector General (OIG) or the MassHealth List of Suspended/Excluded Providers. The FI or my PCM agency can provide me with more information about this.
5. Wages paid to my PCA are established through a collective bargaining agreement (CBA) between the SEIU Local 1199 (the Union), which represents PCAs, and the PCA Quality Home Care Workforce Council (the Council), which represents PCA Consumers.
6. I must complete and submit all required new hire paperwork forms before hiring a PCA. I acknowledge that a PCA will not be paid by MassHealth or the FI before new hire paperwork is processed and the PCA is issued a Unique Identification Number (UID). I also understand that the FI will not be able to pay my PCA if the paperwork is not completed and submitted to the FI in accordance with the FI's instructions.
7. All PCAs must be eligible to work in the United States in accordance with federal law and I delegate my responsibility as the PCA employer to the FI, Tempus Unlimited, Inc., to sign the *E-Verify Memorandum of Understanding for Employers Using an E-Verify Employer Agent* on my behalf. I understand that Tempus will use E-Verify to electronically confirm my PCA's eligibility to work in the United States. I understand that MassHealth and the FI will not pay my PCA if my PCA is not authorized to work in the United States.
8. I am required to use Electronic Visit Verification (EVV) to review and approve my PCA's timesheet unless I have received an approved exemption.
9. I delegate my authority as the PCA employer to the FI to perform certain employer-required tasks on my behalf, as detailed below:
   - receive and process my PCA's activity forms or punches submitted using EVV;
   - deposit my PCA's paychecks directly into my PCA's bank account or to a debit card;
   - prepare and mail paper checks to me every two weeks for me to distribute to my PCA if my PCA has obtained a waiver of the direct deposit requirement;
   - make correct withholdings from my PCA's paychecks;
   - make deductions for PCA union dues and fees, in accordance with the CBA between the Council and the Union, and send these monies to the Union;
   - pay my federal, state, and local employment taxes on my behalf;
   - send all money withheld from my PCA's paychecks to the appropriate agencies;
   - pay my unemployment insurance taxes on my behalf;
   - purchase workers' compensation insurance in my name to cover my PCAs;
   - perform other employer-required tasks such as obtaining an employer identification number (EIN) and filling out, filing, and saving copies of other required employment forms;
   - send me summaries of my payrolls, and my tax filings; and
   - send me summaries (payroll cover sheets) that describe the number of PCA hours MassHealth authorized for me, the number of PCA hours I have used, and the number of PCA hours I have remaining on my prior authorization (PA). I understand that I can share this information with my PCA, so that my PCA and I know if

there are sufficient hours left on my PA to have my PCA work and get paid.

10. The FI will perform certain employer-required tasks on my behalf, **but I am responsible for**:
    - notifying the FI when I hire a new PCA
    - notifying the FI if I move or if I know my PCA has moved
    - submitting a Termination Form to the FI when a PCA no longer works for me;
    - maintaining updated contact information for my PCA and informing the FI of any changes;
    - notifying the FI and my PCM agency when I am admitted to a nursing facility or other inpatient facility. I understand that MassHealth and the FI cannot pay for activity time performed by my PCA when I am in a nursing facility or other inpatient facility. I also understand that any payments made to my PCA for hours worked while I was in a nursing facility or inpatient facility are considered fraud and will be reported to the state Bureau of Special Investigations (BSI) for investigation, and may result in sanctions including termination of my PCA services;
    - informing my PCA that they will receive their payment electronically through direct deposit to their bank account or through a payroll debit card service offered by the FI. The FI will provide the forms needed for my PCA to request payment electronically;
    - informing my PCA that they may not share a bank account with me, my Surrogate, or my Administrative Proxy (AP);
    - ensuring my PCAs are aware of the federal requirement to use EVV for timesheet submission (unless approved for an EVV exemption) and that my PCA correctly completes, signs, and submits their EVV punches daily, or their activity forms (time sheets) bi-weekly that accurately reflect the days and hours my PCA worked for me;
    - approving my PCA's EVV punches or completed activity forms, and submitting to the FI each week, following the FI's instructions and in the timeframe required;
    - following the MassHealth regulations for the PCA Program. My PCM agency can provide me with a copy of these regulations.
11. I must have prior authorization (PA) for MassHealth PCA services and have sufficient units left on my PA before a PCA can be paid. I understand that I will be responsible for paying my PCA if I do not have prior authorization from MassHealth or if I do not have sufficient units left on my PA on the days my PCA worked.
12. I must adhere to the MassHealth PCA Program overtime rules as outlined in 130 CMR 422.418(A)and the maximum weekly hour limit rules as outlined in 130 CMR 422.413(K) and will not schedule my PCA to work more than the maximum weekly hour limit hours in total per week, including hours they work for other Consumers. I will contact my PCM to request an authorization if I need my PCA to work over 50 hours but no more than the maximum weekly hours allowed each week. I understand that if I violate this policy MassHealth and the FI are not responsible for paying my PCAs, and I will be responsible for paying PCAs from my own funds.
13. I may lose my eligibility for PCA services if I do not complete and return the required paperwork to the FI as instructed.
14. I must sign certain forms that will allow the FI to act on my behalf. I understand that my PCA cannot be paid until the forms, including the Consumer Agreement, are completed and returned to the FI. The FI will send me these forms.

