SAMPLE

MassHealth

EXECUTIVE OFFICE OF
HEALTH AND HUMAN SERVICES

# Acquired Brain Injury/Moving Forward Plan Waiver Participant Agreement: Use of Fiscal Intermediary for Self-Directed Waiver Services

I participate in one of the following MassHealth waivers:

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

I choose to use Acquired Brain Injury (ABI) or Moving Forward Plan (MFP) self-directed waiver services.

I understand that I must have authorization for ABI/MFP self-directed waiver services in my plan of care. My ABI/MFP waiver case manager or service coordinator helps me find services that meet my needs.

## The Hiring Process

I understand that

- I am the employer of my direct care workers (DCWs) and must hire my own DCWs.
- My DCW must be at least sixteen (16) years of age.
- My DCW cannot be my spouse, surrogate, or legally responsible relative.
- MassHealth contracts with a fiscal intermediary (FI) who helps me with employer-required tasks.
- I must sign forms that allow the FI to act for me. The FI or my ABI/MFP waiver case manager or service coordinator will give me these forms.
- MassHealth and the FI cannot pay my DCW if my DCW is on the *List of Suspended or Excluded MassHealth Providers* maintained by the U.S. Department of Health and Human Services Office of Inspector General; or any other similar exclusion list. The FI or my ABI/MFP waiver case manager or service coordinator can provide me with more information about this.
- I must complete and submit all required new hire paperwork forms before hiring a DCW. My DCW will not be paid by MassHealth or the FI before new hire paperwork is processed, and they are issued a Unique Identification Number. The FI will not be able to pay my DCW if the paperwork is not completed and submitted to the FI in accordance with the FI's instructions.
- All DCWs must be eligible to work in the United States in accordance with federal law and I delegate my responsibility as the DCW 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. Tempus will use E-Verify to electronically confirm my DCW's eligibility to work in the United States. MassHealth and the FI will not pay my DCW if my DCW is not authorized to work in the United States.
- The FI conducts a Criminal Offense Record Inquiry (CORI) on prospective DCWs. DCWs are required to pass a CORI, as determined by the FI in accordance with 101 CMR 15.09: *Findings from CORI Investigation – Crimes Subject to Review*. This policy is specific to DCWs in the ABI/MFP Waiver program and differs from the process for PCAs. I will not be able to hire a DCW who has not passed a CORI.

## Payment to My Direct Care Worker

I understand that

- My DCWs' weekly timesheets must not have more units than the number authorized by my ABI/MFP waiver case manager or service coordinator for each self-directed service.
- I am responsible for paying my DCWs on my own if
  - I do not have authorization from my ABI/MFP waiver case manager or service coordinator, or
  - I do not have enough units left on my waiver authorization on the days my DCWs worked, or
  - I am not eligible for MassHealth or am not enrolled in an ABI or MFP waiver on the days the DCWs worked, or
  - I have my DCW do work that is not covered or allowed by the waiver.
- I must talk with my DCWs about hours that they are working for other waiver participants or personal care attendant (PCA) consumers.
- DCWs may not work over 50 hours per week in total across employers without an overtime authorization. I must work with my case manager or service coordinator to submit an overtime authorization request if needed.
- I will not schedule my DCW to work more than the weekly hour limit allowable by the PCA/Waiver Program Overtime Rules, as outlined in 130 CMR 422.000: *Personal Care Attendant Services*, HCBS Waiver Provider Bulletin 25, and any successor HCBS Waiver Provider Bulletins. This includes hours they work for other Waiver Participants or PCA Consumers.
- If I violate these policies, MassHealth and the FI are not responsible for paying my DCWs, and I will be responsible for paying DCWs from my own funds.
  - Wages paid to my DCWs who provide waiver Personal Care services are established through a collective bargaining agreement between the Service Employees International Union Local 1199 and the PCA Quality Home Care Workforce Council.
  - Wages paid to my DCWs who provide waiver Adult Companion, Chore, Homemaker, Individual Support and Community Habilitation, and Peer Support services are set by the Executive Office of Health and Human Services.

## The Fiscal Intermediary's Responsibilities

I understand that the FI will

- Receive and process my DCWs' timesheets or punches submitted using EVV.
- Make payroll payments to my DCWs for me.
- Make correct withholdings from my DCWs' paychecks.
- Where applicable, make deductions for PCA union dues and fees and send these monies to the union.
- Send all money withheld from my DCWs' paychecks to the proper agencies.
- Pay my federal, state, and local employment taxes for me.
- Pay my unemployment insurance taxes for me.
- Buy workers' compensation insurance in my name to cover my DCWs.
- Get employer identification numbers (EINs).

