TO: Participants of the ABI MFP Waiver Program

FROM: Fiscal Intermediary Department

RE: Employment Packages

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

ABI MFP Waiver Participant Agreement: The ABI MFP Waiver Participant Agreement explains how Tempus Unlimited, Inc. performs the Federal and State required paperwork in their role as a Fiscal Intermediary for the Participant. The Participant or Legal Guardian completes and signs this form.

SS-4 Application for Employer Identification Number (EIN): Each Participant is an employer in the FI program. You will need an Employer Identification Number (EIN) in order for Tempus Unlimited, Inc. to report tax withholding and other information for your Direct Care Workers (DCWs), to the Internal Revenue Service. This form is required by the Federal Government. The Participant. Legal Guardian or POA completes and signs this form.

Form TA-1 Application for Original Registration: This application is similar to the SS-4 above, however it is required by the State of Massachusetts. The Participant. Legal Guardian or POA completes and signs this form.

8821 Tax Information Authorization: This form will allow Tempus Unlimited, Inc. to inspect and receive information about the tax forms indicated on line 3(b) and for the tax periods indicated on line 3(c) on form 8821. The Participant. Legal Guardian or POA completes and signs this form.

2678 Employer Appointment of Agent: This form will allow Tempus Unlimited, Inc. to file the appropriate forms with the Internal Revenue Service (IRS) as an agent of the Participant. The Participant. Legal Guardian or POA completes and signs this form.

M-2848 Power of Attorney and Declaration of Representative: This form allows Tempus Unlimited, Inc. the Power of Attorney for the following forms we file on your behalf: The State Income Tax withholding and the TA-1 Application. The Participant completes and signs this form.

Fiscal Intermediary Procedure for Submitting Complaints and Grievances: This policy explains how you would proceed in filing a grievance if you were ever unhappy with the services Tempus Unlimited, Inc. provides.

Tempus Unlimited, Inc. Notice of Privacy Practices (NNP): The NNP describes how Protected Health Information (PHI) about you may be used or disclosed, and how you may access this information.

Consent to the Use and Disclosure of Protected Health Information: By completing and signing this form, the Participant acknowledges consent/non-consent regarding the release of PHI and permission to leave detailed voicemails on home/cell phone. The Participant. Legal Guardian or POA completes and signs this form.

Department of Industrial Accidents Notice to Employees: As an employer in Massachusetts, you need to post this Notice where your DCWs can see it. In the event that one of your DCWs is injured while working for you, the name and telephone number of your Workers' Compensation Insurance Company are on the form. **Please fill in your name and address before posting.**

My Ombudsman Program: My Ombudsman is now able to assist any MassHealth member with questions or challenges accessing MassHealth covered benefits or services. The My Ombudsman program is an independent, free service for all MassHealth members as well as members' families, caregivers, and advocates. Many My Ombudsman staff are or have been MassHealth members, and have personal experience with disability. Additional information is available on the Tempus website.

Criminal Record Check (CORI): A name-based criminal record check (CORI) returns information on available Massachusetts arraignments. This type of criminal record check is done by submitting the name and date of birth for a person. That information is then searched against Massachusetts court records to determine if there is a possible record for that person. This type of criminal record check contains only Massachusetts information and is not fingerprint supported. **A CORI check is required for all DCW's.**

To request a CORI check for your Direct Care Worker (DCW), you can either create an online account at Request an Online CORI check (you must have a valid Massachusetts Driver's License or ID), or complete the CORI Request Form on the Tempus website and submit to the address at the top of the form ATTN: CORI Unit.

Sexual Offender Register Information (SORI): An online database to access information about Level 2 and Level 3 offenders. For information on how to conduct and interpret a SORI check, please visit our website.

Change of Participant Address Form: If you (Participant) should move, we require a signed change of address form or a letter of instruction to make the change **(we cannot accept changes over the phone)**. Payroll packages are mailed directly to the Participant/Surrogate address and we cannot re-direct the payroll package unless we have received a signed request.

Emergency Notification System (EverBridge): We will use the system to notify you of office closings, important updates and other information that we need to provide quickly.

Please complete these forms as soon as possible and return them via the fax at the number listed below or mail them to our office at the address listed below. Once we have received your completed FI forms **and you receive a prior approval from MassAbility/MassHealth** informing you of the number of hours you are authorized to use per week, we will mail timesheets and forms for your Direct Care Worker's (DCW'S) to complete in order to process their payrolls.