Consumer Signature	Consumer Printed Name	Consumer ID	Date

Legal Guardian Signature	Legal Guardian Printed Name	Date

Acuerdo del Consumidor para los Servicios de Intermediario Fiscal (FI) en el Programa de Asistente de Cuidados Personales (PCA)

MassHealth
THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

Al firmar este documento, reconozco que soy consumidor(a) de los servicios de Asistente de Cuidados Personales (PCA) que MassHealth ha aprobado y entiendo que:

1. Soy el(la) empleador(a) de mis PCA y debo contratar a mis propios PCA.
2. Puedo realizar una verificación de antecedentes CORI o SORI de mis PCA y dichas solicitudes serán procesadas por el intermediario fiscal (FI) en mi nombre si yo así lo decido.
3. Mi PCA debe tener por lo menos dieciséis (16) años de edad.
4. MassHealth y el FI no pueden pagarle a mi PCA si mi PCA se encuentra en la Lista de Personas y Entidades Excluidas (LEIE) que mantiene la Oficina del Inspector General (OIG) del Departamento de Salud y Servicios Humanos (HHS) de EE. UU. o en la Lista de Proveedores Suspendidos o Excluidos de MassHealth. El FI o mi agencia de PCM pueden brindarme más información sobre esto.
5. Los salarios que se le paguen a mi PCA se establecen mediante un contrato colectivo de trabajo (CBA) entre el SEIU Local 1199 (el Sindicato), que representa a los PCA, y el Consejo para la Calidad de la Fuerza Laboral de Asistencia en el Hogar de PCA (el Consejo), que representa a los Consumidores de PCA.
6. Antes de contratar un PCA, debo completar y entregar todos los formularios para la contratación de nuevos empleados que correspondan. Reconozco que ni MassHealth ni el FI le pagarán a un PCA antes de que la documentación para la contratación de nuevos empleados sea procesada y de que al PCA se le otorgue un Número Único de Identificación (UID). También entiendo que el FI no podrá pagarle a mi PCA si yo no he completado la documentación y no se la he entregado de acuerdo con sus instrucciones.
7. Todos los PCA deben ser elegibles para trabajar en Estados Unidos conforme a la ley federal y yo, como empleador(a) del PCA, delego mi obligación en el FI, Tempus Unlimited, Inc., para que firme, en mi nombre, el *Memorando de Entendimiento de E-Verify para Empleadores que Utilizan un Agente Empleador de E-Verify*. Entiendo que Tempus utilizará E-Verify para confirmar electrónicamente la elegibilidad de mi PCA para trabajar en Estados Unidos. Entiendo que ni MassHealth ni el FI le pagarán a mi PCA si mi PCA no está autorizado a trabajar en Estados Unidos.
8. Es mi obligación utilizar la Verificación Electrónica de Visitas (EVV) para revisar y aprobar la planilla de horas trabajadas de mi PCA, a menos que haya recibido una exención aprobada.
9. Como empleador(a) del PCA, delego mi autoridad en el FI para que realice, en mi nombre, determinadas tareas obligatorias de los empleadores, según el siguiente detalle:
    - recibir y procesar los formularios de actividades de mi PCA o las presentaciones entregadas utilizando la EVV;
    - depositar los cheques de pago de mi PCA directamente en la cuenta bancaria o en una tarjeta de débito de mi PCA;
    - preparar cheques impresos y enviármelos por correo postal cada dos semanas para que yo se los entregue a mi PCA, si mi PCA ha obtenido una exención del requisito de depósito directo;
    - hacer las retenciones exactas de los cheques de pago de mis PCA;
    - hacer las deducciones por cuotas y tarifas del sindicato del PCA de conformidad con el CBA entre el Consejo y el Sindicato, y enviar esas cantidades de dinero al Sindicato;
    - pagar en mi nombre mis impuestos federales, estatales y locales como empleador(a);
    - enviar a las agencias correspondientes todo el dinero retenido de los cheques de pago de mis PCA;
    - pagar en mi nombre mis impuestos del seguro de desempleo;