- Fill out, file, and save copies of required employment forms.
- Send me summaries of my payrolls and my tax filings.
- Send me summaries (payroll cover sheets) that describe the number of hours allowed for me for each self-directed waiver service on my waiver approval, the number of hours I have used for each service, and the number of hours that remain on my waiver approval. I understand I can share this information with my DCW so that we both know if there are enough hours remaining on my waiver approval for them to work and get paid.

## My Responsibilities as the Employer of my DCWs

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

- Complete all paperwork required by the FI. I understand that the FI will not be able to pay my DCWs if the paperwork is not completed and submitted to the FI following their instructions.
- Tell the FI any time I hire or fire a DCW, any time that I move, and any time one of my DCWs moves.
- Tell the FI and my ABI/MFP waiver case manager or service coordinator when I am admitted to a hospital, nursing facility, or other inpatient facility.
    - I understand that MassHealth and the FI cannot pay for my DCWs when I am in a hospital, nursing facility, or other inpatient facility.
    - I understand that any payments made while I am in a such a facility may be the subject of some action taken by MassHealth, which may include termination of my self-directed waiver services or other penalties, and may result in reporting to the state's Bureau of Special Investigations (BSI) or the Attorney General's Office Medicaid Fraud Division (MFD), or both, for fraud investigation.
- Tell my DCWs that they will get their payments electronically through direct deposit in their bank accounts or through a debit-card service offered by the FI. The FI can provide the forms needed for my DCWs to process payment electronically.
- Inform my DCW that they may not share a bank account with me or my Surrogate.
- Make sure that each week my DCWs sign and fill out their timesheets.
- Make sure that each of my DCW's timesheets show the correct days and hours they worked and the correct service they provided.
- Send my DCWs' completed timesheets to the FI, following the FI's instructions and in the timeframe provided by the FI.
- Use the Electronic Visit Verification (EVV) system in place of a paper or other timesheet, as directed by MassHealth, unless I and my DCW qualify for an EVV exemption.
- Ensure my DCWs are aware of the federal requirement to use EVV for timesheet submission (unless approved for an EVV exemption) and ensure that my DCW correctly completes, signs, and submits their time in a way that accurately reflect the days and hours my DCW worked for me.

*(Continued on following page)*

SAMPLE

Waiver participant signature **Waiver Participant Signature** Date **Waiver Signature Date**

Waiver participant printed name **Waiver Participant Printed Name**

Waiver participant email address **Waiver Participant Email Address**

Waiver participant ID (assigned by FI) **Waiver Participant ID**

OR

Legal guardian signature **Legal Guardian Signature** Date **Legal Signature Date**

Legal guardian printed name **Legal Guardian Printed Name**

Legal guardian email address **Legal Guardian Email Address**

SAMPLE

MassHealth

EXECUTIVE OFFICE OF
HEALTH AND HUMAN SERVICES

# Acuerdo del beneficiario de la exención por Lesión Cerebral Adquirida (ABI) o del Plan Seguir Adelante (MFP): Uso del intermediario fiscal para los servicios autodirigidos de la exención

Soy beneficiario de una de las siguientes exenciones de MassHealth:

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

Elijo usar los servicios de la exención por Lesión Cerebral Adquirida (ABI) o del Plan Seguir Adelante (MFP).

Entiendo que debo tener autorización para los servicios autodirigidos de la exención ABI o MPF en mi plan de atención. Mi administrador de casos o coordinador de servicios de la exención ABI o MFP me ayuda a encontrar servicios que satisfagan mis necesidades.