If you have any questions, please contact Tempus Unlimited, Inc. at Toll-Free at 1-877-479-7577 Monday through Friday between the hours of 7:30AM and 4:30PM. One of our Consumer Relations Specialists will be happy to assist you.

TEMPUS UNLIMITED, INC.
Opportunities for Independence

Fiscal Intermediary
Procedure for submitting Complaints and Grievances

Tempus Unlimited, Inc. processes payrolls and related tax filings as the Fiscal Intermediary (FI) for consumers in the Acquired Brain Injury and Moving Forward Plan (ABI MFP) Waiver Program. Tempus Unlimited, Inc. is obligated to provide these services in a professional, courteous and timely manner. Consumers or Surrogates should feel free to voice their concerns whenever they believe these standards are not being met.

COMPLAINTS: Examples of Complaints are: poor service attitude, perceived failure of staff members to treat an Employer/Surrogate/Worker with respect and/or lack of accessibility and timeliness of Tempus as the Fiscal Intermediary.

GRIEVANCES: Grievances are when an Employer/Surrogate/Worker feels they were wrongly denied services he/she is eligible for. Grievances are only filed AFTER addressing the Complaint with Tempus has been unsuccessful.

Complaints and Grievances may be reported using the form below

Tempus Complaints and Grievances Request Form is located on the Tempus Website
https://tempusunlimited.org/

If an employer, surrogate or worker is unhappy with the service, or with a representative of the FI, they can call (toll-free at 877-479-7577), fax, (800-359-2884) , email to: MAFMS@tempusunlimited.org, include the word "Complaint" in the subject line, or mail your letter to the Consumer Relations Supervisor at Tempus Unlimited, Inc., 600 Technology Center Drive, Stoughton, MA 02072. The Consumer Relations Supervisor will review the circumstances regarding the complaint and attempt to resolve the issue within 72 hours of receiving the request. The employer, surrogate or worker will be informed of the resolution using the same method as the complainant (telephone, fax, or mail).

If they are not satisfied with the action taken by the Consumer Relations Supervisor, and they feel strongly that their complaint is the result of a violation of law, or regulation, or egregious error or service, they can send an email to: Grievance@tempusunlimited.org, or mail to 600 Technology Center Drive, Stoughton, MA. 02072, ATTN: Compliance Department. The Compliance Office will review the circumstances regarding the grievance and will attempt to resolve the issue within 72 hours of receiving the request.

If they are not satisfied with the action taken by the Compliance Department, the grievance will be forwarded to the CEO via email and/or they should submit their grievance by US Mail to Chief Executive Officer, 600 Technology Center, Stoughton, MA 02072. The CEO will conduct an investigation of the circumstances through telephone interviews, personal interviews and/or reviews of written or printed documents relating to the issues.

Within ten days of receiving the written grievance, the CEO will issue a decision in writing to the employer, surrogate or worker using the same method as the complainant (email or mail).

If the employer, surrogate or worker is dissatisfied with the decision of the CEO, the grievance will be transferred to the appropriate parties at MassHealth.

Notice of Privacy Practices

Effective Date: June 24, 2026

This notice describes how Protected Health Information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. This Notice is provided on behalf of **Tempus Unlimited Inc.** (referred to as "the Agency").

PURPOSE

This notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out payment for Fiscal Intermediary program services, required by the contract entered between the Massachusetts Executive Office of Health and Human Services and Tempus Unlimited, Inc.

Protected Health Information is information that may identify the Consumer and that relates to the consumer's past, present or future physical or mental health, and may include name, address, phone numbers, and other identifying information.

[2026 ADDITION] The Agency operates as a Fiscal Intermediary and provides administrative, payment, and oversight services. The Agency does not provide clinical treatment services and does not originate medical or behavioral health treatment records.

We are required by law to give you this notice and to maintain the privacy and security of your protected health information. We must follow the duties and privacy practices described in this notice and give you a copy of it.

We reserve the right to change the privacy practices described in it. A current version of this Notice may be obtained from the Agency website, www.tempusunlimited.org and will be posted in our offices. You may also request a current copy by sending a written request to the Agency Compliance Department, 600 Technology Center Drive, Stoughton, MA 02072.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of Agency health care professionals, employees, volunteers, and others who work in any of the Tempus Unlimited, Inc. Programs that you may participate in.