Acuerdo del Consumidor para los Servicios de Intermediario Fiscal (FI) en el Programa de Asistente de Cuidados Personales (PCA)

MassHealth
THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

Al firmar este documento, reconozco que soy consumidor(a) de los servicios de Asistente de Cuidados Personales (PCA) que MassHealth ha aprobado y entiendo que:

1. Soy el(la) empleador(a) de mis PCA y debo contratar a mis propios PCA.
2. Puedo realizar una verificación de antecedentes CORI o SORI de mis PCA y dichas solicitudes serán procesadas por el intermediario fiscal (FI) en mi nombre si yo así lo decido.
3. Mi PCA debe tener por lo menos dieciséis (16) años de edad.
4. MassHealth y el FI no pueden pagarle a mi PCA si mi PCA se encuentra en la Lista de Personas y Entidades Excluidas (LEIE) que mantiene la Oficina del Inspector General (OIG) del Departamento de Salud y Servicios Humanos (HHS) de EE. UU. o en la Lista de Proveedores Suspendidos o Excluidos de MassHealth. El FI o mi agencia de PCM pueden brindarme más información sobre esto.
5. Los salarios que se le paguen a mi PCA se establecen mediante un contrato colectivo de trabajo (CBA) entre el SEIU Local 1199 (el Sindicato), que representa a los PCA, y el Consejo para la Calidad de la Fuerza Laboral de Asistencia en el Hogar de PCA (el Consejo), que representa a los Consumidores de PCA.
6. Antes de contratar un PCA, debo completar y entregar todos los formularios para la contratación de nuevos empleados que correspondan. Reconozco que ni MassHealth ni el FI le pagarán a un PCA antes de que la documentación para la contratación de nuevos empleados sea procesada y de que al PCA se le otorgue un Número Único de Identificación (UID). También entiendo que el FI no podrá pagarle a mi PCA si yo no he completado la documentación y no se la he entregado de acuerdo con sus instrucciones.
7. Todos los PCA deben ser elegibles para trabajar en Estados Unidos conforme a la ley federal y yo, como empleador(a) del PCA, delego mi obligación en el FI, Tempus Unlimited, Inc., para que firme, en mi nombre, el *Memorando de Entendimiento de E-Verify para Empleadores que Utilizan un Agente Empleador de E-Verify*. Entiendo que Tempus utilizará E-Verify para confirmar electrónicamente la elegibilidad de mi PCA para trabajar en Estados Unidos. Entiendo que ni MassHealth ni el FI le pagarán a mi PCA si mi PCA no está autorizado a trabajar en Estados Unidos.
8. Es mi obligación utilizar la Verificación Electrónica de Visitas (EVV) para revisar y aprobar la planilla de horas trabajadas de mi PCA, a menos que haya recibido una exención aprobada.
9. Como empleador(a) del PCA, delego mi autoridad en el FI para que realice, en mi nombre, determinadas tareas obligatorias de los empleadores, según el siguiente detalle:
   - recibir y procesar los formularios de actividades de mi PCA o las presentaciones entregadas utilizando la EVV;
   - depositar los cheques de pago de mi PCA directamente en la cuenta bancaria o en una tarjeta de débito de mi PCA;
   - preparar cheques impresos y enviármelos por correo postal cada dos semanas para que yo se los entregue a mi PCA, si mi PCA ha obtenido una exención del requisito de depósito directo;
   - hacer las retenciones exactas de los cheques de pago de mis PCA;
   - hacer las deducciones por cuotas y tarifas del sindicato del PCA de conformidad con el CBA entre el Consejo y el Sindicato, y enviar esas cantidades de dinero al Sindicato;
   - pagar en mi nombre mis impuestos federales, estatales y locales como empleador(a);
   - enviar a las agencias correspondientes todo el dinero retenido de los cheques de pago de mis PCA;
   - pagar en mi nombre mis impuestos del seguro de desempleo;

- adquirir en mi nombre el seguro de compensación por riesgo laboral (*workers' compensation*) para cubrir a mis PCA;
- realizar otras tareas obligatorias de los empleadores, tales como obtener un número de identificación del empleador (EIN) y completar, presentar y guardar copias de los demás formularios de empleo requeridos;
- enviarme resúmenes de mis nóminas y mis presentaciones de impuestos, y
- enviarme resúmenes (portadas de la nómina) que describan la cantidad de horas de servicio de PCA que MassHealth me ha autorizado, la cantidad de horas de servicio de PCA que he utilizado y la cantidad de horas de servicio de PCA que todavía me quedan en mi autorización previa (PA). Entiendo que puedo compartir esta información con mi PCA, de modo que ambos sepamos si quedan horas suficientes en mi PA para que mi PCA trabaje y cobre.