## El proceso de contratación

Entiendo que

- Soy el empleador de mis asistentes de atención directa (DCW) y que debo contratar a mis propios DCW.
- Mi DCW debe tener por lo menos dieciséis (16) años.
- Mi DCW no puede ser ni mi cónyuge, ni un representante, ni un familiar legalmente responsable.
- MassHealth contrata a un intermediario fiscal (FI) que me ayuda con las tareas relacionadas con ser empleador.
- Debo firmar formularios que le permitan al FI actuar en mi nombre. Estos formularios me los dará el FI o mi administrador de casos o coordinador de servicios de la exención ABI o MFP.
- MassHealth y el FI no pueden pagarle a mi DCW si este se encuentra en la *Lista de MassHealth de proveedores suspendidos o excluidos* que mantiene la Oficina del Inspector General del Departamento de Salud y Servicios Humanos de EE. UU. o en cualquier otra lista de exclusión similar. El FI o mi administrador de casos o coordinador de servicios de la exención ABI o MFP puede brindarme más información al respecto.
- Antes de contratar a un DCW, debo completar y enviar todos los formularios requeridos para la contratación de nuevos empleados. Ni MassHealth ni el FI le pagarán a mi DCW antes de que se procese la documentación para la contratación de nuevos empleados y de que al DCW se le otorgue un Número Único de Identificación. El FI no podrá pagarle a mi DCW si la documentación no se ha completado y no se le ha enviado de acuerdo con sus instrucciones.
- Todos los DCW deben ser elegibles para trabajar en Estados Unidos conforme a la ley federal, y yo, como empleador(a) del DCW, delego en el FI, Tempus Unlimited, Inc., mi responsabilidad para que firme, en mi nombre, el *Memorando de entendimiento de E-Verify para empleadores que utilizan un agente empleador de E-Verify*. Tempus utilizará E-Verify para confirmar electrónicamente la elegibilidad de mi DCW para trabajar en Estados Unidos. Ni MassHealth ni el FI le pagarán a mi DCW si este no está autorizado a trabajar en Estados Unidos.
- El FI realiza una investigación de la Información del Registro de Delincuencia Criminal (CORI) en los futuros DCW. Los DCW están obligados a tener una CORI aprobada, tal como lo determina el FI de acuerdo con 101 CMR 15.09: *Hallazgos de la Investigación CORI – Delitos sujetos a revisión*. Esta norma es específica para los DCW en el programa de exenciones ABI o MFP, y es diferente del proceso para los PCA. No podré contratar a un DCW que no tenga una CORI aprobada.

## Pagos para mi asistente de atención directa

Entiendo que

- Las planillas semanales de horas trabajadas de mis DCW no deben tener más unidades que el número autorizado por mi administrador de casos o coordinador de servicios de la exención ABI o MFP para cada servicio autodirigido.
- Soy responsable de pagar por mi cuenta a mis DCW
  - si no tengo autorización de mi administrador de casos o coordinador de servicios de la exención ABI o si MFP, o
  - si no me quedan muchas unidades en la autorización de mi exención en los días en que trabajaron mis DCW, o
  - si no soy elegible para recibir MassHealth o no estoy inscrito en las exenciones ABI o MFP en los días en que trabajaron los DCW, o
  - si pido mi DCW que realice tareas que no están cubiertas ni permitidas por la exención.
- Debo hablar con mis DCW sobre las horas en las que están trabajando para otros beneficiarios de la exención o para consumidores de servicios de asistentes de cuidados personales (PCA).
- Los DCW no pueden trabajar más de 50 horas por semana en total entre todos los empleadores sin una autorización de horas extras. Debo trabajar con mi administrador de casos o coordinador de servicios para enviar una solicitud de autorización de horas extras si son necesarias.
- No programaré a mi DCW para que trabaje más del límite de horas semanales permitido por los Requisitos de horas extras del programa de exención o de PCA, tal como se estipula en 130 CMR 422.000: *Servicios de Asistentes de Cuidados Personales* , el Boletín n.° 25 para Proveedores de la exención HCBS y cualquier Boletín para Proveedores de la Exención HCBS posterior. Esto incluye las horas que trabajan para otros beneficiarios de la exención o para consumidores de servicios de PCA.
- Si no cumplo con estas normas, MassHealth y el FI no serán responsables de pagarle a mis DCW, y seré yo el/la responsable de pagarles de mis propios fondos.
  - Los salarios que se pagan a mis DCW que prestan servicios de la exención de cuidados personales están establecidos mediante un contrato colectivo de trabajo entre el Sindicato Internacional de Empleados de Servicios (Service Employees International Union) Local 1199 y el Consejo para la Calidad de la Fuerza Laboral de Asistencia en el Hogar de PCA (PCA Quality Home Care Workforce Council).
  - Los salarios que se pagan a mis DCW que prestan servicios de la exención de acompañante para adultos, quehaceres, ayudante de quehaceres domésticos, apoyo individual y habilitación comunitaria, y apoyo de pares están establecidos por la Oficina Ejecutiva de Salud y Servicios Humanos (EOHHS).