YOUR PRIVACY RIGHTS

You have the following rights relating to your Protected Health Information:

- Obtain a current paper copy of this Notice.
- You have the right to inspect or obtain a copy of your Protected Health Information that we maintain in a designated record set (for example, payment, enrollment, or administrative records). Your request must be in writing or in a format that allows us to verify your identity. We may charge a reasonable, cost-based fee for copies.
- If you believe that the Protected Health Information we have about you is incorrect or incomplete, you may request that we amend it. Your request must be in writing and must explain why the amendment is needed.
  We may deny your request if the information was not created by us (unless you provide a reasonable basis for believing the originator is no longer available to act on the request), is not part of the designated record set, or is accurate and complete. If we deny your request, we will provide a written explanation, and you may submit a statement of disagreement that will be included with your records.
- You have the right to request an accounting of certain disclosures of your Protected Health Information that we have made in the six years prior to your request. This accounting will not include disclosures made for payment or health care operations, disclosures made to you or with your authorization, or certain other disclosures exempt by law. Your first accounting in a 12-month period is free; we may charge a reasonable fee for additional requests.
- You may request that we communicate with you about your health information in a specific way or at a specific location. We will accommodate reasonable requests. Your request must be in writing and specify how or where you wish to be contacted.
- We will not use or disclose your Protected Health Information for purposes not described in this Notice unless you give us a signed, written authorization. You may revoke that authorization in writing at any time, except to the extent we have already relied on it. We will offer reasonable assistance to document your revocation if you need it.

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Reproductive Health Care Privacy
We will not use or disclose your Protected Health Information for the purpose of conducting a criminal, civil, or administrative investigation into, or imposing liability on, any person for seeking, obtaining, providing, or facilitating reproductive health care that is lawful under the circumstances in which it was provided, or to identify any person for such purposes. When we receive a request for PHI potentially related to reproductive health care, we will require a valid attestation from the requestor confirming that the use or disclosure is not for a prohibited purpose, before releasing the information, except as otherwise permitted by law.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information and to abide by the terms of this Notice. We are required to notify you following a breach of unsecured Protected Health Information. We will provide you with written notice without unreasonable delay, and no later than 60 days after discovery of the breach, consistent with applicable law.

NONDISCRIMINATION STATEMENT

Tempus Unlimited, Inc complies with applicable federal and state civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, sexual orientation, gender identity, religion, creed, marital status, veteran status, genetic information, or any other characteristic protected by law.

[2026 ADDITION] In some circumstances, federal or state laws may impose more restrictive limits on the use and disclosure of certain health information. When such laws apply, the Agency complies with the more restrictive legal requirement.

We will not use or disclose your information other than as described here unless you tell us we can. If you tell us we can, you may change your mind at any time. We will request that you submit that request in writing. We will offer an accommodation to document your request if needed.

EXAMPLES OF USES AND DISCLOSURES

We will use your Protected Health information to provide **payment and health care operations including but not limited to; processing attendant payroll, verifying eligibility, program oversight, billing.**

If the Agency were ever to possess the type of clinical information that must be reported for public health purposes, we may disclose it only as required by law

- **Public Health**: We may give your Protected Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and is required by law.
- **Communicable Disease**: We may disclose your Protected Health information to a person who may have been exposed to a communicable disease or may be otherwise at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.
- **Required by Law and Legal Proceedings**
  We may disclose your Protected Health Information when required by federal, state, or local law, or in response to a valid court order, subpoena, discovery request, or other lawful process. Because the Agency does not create clinical or treatment records, we may redirect requests for such records to the originating provider. We will comply with any applicable confidentiality laws that impose additional restrictions.
- **As Required by Law**: [**2026 REVISED**] We disclose Protected Health Information when required by federal, state, or local law and in accordance with any applicable confidentiality requirements that may impose additional restrictions.
- **Health Oversight Activities**: We may disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight Agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.
- **Abuse or Neglect**: We may disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect.