10. El FI realizará en mi nombre determinadas tareas obligatorias de los empleadores, **pero es mi obligación:**
    - notificarle al FI cuando yo contrate a un PCA nuevo;
    - notificarle al FI si me mudo o si sé que mi PCA se ha mudado;
    - entregarle al FI un Formulario de Terminación de la Relación Laboral cuando un PCA deje de trabajar para mí;
    - mantener actualizados los datos de contratación de mi PCA e informarle al FI cualquier cambio que se produzca;
    - notificarles al FI y a mi agencia de PCM cuando sea yo admitido(a) en un centro de enfermería u otro centro hospitalario. Entiendo que ni MassHealth ni el FI pueden pagarle a mi PCA ningún tiempo de desempeño de actividades mientras yo permanezca en un centro de enfermería u otro centro hospitalario. Entiendo también que todo pago efectuado a mi PCA por horas trabajadas durante mi permanencia en un centro de enfermería o centro hospitalario será considerado fraude e informado a la Agencia de Investigaciones Especiales (BSI) estatal para que lo investigue, y que de su resultado pueden derivar sanciones incluida la cancelación de mis servicios de PCA;
    - informarle a mi PCA que recibirá sus pagos de manera electrónica mediante depósito directo en su cuenta bancaria o mediante un servicio de tarjeta de débito de nómina ofrecido por el FI. El FI proporcionará los formularios necesarios para que mi PCA solicite los pagos de manera electrónica;
    - informarle a mi PCA que no puede compartir una cuenta bancaria conmigo, con mi Representante ni con mi Apoderado administrativo (AP);
    - asegurarme de que mi PCA conozca el requisito federal de utilizar la EVV para entregar planillas (a menos que le hayan aprobado una exención de EVV) y que mi PCA complete correctamente, firme y entregue su presentación de EVV a diario o su formulario de actividades (planilla de horas trabajadas) cada dos semanas, donde se reflejen con exactitud los días y las horas que mi PCA trabajó para mí;
    - aprobar las presentaciones a la EVV o los formularios de actividades completos de mi PCA y entregárselos al FI cada semana siguiendo sus instrucciones y en los plazos establecidos;
    - cumplir con el reglamento de MassHealth para el Programa de PCA. Mi agencia de PCM puede proveerme con una copia de este reglamento.
11. Antes de que un PCA pueda cobrar, debo tener una autorización previa (PA) de servicios de PCA de MassHealth y tener unidades suficientes en mi PA. Entiendo que seré responsable de pagarle a mi PCA si no tengo la autorización previa de MassHealth o si no tengo unidades suficientes en mi PA en los días que mi PCA trabajó.
12. Debo cumplir con los requisitos sobre horas extras de los PCA de MassHealth según lo estipulado en 130 CMR 422.418(A), y con las normas sobre el límite máximo de horas semanales según lo estipulado en 130 CMR 422.413(K), y no programaré a mi PCA para que trabaje más del límite máximo de horas semanales incluidas las horas que trabaje para otros consumidores. Me comunicaré con mi agencia de PCM para solicitar una autorización si necesito que mi PCA trabaje más de 50 horas, pero no mas del máximo límite de horas semanales. Entiendo que, si no cumplo con esta norma, MassHealth y el FI no serán responsables de pagarle a mi PCA y que seré yo el(la) responsable de pagarle de mis propios fondos.
13. Puedo perder mi elegibilidad para recibir servicios de PCA si no completo la documentación requerida y se la envío al FI conforme a lo indicado.

14. Debo firmar determinados formularios que le permitirán al FI actuar en mi nombre. Entiendo que mi PCA no podrá cobrar hasta que los formularios, incluido el Acuerdo del Consumidor, se completen y se envíen al FI. El FI me enviará estos formularios.