## Responsabilidades del intermediario fiscal

Entiendo que el FI

- Recibirá y procesará las planillas de horas trabajadas o los horarios de trabajo de mis DCW que se envíen utilizando la EVV.
- Hará pagos de nómina a mis DCW en mi nombre.
- Hará las retenciones correctas de los cheques de pago de mis DCW.
- Cuando corresponda, hará las deducciones por cuotas y tarifas del sindicato del PCA y enviará dichas cantidades al sindicato.
- Enviará a las agencias correspondientes el dinero retenido de los cheques de pago de mis DCW.
- Pagará por mí los impuestos federales, estatales y locales sobre la nómina.

- Pagará por mí las tasas del seguro de desempleo.
- Adquirirá en mi nombre el seguro de compensación por riesgo laboral (*workers' compensation*) para cubrir a mis DCW.
- Obtendrá números de identificación del empleador (EIN).
- Completará, presentará y guardará copias de los formularios de empleo requeridos.
- Me enviará resúmenes de mis nóminas y mis presentaciones de impuestos.
- Me enviará resúmenes (carátulas de la nómina) que describan el número de horas que se me autorizan para cada servicio autodirigido de la exención en la aprobación de mi exención, el número de horas que he usado para cada servicio y el número de horas que quedan en la aprobación de mi exención. Entiendo que puedo compartir esta información con mi DCW para que ambos sepamos si quedan suficientes horas en la aprobación de mi exención para que trabaje y reciba un pago.

## Mis responsabilidades como empleador de mis DCW

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

- Completar toda la documentación solicitada por el FI. Entiendo que el FI no podrá pagar a mis DCW si no completé la documentación y no se la envié siguiendo sus instrucciones.
- Notificar al FI cada vez que contrate a un DCW o finalice la relación laboral, cada vez que me mude y cada vez que mis DCW se muden.
- Notificar al FI y a mi administrador de casos o coordinador de servicios de la exención ABI o MFP cuando sea admitido en un hospital, un centro de enfermería u otro centro hospitalario.
    - Entiendo que MassHealth y el FI no podrán pagar a mis DCW cuando yo esté en un hospital, un centro de enfermería u otro centro hospitalario.
    - Entiendo que cualquier pago hecho mientras esté en dichos establecimientos puede verse sujeto a alguna decisión tomada por MassHealth, que puede incluir la cancelación de mis servicios autodirigidos de la exención u otras sanciones, y puede causar la notificación a la Agencia de Investigaciones Especiales (BSI) o a la División de Fraude contra Medicaid de la Oficina del Fiscal General (MFD), o a ambas, para investigar casos de fraude.
- Notificar a mis DCW que recibirán sus pagos de manera electrónica mediante un depósito directo en su cuenta bancaria o mediante un servicio de tarjeta de débito ofrecido por el FI. El FI puede proporcionar los formularios necesarios para que mis DCW procesen los pagos electrónicamente.
- Informarle a mi DCW que no puede compartir una cuenta bancaria conmigo ni con mi representante.
- Asegurarme de que, cada semana, mis DCW firmen y completen sus planillas de horas trabajadas.
- Asegurarme de que cada planilla de horas trabajadas de mis DCW muestre los días y las horas correctos que han trabajado y el servicio prestado correcto.
- Enviar al FI las planillas de horas trabajadas de mis DCW, siguiendo las instrucciones del FI y en el plazo provisto por el FI.
- Usar el sistema de Verificación Electrónica de Visitas (EVV) en lugar de papel u otras planillas de horas trabajadas, tal como lo estipula MassHealth, a menos que mi DCW y yo califiquemos para una exención de la EVV.
- Asegurarme de que mis DCW estén informados del requisito federal de utilizar la EVV para entregar planillas (a menos que estén aprobados para una exención de la EVV) y de que mi DCW complete, firme y envíe correctamente sus horas trabajadas de una forma que refleje con exactitud los días y las horas que mi DCW trabajó para mí.

*(Continúa en la página siguiente)*

SAMPLE

Firma del beneficiario de la exención **Firma del beneficiario de la exención** Fecha **Fecha**

Nombre del beneficiario de la exención en letra de imprenta **Nombre del beneficiario de la exención en letra de imprenta**

Dirección de correo electrónico del beneficiario de la exención **Dirección de correo electrónico del beneficiario de la exención**

ID del beneficiario de la exención (asignada por el FI) **ID del beneficiario de la exención**

O BIEN

Firma del tutor legal **Firma del tutor legal** Fecha **Fecha**

Nombre del tutor legal en letra de imprenta **Nombre del tutor legal en letra de imprenta**

Dirección de correo electrónico del tutor legal **Dirección de correo electrónico del tutor legal**

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
**EMPLOYER'S NAME HCSR**

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

3 Executor, administrator, trustee, "care of" name
**EMPLOYER'S PHYSICAL ADDRESS**

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

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

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

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

6 County and state where principal business is located

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

7b SSN, ITIN, or EIN
**EMPLOYER'S SSN, ITIN, 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 "Y



- ☐ Sole proprietor (SSN)
- ☐ Partnership
- ☐ Corporation (enter form number to be filed)
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify)
- ◉ Other (specify) **HCSR**

☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any

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

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

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

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

12 Closing month of accounting year
**DECEMBER**

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.