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- **Required Uses and Disclosures**: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.
- **To Avoid Serious Threat to Health or Safety**: We may use and disclose Protected Health Information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
- **Specialized Government Functions**: If you are a member of the armed forces or a veteran, we may disclose your PHI as required by military command authorities or for the purpose of determining eligibility for veterans' benefits. We may also disclose PHI for national security and intelligence activities as authorized by law.

COMPLAINTS

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your Protected Health Information. We create a record of the care and services you receive at the Agency. We need this record to provide services to you and to comply with certain legal requirements.

If you believe your Privacy Rights have been violated, you may make a complaint to us or to the US Secretary of Health and Human Services at: http://www.hhs.gov/

Complaints to the Agency may be submitted to:

Tempus Unlimited, Inc. Compliance Department
600 Technology Center Drive
Stoughton, MA 02072

Email a complaint to: Grievance@TempusUnlimited.org.

There will be no retaliation for filing a complaint.

Aviso Sobre Prácticas de Privacidad

Fecha Efectiva: Junio 24, 2026

Este aviso describe cómo se puede utilizar y compartir la Información Médica Protegida sobre usted, y cómo puede acceder a esta información. Por favor léalo con mucha atención. Este aviso se proporciona en nombre de **Tempus Unlimited Inc.** (referido como "la Agencia").

PROPÓSITO

Este aviso sobre prácticas de privacidad describe cómo podemos utilizar y compartir su Información Médica Protegida (PHI) para realizar el pago de los servicios del programa Intermediario Fiscal, tal y como lo exige el contrato establecido entre la Oficina Ejecutiva de Salud y Servicios Humanos de Massachusetts y Tempus Unlimited, Inc.

La Información Médica Protegida es información que puede identificar al consumidor/a y que se refiere a su salud física o mental pasada, presente o futura, y puede incluir nombre, dirección, números de teléfono y otra información identificativa.

[2026 ADICIÓN] La Agencia opera como Intermediario Fiscal y presta servicios administrativos, de pago y de supervisión. La Agencia no presta servicios de tratamiento clínico y no genera registros médicos ni de tratamiento de salud mental.

La ley nos exige que le proporcionemos este aviso y que mantengamos la privacidad y seguridad de su información médica protegida. Debemos cumplir con las obligaciones y prácticas de privacidad descritas en este aviso y proporcionarle una copia a usted.

Nos reservamos el derecho de modificar las prácticas de privacidad descritas en este Aviso. Puede obtener la versión más reciente de este Aviso en la **página web** de la Agencia, **www.tempusunlimited.org**, y también estará disponible en nuestras oficinas. Asimismo, puede solicitar una copia actualizada enviando una solicitud por escrito al Departamento de Cumplimiento de la Agencia, 600 Technology Center Drive, Stoughton, MA 02072.

QUIÉN DEBERÁ SEGUIR ESTE AVISO

Este aviso describe las prácticas de los profesionales de la salud, empleados, voluntarios y otras personas que trabajan en cualquiera de los programas de Tempus Unlimited, Inc. Programas en los que usted pueda participar.

SUS DERECHOS DE PRIVACIDAD

Usted tiene los siguientes derechos en relación con su Información Médica Protegida:

- Obtenga una copia actualizada en papel de este aviso.
  - Usted tiene derecho a revisar o obtener una copia de su Información Médica Protegida que mantenemos en un conjunto designado de registros (por ejemplo, registros de pagos, inscripción o administrativos). Su solicitud debe hacerse por escrito o en un formato que nos permita verificar su identidad. Podemos cobrar un cargo razonable, basado en el costo, por las copias.
  - Si considera que la Información Médica Protegida que tenemos sobre usted es incorrecta o está incompleta, puede solicitar que la corrijamos. Su solicitud debe hacerse por escrito y debe explicar por qué es necesaria la corrección. Podemos negar su solicitud si la información no fue creada por nosotros (a menos que usted proporcione una base razonable para creer que quien creó la información ya no está disponible para atender la solicitud), si no forma parte del conjunto designado de registros, o si la información es correcta y está completa. Si negamos su solicitud, le proporcionaremos una explicación por escrito y usted podrá presentar una declaración de desacuerdo que será incluida en sus registros.
  - Usted tiene derecho a solicitar un registro de ciertas divulgaciones de su Información Médica Protegida que hayamos realizado durante los seis años anteriores a su solicitud. Este registro no incluirá las divulgaciones realizadas para pagos o operaciones de atención médica, las divulgaciones hechas a usted o con su autorización, ni otras divulgaciones exentas por ley. El primer registro solicitado dentro de un período de 12 meses es gratuito; podremos cobrar un cargo razonable por solicitudes adicionales.
  - Puede solicitar que nos comuniquemos con usted sobre su información médica de una manera específica o en un lugar determinado. Atenderemos las solicitudes razonables. Su solicitud debe hacerse por escrito e indicar cómo o dónde desea ser contactado.
  - No utilizaremos ni divulgaremos su Información Médica Protegida para fines que no estén descritos en este Aviso, a menos que usted nos proporcione una autorización firmada por escrito. Usted puede revocar esa autorización por escrito en