Firma del Consumidor	Nombre del Consumidor en letra de imprenta	ID del Consumidor	Fecha

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Firma del Tutor legal	Nombre del Tutor legal en letra de imprenta	Fecha

Form **SS-4**
(Rev. December 2025)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)
See separate instructions for each line. Keep a copy for your records.
Go to *www.irs.gov/FormSS4* for instructions and the latest information.

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested

2 Trade name of business (if different from name on line 1)
3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)
5a Street address (if different) (Don't enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)
5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party
7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? . . . . ☐ Yes ☐ No
8b If 8a is "Yes," enter the number of LLC members . . . .

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

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

- ☐ Sole proprietor (SSN) ____________
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ____________
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ____________
- ☐ Other (specify)
- ☐ Estate (SSN of decedent) ____________
- ☐ Plan administrator (TIN) ____________
- ☐ Trust (TIN of grantor) ____________
- ☐ Military/National Guard
- ☐ State/local government
- ☐ Farmers' cooperative
- ☐ Federal government
- ☐ REMIC
- ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any

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

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

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

11 Date business started or acquired (month, day, year). See instructions.
12 Closing month of accounting year

13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.

Agricultural	Household	Other

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability will generally be $1,000 or less if you expect to pay $5,000 or less, $6,536 or less if you're in a U.S. territory, in total wages.) If you don't check this box, you must file Form 941 for every quarter . . . . ☐

15 First date wages or annuities were paid (month, day, year). **Note:** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) . . . .

16 Check **one** box that best describes the principal activity of your business.

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

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

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

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name | Designee's telephone number (include area code)

Address and ZIP code | Designee's fax number (include area code)

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.
Applicant's telephone number (include area code)

Name and title (type or print clearly)

Applicant's fax number (include area code)

Signature | Date

See below to determine whether you need an EIN. However, for further information on applying for an EIN, including how to submit an EIN application, see the separate instructions at www.irs.gov/FormSS4.

Do I Need an EIN?

File Form SS-4 if the applicant entity doesn't already have an EIN but is required to show an EIN on any return, statement, or other document.[1] See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
started a new business	doesn't currently have (nor expect to have) employees	complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–14, and 16–18.
hired (or will hire) employees, including household employees	doesn't already have an EIN	complete lines 1, 2, 4a–6, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–18.
opened a bank account	needs an EIN for banking purposes only	complete lines 1–5b, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
changed type of organization	either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership)[2]	complete lines 1–18 (as applicable).
purchased a going business[3]	doesn't already have an EIN	complete lines 1–18 (as applicable).
created a trust	the trust is other than a grantor trust or an IRA trust[4]	complete lines 1–18 (as applicable).
created a pension plan as a plan administrator[5]	needs an EIN for reporting purposes	complete lines 1, 3, 4a–5b, 7a–b, 9a, 10, and 18.
is a foreign person needing an EIN to comply with IRS withholding regulations	needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits[6]	complete lines 1–5b, 7a–b (SSN or ITIN as applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
is administering an estate	needs an EIN to report estate income on Form 1041	complete lines 1–7b, 9a, 10–12, 13–17 (if applicable), and 18.
is a withholding agent for taxes on nonwage income paid to an alien (that is, individual, corporation, or partnership, etc.)	is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	complete lines 1, 2, 3 (if applicable), 4a–5b, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
is a state or local agency	serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581[7]	complete lines 1, 2, 4a–5b, 7a–b, 9a, 10, and 18.
is a single-member LLC (or similar single-member entity)	needs an EIN to file Form 8832, Entity Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes[8], or is a foreign-owned U.S. disregarded entity and needs an EIN to file Form 5472, Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business	complete lines 1–18 (as applicable).
is an S corporation	needs an EIN to file Form 2553, Election by a Small Business Corporation[9]	complete lines 1–18 (as applicable).

1 For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity doesn't have employees.

2 However, don't apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

3 Don't use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

4 However, grantor trusts that don't file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

5 A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

6 Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

7 See also *Household employer agent* in the instructions. **Note:** State or local agencies may need an EIN for other reasons, for example, hired employees.