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

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

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ◉ No
If "Yes," write previous EIN here **UNLESS EMPLOYER HAS EIN HE/SHE MUST CHECK THIS BOX**

**Third Party Designee**

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

Designee's name
**INTAKE SUPERVISOR**

Designee's telephone number (include area code)
**877-479-7577**

Address and ZIP code
**600 TECHNOLOGY CENTER DRIVE, STOUGHTON, MA 02702**

Designee's fax number (include area code)
**617-934-1191**

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

Applicant's telephone number (include area code)

Name and title (type or print clearly) **EMPLOYER'S NAME: HOUSEHOLD EMPLOYER**

Applicant's fax number (include area code)

Signature **EMPLOYER'S SIGNATURE OR SIGNATURE & SOCIAL SECURITY NUMBER PF PARENT OR LEGAL GUARDIAN, IF MINOR CHILD** Date **TODAY'S 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.

**SAMPLE**

# Form TA-1
# Application for Original Registration

Rev. 12/02

**Massachusetts Department of Revenue**

## 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 #**

**4.** No. of locations

## Principal Place of Business

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

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

**7.** City or town: STOUGHTON

**8.** State: MA

**9.** Zip: 02072—4708

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

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

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

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

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

**14.** Business activity code: 8050

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

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

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

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

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

Close date: Mo / Day / Yr

## Background Information

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

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

## Exempt Organizations

**21.** If you are applying for exempt purchaser status, be sure to include a copy of your IRS letter of exemption under Section 501(c)(3) of the Internal Revenue Code. Subordinate organizations covered under an IRS group exemption letter should include a copy of the group exemption ruling **and** a copy of the organization's directory page listing the organization as an approved subordinate. Both of the questions below must be answered.
A. Are you exempt from paying U.S. income taxes? ☐ Yes ☑ No. B. Are you exempt from paying local property taxes? ☐ Yes ☑ No.

## Location of business

Federal Identification number _____

**22.** Trade name: EMPLOYER NAME

Trade name (cont'd.)

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

**24.** City or town: EMPLOYER CITY STATE

**25.** State

**26.** Zip: ZIP —CODE

**27.** (Area code) Telephone number: (PHONE —#

**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:

APPROX # OF EMPLOYEES TO BE PAID EACH PAYROLL

APPROX DATE OF FIRST PAYROLL

### Sales/Use Tax on Goods

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

### Sales/Use Tax on Telecommunications Services

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

### Meals Tax on Food and All Beverages

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

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

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

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

**42.** Seating capacity:

### Room Occupancy

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

**44.** Locality code

**45.** Number of rooms:

### Use Tax Purchaser

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

### Convention Center Financing Surcharges

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

b. Boston Vehicular Rental Transaction Surcharge. Mo Day Yr

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

### Cigar and Smoking Tobacco Excise

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

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

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

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

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

# Tax Information Authorization

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

OMB No. 1545-1165

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

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

| Taxpayer name and address | Taxpayer identification number(s) | |
|---|---|---|
| **Employer Name**<br>**Employer Address** | **TAX ID NUMBER** | |
| | Daytime telephone number | Plan number (if applicable) |

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

| Name and address | |
|---|---|
| **TEMPUS UNLIMITED, INC.**<br>**600 TECHNOLOGY CENTER DRIVE**<br>**STOUGHTON, MA. 02072** | CAF No. **0312-75867R**<br>PTIN<br>Telephone No. **877-479-7577**<br>Fax No. **617-934-1191** |
| **Check if to be sent copies of notices and communications** ☑ | Check if new: Address ☐ Telephone No. ☐ Fax No. ☐ |
| Name and address | CAF No. **0312-75867R**<br>PTIN<br>Telephone No. **877-479-7577**<br>Fax No. **617-934-1191** |
| **Check if to be sent copies of notices and communications** ☐ | Check if new: Address ☐ Telephone No. ☐ Fax No. ☐ |