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cualquier momento, excepto en la medida en que ya hayamos actuado basándonos en ella. Si lo necesita, le ofreceremos asistencia razonable para documentar la revocación.

PRIVACIDAD DE LA ATENCIÓN DE SALUD REPRODUCTIVA

No utilizaremos ni divulgaremos su Información Médica Protegida con el propósito de realizar una investigación penal, civil o administrativa, ni para imponer responsabilidad a ninguna persona por buscar, obtener, proporcionar o facilitar servicios de salud reproductiva que sean legales conforme a las circunstancias en que fueron prestados, ni para identificar a ninguna persona con esos fines. Cuando recibamos una solicitud de Información Médica Protegida que pudiera estar relacionada con servicios de salud reproductiva, exigiremos una certificación válida del solicitante que confirme que el uso o la divulgación de la información no tiene un propósito prohibido antes de divulgarla, salvo cuando la ley permita lo contrario.

NUESTRAS RESPONSABILIDADES

Estamos obligados por ley a mantener la privacidad y la seguridad de su Información Médica Protegida y a cumplir con los términos de este Aviso. También estamos obligados a notificarle si ocurre una violación de la seguridad de su Información Médica Protegida no protegida. Le proporcionaremos una notificación por escrito sin demoras irrazonables y, a más tardar, dentro de los 60 días posteriores al descubrimiento de la violación, de conformidad con la legislación aplicable.

DECLARACIÓN DE NO DISCRIMINACIÓN

Tempus Unlimited, Inc. cumple con la legislación federal y estatal aplicables sobre derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, sexo, orientación sexual, identidad de género, religión, credo, estado civil, condición de veterano, información genética o cualquier otra característica protegida por la ley.

[2026 ADICIÓN] En algunas circunstancias, las leyes federales o estatales pueden imponer límites más restrictivos al uso y la divulgación de cierta información médica. Cuando se aplican esas leyes, la Agencia cumple con los requisitos legales más restrictivos.

No utilizaremos ni divulgaremos su información fuera de lo aquí descrito, a menos que usted nos autorice a hacerlo. Si nos autoriza, puede cambiar de decisión en cualquier momento. Le pediremos que envíe su solicitud por escrito. Le proporcionaremos un medio para documentar su solicitud si es necesario.

EJEMPLOS DE USOS Y DIVULGACIONES

Utilizaremos su Información Médica Protegida para llevar a cabo **pagos y operaciones de atención médica, incluyendo, entre otras actividades, el procesamiento de la nómina de los asistentes, la verificación de elegibilidad, la supervisión del programa y la facturación.**

Si la Agencia llegara a poseer información clínica que deba ser reportada para fines de salud pública, solo la divulgaremos cuando así lo exija la ley.

- **Salud Pública**: Podemos dar su Información Médica Protegida a agencias de salud pública que se encargan de prevenir o controlar enfermedades, heridas o discapacidades y es requerido por la ley.
- **Enfermedad Transmisible**: Podemos divulgar su Información Médica Protegida a una persona que pueda haber estado expuesta a una enfermedad contagiosa o que pueda correr el riesgo de contraer o transmitir la enfermedad o condición, si está autorizado por la ley, como en el caso de una enfermedad que requiera cuarentena.
- **Requerido por la Ley y Procesos Legales**
  Podemos divulgar su Información Médica Protegida cuando así lo exijan las leyes federales, estatales o locales, o en respuesta a una orden judicial válida, una citación, una solicitud de presentación de pruebas o otro proceso legal autorizado. Debido a que la Agencia no crea registros clínicos ni de tratamiento, podremos remitir las solicitudes de dichos registros al proveedor que los originó. Cumpliremos con todas las leyes de confidencialidad aplicables que impongan restricciones adicionales.
- **Según lo exige la ley**: [**2026 REVISADO**] Divulgamos la Información Médica Protegida cuando así lo exige la legislación federal, estatal o local, y de acuerdo con cualquier requisito de confidencialidad aplicable que pueda imponer restricciones adicionales.
- **Actividades de Supervisión de Salud**: Podemos divulgar su Información Médica Protegida a una agencia de supervisión de la salud para actividades autorizadas por la ley, tales como investigaciones y inspecciones. Las agencias de supervisión son aquellas que