8 See *Disregarded entities* in the instructions for details on completing Form SS-4 for an LLC.

9 An existing corporation that is electing or revoking S corporation status should use its previously assigned EIN.

Rev. 12/02

Massachusetts Department of Revenue

Form TA-1
Application for Original Registration

Check As Many As Apply

1. A 1. ☐ Employer under the Income Tax Withholding Law (payroll tax)
2. ☐ Withholding for Pension Plans, Annuities and Retirement Distributions

B 1. ☐ Sales/Use Tax on Goods Vendor
2. ☐ Sales/Use Tax on Telecommunications Services Vendor
3. ☐ Meals Tax on Food and All Beverages
4. ☐ Purchasing in MA for Out-of-State Resale Only

C ☐ Room Occupancy Excise

D ☐ Governmental or Charitable Exempt Purchaser
E ☐ Chapter 180 Organization Selling Alcoholic Beverages
F ☐ Use Tax Purchaser
G ☐ Boston Sightseeing Tour Surcharge
H ☐ Boston Vehicular Rental Transaction Surcharge
I ☐ Parking Facilities Surcharge in Boston, Springfield and/or Worcester
J ☐ Cigar and Smoking Tobacco Excise

Note: If you are selling cigarettes at retail, see instructions.

2. Federal Identification number

3. Social Security number

4. No. of locations

Principal Place of Business

5. Owner, partnership or legal corporate name

Name (cont'd.)

6. Number and street

7. City or town

8. State

9. Zip —

10. (Area code) Telephone number ( ) —

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

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

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

13. Describe nature of business: ______

14. Business activity code

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

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

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

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

Federal Identification number

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

Federal Identification number

Close date: Mo Day Yr

Background Information

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

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

Exempt Organizations

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

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

Location of business

Federal Identification number ______

22. Trade name

Trade name (cont'd.)

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

24. City or town

25. State

26. Zip —

27. (Area code) Telephone number ( ) —

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

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

Convention Center Financing District

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

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

Filing Frequencies

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

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

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

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

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

Tax Type Information

Withholding

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

35. Number of employees in Massachusetts:

Sales/Use Tax on Goods

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

Sales/Use Tax on Telecommunications Services

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

Meals Tax on Food and All Beverages

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

39. Check if food/beverage vending machine: ☐

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

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

42. Seating capacity:

Room Occupancy

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

44. Locality code

45. Number of rooms:

Use Tax Purchaser

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

Convention Center Financing Surcharges

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

b. Boston Vehicular Rental Transaction Surcharge. Mo Day Yr

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

Cigar and Smoking Tobacco Excise

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

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

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

Your signature	Title	Date

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

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

OMB No. 1545-1165

For IRS Use Only
Received by:
Name
Telephone
Function
Date

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

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number	Plan number (if applicable)

2 Designee(s). If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached ▶** ☐

Name and address	CAF No. PTIN Telephone No. Fax No.
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. PTIN Telephone No. Fax No.
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax information. Each designee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

☐ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters

4 Specific use not recorded on the Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip line 5 . . . . . . ▶ ☐

5 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain . . . . ▶ ☐

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

6 Taxpayer signature. If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ IF NOT COMPLETED, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.

▶ DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

Signature | Date

Print Name | Title (if applicable)

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

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

OMB No. 1545-0029

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

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

Note: This appointment isn't effective until we approve your request. See the instructions for more information.

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

For IRS use:

Part 1: Why you're filing this form.

(Check one)

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

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

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

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

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

3 Trade name (if any)

4 Address

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. *(Check all that apply.)*

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series)	☐	☐
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	☐	☐
Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)	☐	☐
Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)	☐	☐
Form 945, Annual Return of Withheld Federal Income Tax	☐	☐
Form CT-1, Employer's Annual Railroad Retirement Tax Return	☐	☐
Form CT-2, Employee Representative's Quarterly Railroad Tax Return	☐	☐

* Generally, you can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

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

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

Sign your name here

Print your name here

Print your title here

Date

Best daytime phone

Now give this form to the agent to complete.

Part 3: Agent Information: If you'll be an agent for an employer or payer, or want to revoke an appointment, complete this part.

6 Agent's employer identification number (EIN) ☐☐ – ☐☐☐☐☐☐☐

7 Agent's name (not trade name)

8 Trade name (if any)

9 Address

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

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

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

Sign your name here

Print your name here

Print your title here

Date

Best daytime phone

Massachusetts Department of Revenue

Form M-2848

Power of Attorney and Declaration of Representative

Part 1. Power of Attorney

Name of taxpayer(s) or principal reporting corporation	Social Security number(s)
Mailing address	Federal Identification number
City/Town	State Zip
Phone number	Email address

Representative Information

Hereby appoint(s) the following individual(s) as attorney(s)-in-fact to represent the taxpayer(s) before any office of the Massachusetts Department of Revenue for the following tax type(s) and filing period(s) [specify the tax type(s) and year(s) or filing period(s) (date of death if estate tax)]:

Name of individual and firm	Address	Email address/phone number

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

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

Tax type(s)	Filing period(s)

The representative is authorized, subject to any limitations set forth below or to revocation, to receive confidential information and to perform any and all acts that the principal(s) can perform with respect to the above specified tax matters, such as the authority to sign any agreements, consents or other documents. The authority does not include the power to receive refund checks.

