

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

Consumer Signature

Consumer Printed Name

Consumer ID

Date

**Legal Guardian Signature**

**Legal Guardian Printed Name**

**Date**

Legal Guardian Signature

Legal Guardian Printed Name

Date

**SAMPLE**

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

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;

# SAMPLE

- 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 más 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.

<b>Firma del Consumidor</b>	<b>Nombre del Consumidor en letra de imprenta</b>	<b>ID del Consumidor</b>	<b>Fecha</b>
<hr/> Firma del Consumidor	<hr/> Nombre del Consumidor en letra de imprenta	<hr/> ID del Consumidor	<hr/> Fecha

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<b>Firma del Tutor legal</b>	<b>Nombre del Tutor legal en letra de imprenta</b>	<b>Fecha</b>
<hr/> Firma del Tutor legal	<hr/> Nombre del Tutor legal en letra de imprenta	<hr/> Fecha

**SAMPLE**

**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](http://www.irs.gov/FormSS4) for instructions and the latest information.

EIN

<b>Type or print clearly.</b>	<b>1</b> Legal name of entity (or individual) for whom the EIN is being requested <b>EMPLOYER'S NAME HCSR</b>	
	<b>2</b> Trade name of business (if different from name on line 1)	<b>3</b> Executor, administrator, trustee, "care of" name <b>EMPLOYER'S PHYSICAL ADDRESS</b>
	<b>4a</b> Mailing address (room, apt., suite no. and street, or P.O. box) <b>PO BOX 936</b>	<b>5a</b> Street address (if different) (Don't enter a P.O. box.) <b>EMPLOYER'S STREET ADDRESS</b>
	<b>4b</b> City, state, and ZIP code (if foreign, see instructions) <b>RANDOLPH, MA 02368</b>	<b>5b</b> City, state, and ZIP code (if foreign, see instructions) <b>EMPLOYER'S CITY, STATE ZIP CODE</b>
	<b>6</b> County and state where principal business is located	
	<b>7a</b> Name of responsible party <b>EMPLOYER'S NAME</b>	<b>7b</b> SSN, ITIN, or EIN <b>EMPLOYER'S SSN, ITIN, EIN</b>
<b>8a</b> Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<b>8b</b> If 8a is "Yes," enter the number of LLC members <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>8c</b> If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
<b>9a</b> Type of entity (check only one box). <b>Caution:</b> If 8a is "Yes,"		
<div style="border: 2px solid black; padding: 20px; font-size: 48px; font-weight: bold; display: inline-block;">SAMPLE</div>		
<input type="checkbox"/> Sole proprietor (SSN) _____ <input type="checkbox"/> Partnership _____ <input type="checkbox"/> Corporation (enter form number to be filed) _____ <input type="checkbox"/> Personal service corporation _____ <input type="checkbox"/> Church or church-controlled organization _____ <input type="checkbox"/> Other nonprofit organization (specify) _____ <input checked="" type="checkbox"/> Other (specify) <b>HCSR</b> _____		
<input type="checkbox"/> REMIC _____ <input type="checkbox"/> Indian tribal governments/enterprises _____ Group Exemption Number (GEN) if any _____		
<b>9b</b> If a corporation, name the state or foreign country (if applicable) where incorporated	State _____	Foreign country _____
<b>10</b> Reason for applying (check only one box)		
<input type="checkbox"/> Started new business (specify type) _____ <input type="checkbox"/> Hired employees (Check the box and see line 13.) _____ <input type="checkbox"/> Compliance with IRS withholding regulations _____ <input checked="" type="checkbox"/> Other (specify) <b>HCSR</b> _____		
<input type="checkbox"/> Banking purpose (specify purpose) _____ <input type="checkbox"/> Changed type of organization (specify new type) _____ <input type="checkbox"/> Purchased going business _____ <input type="checkbox"/> Created a trust (specify type) _____ <input type="checkbox"/> Created a pension plan (specify type) _____		
<b>11</b> Date business started or acquired (month, day, year). See instructions.	<b>12</b> Closing month of accounting year <b>DECEMBER</b>	
<b>13</b> Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.		
Agricultural	Household	Other
<b>14</b> 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 <input type="checkbox"/>		
<b>15</b> First date wages or annuities were paid (month, day, year). <b>Note:</b> If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) _____		
<b>16</b> Check <b>one</b> box that best describes the principal activity of your business.		
<input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale—agent/broker <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input checked="" type="checkbox"/> Other (specify) <b>HCSR</b> <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale—other <input type="checkbox"/> Retail		
<b>17</b> Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. <b>HCSR</b>		
<b>18</b> Has the applicant entity shown on line 1 ever applied for and received an EIN? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If "Yes," write previous EIN here <b>UNLESS EMPLOYER HAS EIN HE/SHE MUST CHECK THIS BOX</b>		
<b>Third Party Designee</b>	Complete this section <b>only</b> 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 <b>INTAKE SUPERVISOR</b>	Designee's telephone number (include area code) <b>877-479-7577</b>
	Address and ZIP code <b>600 TECHNOLOGY CENTER DRIVE, STOUGHTON, MA 02702</b>	Designee's fax number (include area code) <b>617-934-1191</b>
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) <b>EMPLOYER'S NAME: HOUSEHOLD EMPLOYER</b>		Applicant's fax number (include area code)
Signature <b>EMPLOYER'S SIGNATURE OR SIGNATURE &amp; SOCIAL SECURITY NUMBER</b> <b>PF PARENT OR LEGAL GUARDIAN, IF MINOR CHILD</b>	Date <b>TODAY'S DATE</b>	