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

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

| (a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.) | (b) Tax Form Number (1040, 941, 720, etc.) | (c) Year(s) or Period(s) | (d) Specific Tax Matters |
|---|---|---|---|
| **INCOME TAX WITHHOLDING AND EMPLOYMENT TAX** | **940,940R,940EZ,941,941R,941X,941 (C), 843, W-2,W-2(C), W-3,W-3 (C),SS-4.** | **QUARTERS 1,2,3,4 2024 - 2026** | **TAX LIABILITY** |
| | **147-C** | | **VERIFICATION LETTER** |
| | | | |

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

**Authorization for SS-4 and 147C**

**5 Retention/revocation of pr**[illegible]**d, skip this line. If the line 4 box isn't checked, the IRS will a**[illegible] **file unless you check the line 5 box and attach a copy of th**[illegible] . . . . . ► ☐

To revoke a prior tax inform[illegible]e the line 5 instructions.

**SAMPLE**

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

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

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

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

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

**SAMPLE**

Consumer #

(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) EMPLOYER NAME

3 **Trade name** (if any)

4 **Address** EMPLOYER ADDRESS

Number Street Suite or room number

EMPLOYER CITY | STATE | ZIP CODE

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** EMPLOYER OR LEGAL GUARDIAN SIGNATURE

Date DATE

Print your name here EMPLOYER NAME

Print your title here HCSR

Best daytime phone EMPLOYER PH#

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

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

**6 Agent's employer identification number (EIN)** 04-3770178

**7 Agent's name** (not trade name) Tempus Unlimited, Inc.

**8 Trade name** (if any)

**9 Address** 600 Technology Center Drive
Number Street Suite or room number

Stoughton | MA | 02072
City | State | ZIP code

Foreign country name | Foreign province/county | Foreign postal code

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

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

**Sign your name here** INTAKE COORDINATOR SIGNATURE

Print your name here INTAKE COORDINATOR NAME

Print your title here Intake Coordinator

Date DATE

Best daytime phone 1-877-479-7577

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) |
|---|---|
| EMPLOYER/CONSUMER NAME | EMPLOYER/CONSUMER SSN# |
| **Mailing address** | **Federal Identification number** |
| EMPLOYER/CONSUMER ADDRESS | |
| **City/Town** | **State** / **Zip** |
| EMPLOYER/CONSUMER CITY | STATE / ZIP CODE |
| **Phone number** | **Email address** |
| EMPLOYER/CONSUMER PHONE NUMBER | EMPLOYER/CONSUMER EMAIL ADDRESS |

**Representative Information**

Hereby appoint(s) the following indi… …e of the Massachusetts Department of Revenue for the following tax type(s… …(date of death if estate tax)]:



| Name of individual and firm | | Email address/phone number |
|---|---|---|
| DAVID GOLDBERG | 600 Technology Center Drive<br>Stoughton, MA. 02072 | (781) 297 - 5400 |
| | | |
| | | |

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

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

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

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

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

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

**1** ☉ Appointee first named above, or

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

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

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

| Signature (see instructions) | Title (if applicable) | Date |
|---|---|---|
| EMPLOYER/CONSUMER SIGNATURE | EMPLOYER | TODAY'S 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** |
|---|---|---|---|---|
| **2** | **MA** |  | **David Goldberg**<br>**Email: DGoldberg@tempusunlimited.org** | |
| | | | | |
| | | | | |
| | | | | |

**SAMPLE**

## 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:** | **Name** | **Relationship:** | **Relationship** |
| **Name:** | **Name** | **Relationship:** | **Relationship** |

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

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

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

| **Password:** | **Password** | **Effective Date:** | **Effective Date** |
|---|---|---|---|

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

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

| ✍ **Consumer/Surrogate/Legal Guardian Signature** | **Printed Name** | **Date** |
|---|---|---|
| **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

**SAMPLE**

**Consentimiento para el Uso y la Divulgación de**
**Información Protegida de Salud (PHI) y Información de Identificación Personal (PII)**

Tempus Unlimited Fiscal Intermediary

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:** | **Nombre** | **Relación:** | **Relación** |
| **Nombre:** | **Nombre** | **Relación:** | **Relación** |

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

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

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

| **Contraseña:** | **Contraseña** | **Fecha de vigencia:** | **Fecha de vigencia** |
|---|---|---|---|

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

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

| **Firma del Consumidor/ Representante/Tutor legal** | **Nombre impreso** | **Fecha** |
|---|---|---|
| **Firma del Consumidor/Representante/Tutor Legal** | **Nombre impreso** | **Fecha** |



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