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

Originals of notices and other written communications go to the taxpayer(s). Send copies of all notices and all other written communications addressed to the taxpayer(s) in proceedings involving the above tax matters to:

1 ☐ Appointee first named above, or

2 ☐ Another appointee designated above. Name ______________________________

This power of attorney revokes all earlier powers of attorney on file with the Department of Revenue for the same tax matters and years or periods covered by this power of attorney, except the following (specify to whom granted, date and address including Zip code or attach copies of earlier powers):

Signature of taxpayer(s) or authorized individual of principal reporting entity. See instructions. If signed by a corporate officer, partner, or fiduciary on behalf of the taxpayer, I certify that I have the authority to execute this power of attorney on behalf of the taxpayer and/or principal reporting entity.

Signature (see instructions)	Title (if applicable)	Date

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

Signature (see instructions)	Title (if applicable)	Date

Part 2. Declaration of Representative. All representatives must complete this section.

I declare that I am not currently under suspension or disbarment from practice within the Commonwealth or in any jurisdiction, that I am aware of regulations governing the practice of attorneys, certified public accountants, public accountants, enrolled agents and others, and that I am one of the following:

1 a member in good standing of the bar of the highest court of the jurisdiction shown below;

2 duly qualified to practice as a certified public accountant or public accountant in the jurisdiction shown below;

3 enrolled as an agent under the requirements of Treasury Department Circular No. 230;

4 a bona fide officer of the taxpayer organization or principal reporting corporation;

5 a full-time employee of the taxpayer;

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

7 a fiduciary for the taxpayer;

8 other (describe relationship) ______________________________

and that I am authorized to represent the taxpayer identified in Part 1 for the tax matters specified there.

Designation (insert appropriate number from above list)	**Jurisdiction** (state, etc.) or enrollment card number	**Signature** (see instructions)	**Print name**	**Date**

Form M-2848 Instructions

General Information

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

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

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

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

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

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

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

How to Complete Form M-2848

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important Note Regarding Electronic Signatures and Filing

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

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

Part 2. Declaration of Representative

Your representative must complete Part 2.

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

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

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

Consent to the Use and Disclosure of Protected Health Information (PHI) And Personally Identifiable Information (PII)

Tempus Unlimited Fiscal Intermediary

I hereby give my consent for Tempus Unlimited, Inc. to use and disclose Protected Health Information (PHI) and Personally Identifiable Information (PII) on my behalf to enable billing and reimbursement for services provided by the Tempus Unlimited Fiscal Intermediary program.

I understand that Tempus Unlimited, Inc. staff may have access to PHI and PII and may use this information to either approve or deny timesheets and/or to submit billing for reimbursement, process payroll, and support program operations. Types of PHI and PII that we may share could be a MassHealth ID, other payer Insurance IDs, admit and discharge paperwork for inpatient stays, and information of your stay at a long term care facility. We only use this information to provide documentation to MassHealth and other payers for reimbursement for FI services. We also use this information to ensure that timesheets are not submitted fraudulently and that we are billing MassHealth for actual work done by PCA or worker that you have authorized. We also use this information for staff training and for conducting quality assurance (monitoring the need, appropriateness, and quality of services provided).

I have been given a Notice of Privacy Practices that fully explains the uses and disclosures of PHI and PII that Tempus Unlimited, Inc. will make with my Protected Health Information (PHI).

I understand that I do not have to consent to the use or disclosure of my Protected Health Information for payment, and health care operations, but that if I do not consent, Tempus Unlimited, Inc. may refuse to provide me Fiscal Intermediary services unless applicable state or federal law requires Tempus Unlimited, Inc. to provide such services. If Tempus Unlimited, Inc. does agree to my requested restrictions, it is bound by this agreement.

I understand that Tempus Unlimited, Inc. may disclose my PHI and/or PII without authorization when required or permitted by law, including court orders, subpoenas, or government agency requests.

The following person(s) have my consent regarding my protected health information. **You have my permission** to release information to them, or **I am adding the access** of the following persons:			
Name:		**Relationship:**	
Name:		**Relationship:**	

I understand that I have the right to object to the use and/or disclosure of my Protected Health Information to family members.