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](http://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.<sup>1</sup> 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) <sup>2</sup>	complete lines 1-18 (as applicable).
purchased a going business <sup>3</sup>	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 <sup>4</sup>	complete lines 1-18 (as applicable).
created a pension plan as a plan administrator <sup>5</sup>	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 <sup>6</sup>	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 <sup>7</sup>	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 <sup>8</sup> , 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 <sup>9</sup>	complete lines 1-18 (as applicable).

<sup>1</sup> 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.

<sup>2</sup> 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).

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

<sup>4</sup> 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.

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

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

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

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

<sup>9</sup> 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  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  
**E M P L O Y E R N A M E**  
 Name (cont'd.)  
 c/o **T E M P U S U N L I M I T E D I N C**

6. Number and street  
**6 0 0 T E C H N O L O G Y C E N T E R D R**

7. City or town  
**S T O U G H T O N**

8. State **M A** 9. Zip **0 2 0 7 2 - 4 7 0 8**

10. (Area code) Telephone number  
**( 8 7 7 ) 4 7 9 - 7 5 7 7**

**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  **8 0 5 0** 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

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

**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  
**E M P L O Y E R N A M E**  
 Trade name (cont'd.)

23. Number and street (PO box is not acceptable)  
**E M P L O Y E R A D D R E S S**

24. City or town  
**E M P L O Y E R C I T Y S T A T E**

25. State \_\_\_\_\_ 26. Zip \_\_\_\_\_  
**Z I P \_ \_ \_ \_ \_ C O D E**

27. (Area code) Telephone number  
**( P H O ) N E \_ \_ # \_ \_ \_**

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) <input type="checkbox"/> Yes <input type="checkbox"/> No. If "yes," check month(s) or partial month(s) business operates.													33. Indicate 12-month estimate of tax to be withheld, collected or paid for each applicable tax. Check the appropriate box(es).				
Check month(s)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Check appropriate box	\$0–\$100	\$101–\$1,200	\$1,201–\$25,000	over \$25,000
Withholding													Withholding		<input checked="" type="checkbox"/>		
Sales/Use on Goods													Check appropriate box(es)	\$0–\$100	\$101–\$1,200	over \$1,200	
Sales/Use on Telecom. Services													Sales/Use on Goods				
Meals													Sales/Use on Telecom. Services				
Room Occupancy													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 <b>EMPLOYER'S SIGNATURE</b>	Title <b>OWNER</b>	Date <b>TODAY'S DATE</b>
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**SAMPLE**

Consumer #

**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)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945, Annual Return of Withheld Federal Income Tax	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1, Employer's Annual Railroad Retirement Tax Return	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2, Employee Representative's Quarterly Railroad Tax Return	<input type="checkbox"/>	<input type="checkbox"/>

\* 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)**   -

**7 Agent's name (not trade name)**

**8 Trade name (if any)**

**9 Address**

<small>Number</small>	<small>Street</small>	<small>Suite or room number</small>
<input type="text"/>	<input type="text" value="Stoughton"/>	<input type="text" value="MA"/>
<small>City</small>	<small>State</small>	<small>ZIP code</small>
<input type="text"/>	<input type="text" value="02072"/>	<input type="text"/>
<small>Foreign country name</small>	<small>Foreign province/county</small>	<small>Foreign postal code</small>

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

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: EMPLOYER/CONSUMER NAME
Social Security number(s): EMPLOYER/CONSUMER SSN#
Mailing address: EMPLOYER/CONSUMER ADDRESS
Federal Identification number
City/Town: EMPLOYER/CONSUMER CITY
State: STATE Zip: ZIP CODE
Phone number: EMPLOYER/CONSUMER PHONE NUMBER
Email address: EMPLOYER/CONSUMER EMAIL ADDRESS

Representative Information

Hereby appoint(s) the following individual as representative of the Massachusetts Department of Revenue for the following tax type(s) (date of death if estate tax):



Table with 3 columns: Name of individual and firm, Address, Email address/phone number. Row 1: DAVID GOLDBERG, 600 Technology Center Drive 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

Table with 2 columns: Tax type(s), Filing period(s). Row 1: 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 [X] 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): EMPLOYER/CONSUMER SIGNATURE
Title (if applicable): EMPLOYER
Date: 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
<b>2</b>	<b>MA</b>		<b>David Goldberg</b> Email: <a href="mailto:DGoldberg@tempusunlimited.org">DGoldberg@tempusunlimited.org</a>	

## 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
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**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**

## 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 pagadoras 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