You do not have my permission to release information to them, or **I am revoking the access** of the following persons:			
Name:		**Relationship:**	
Name:		**Relationship:**	

Password: I would like to have a password added to my account. Information will not be disclosed over the phone unless the following password is used:

Password:		**Effective Date:**	

Permission to leave detailed voicemails on my home or cell phone voicemail:	
☐ Yes, you have my permission	☐ No, you do not have my permission

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Tempus Unlimited, Inc. has already taken action based on my earlier consent. **This consent will be in effect, if not revoked, until one month after the termination date of your Program.**

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Consumer/Surrogate/Legal Guardian Signature **Printed Name** **Date**

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

Por este medio le doy mi consentimiento a Tempus Unlimited, Inc. para utilizar y divulgar Información Protegida de Salud (PHI) y Información de Identificación Personal (PII) en mi nombre con el fin de facilitar la facturación y el reembolso de los servicios ofrecidos por el programa de Intermediario Fiscal de Tempus Unlimited.

Entiendo que el personal de Tempus Unlimited, Inc. puede tener acceso a PHI y PII, y que puede utilizar esta información para aprobar o rechazar hojas de horarios y/o para presentar facturas con fines de reembolso, procesar nóminas y apoyar las operaciones del programa. Los siguientes son algunos ejemplos de datos de PHI y PII que podríamos compartir incluyen el número de ID de MassHealth, otros números de ID de aseguradores, la documentación de hospitalización y de alta de pacientes hospitalizados, y información sobre su hospitalización en un centro de cuidados de larga duración.

Solo utilizamos esta información para presentar documentación a MassHealth y a otras instituciones pagadores para obtener el reembolso de los servicios de FI. También utilizamos esta información para garantizar que las hojas de horarios no se presenten de forma fraudulenta y que facturamos a MassHealth únicamente por el trabajo realmente realizado por el/la PCA o trabajador/a que usted haya autorizado. Nosotros también utilizamos esta información para la formación del personal y llevar a cabo controles de calidad (supervisando la necesidad, la adecuación y la calidad de los servicios ofrecidos).

Se me ha entregado un Aviso sobre Prácticas de Privacidad que explica detalladamente los usos y las divulgaciones de PHI y PII que Tempus Unlimited, Inc. realizará con mi Información Protegida de Salud (PHI).

Entiendo que no estoy obligado a dar mi consentimiento para el uso o la divulgación de mi Información Protegida de Salud para pago y operaciones de cuidado de salud, pero si no doy mi consentimiento, Tempus Unlimited, Inc. podrá negarse a prestarme servicios de Intermediario Fiscal, a menos que la legislación estatal o federal aplicable exija a Tempus Unlimited, Inc. la prestación de dichos servicios. Si Tempus Unlimited, Inc. acepta las restricciones que he solicitado, quedará obligado por el presente acuerdo.

Entiendo que Tempus Unlimited, Inc. puede divulgar mi Información Protegida de Salud (PHI) y/o Información de Identificación Personal (PII) sin autorización cuando lo exija o lo permita la ley, incluyendo órdenes judiciales, citaciones o solicitudes de agencia gubernamental.

La(s) siguiente(s) persona(s) tiene(n) mi consentimiento con respecto a mi información de salud. **Usted tiene mi permiso** para divulgarles información o **le estoy añadiendo acceso** a la(s) siguiente(s) persona(s):			
Nombre:		**Relación:**	
Nombre:		**Relación:**	

Entiendo que tengo el derecho a objetar al uso y/o divulgación de mi información de salud a familiares.

Usted no tiene mi permiso para divulgarles información a ellos o **le estoy revocando el acceso** de las siguientes personas:			
Nombre:		**Relación:**	
Nombre:		**Relación:**	

Contraseña: Me gustaría añadirle una contraseña a mi cuenta. Información no será discutida por teléfono a menos que la siguiente contraseña sea usada:

Contraseña:		**Fecha de vigencia:**	

Permiso para dejar mensajes de voz detallados en mi grabadora de mensajes en mi hogar o teléfono celular:	
☐ Si, usted tiene mi permiso	☐ No, usted no tiene mi permiso

Entiendo que puedo revocar este consentimiento por escrito pero que la revocación no estará en efecto hasta el punto que Tempus Unlimited, Inc. ya haya tomado acción basada en mi consentimiento anterior. **Este consentimiento estará en efecto, de no ser revocado, hasta un mes luego de la fecha de terminación de su programa.**

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Firma del Consumidor/Representante/Tutor Legal **Nombre impreso** **Fecha**

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