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supervisan el sistema de salud, los programas de beneficios gubernamentales, como Medicaid, y otros programas reguladores del gobierno.

- **Abuso o Negligencia**: Podemos divulgar su Información Médica Protegida a las autoridades gubernamentales que estén autorizadas por ley a recibir informes de sospechas de abuso o negligencia.
- **Procedimientos Legales**: Podemos divulgar su Información Médica Protegida durante cualquier procedimiento judicial o administrativo, o en respuesta a una orden judicial, citación, solicitud de descubrimiento o otro proceso legal.
- **Usos y Divulgaciones Requeridos**: Debemos divulgar información cuando así lo requiera el Secretario del Departamento de Salud y Servicios Humanos para investigar o determinar nuestro cumplimiento de las Regulaciones de Privacidad de HIPAA.
- **Para Evitar Amenazas Graves para la Salud o la Seguridad**: Podemos utilizar y divulgar su Información Médica Protegida cuando sea necesario para prevenir una amenaza grave para su salud o seguridad, o para la salud o seguridad del público o de otra persona.
- **Funciones Especiales del Gobierno**: Si usted es miembro de las Fuerzas Armadas o es veterano, podremos divulgar su Información Médica Protegida cuando así lo requieran las autoridades militares competentes o para determinar su elegibilidad para beneficios para veteranos. También podremos divulgar su Información Médica Protegida para actividades de seguridad nacional y de inteligencia cuando así lo autorice la ley.

QUEJAS

Entendemos que la información médica sobre usted y su salud es personal y confidencial, y nos comprometemos a proteger la confidencialidad de su Información Médica Protegida. Creamos un registro de la atención y los servicios que recibe en la Agencia. Necesitamos este registro para proporcionarle servicios y cumplir con ciertos requisitos legales.

Si cree que se han violado sus Derechos de Privacidad, puede presentar una queja ante nosotros o ante el Secretario de Salud y Servicios Humanos de los Estados Unidos en: http://www.hhs.gov/

Las quejas dirigidas a la Agencia pueden enviarse a:

Tempus Unlimited, Inc. Compliance Department
600 Technology Center Drive
Stoughton, MA 02072

Envíe una queja por correo electrónico a: Grievance@TempusUnlimited.org.

No habrá repercusiones por presentar una queja.

Change Form and Supply Request

Tempus Unlimited, Inc. 600 Technology Center Drive Stoughton MA 02072 Phone (877)479-7577 Fax (800)359-2884 Email MAFMS@tempusunlimited.org

This Change Form is submitted to change information for **(check one):** ☐ Consumer/Participant ☐ PCA/Worker ☐ Surrogate

Consumer/Participant #

Consumer/Participant Name

Last 4 Digits of SSN

PCA/Worker Name

Type of Change (Required)

- ☐ Consumer/Participant Address
- ☐ PCA/Worker Address
- ☐ Surrogate Address

Change Requested By (Required)

- ☐ Consumer/Participant
- ☐ Surrogate
- ☐ PCA/Worker
- ☐ PCM/CM

If you have terminated a PCA/Worker, you must complete a PCA/Worker Employment Termination Form. You can obtain this form from our website https://tempusunlimited.org/ or by contacting us @ 1-877-479-7577. A Consumer Relations Specialist will be happy to assist.

First Name

Initial

Last Name

Address Type ☐ Home ☐ Mailing ☐ Home and Mailing are the same

Address

City

State

ZIP Code

Phone Number - -

Cell Phone Number - -

Email Address

Name (Print)

Signature (only the signature of the requestor is required)

Date

Supply Request:

☐ Timesheets ☐ FI Paid Time Off Timesheets ☐ Payment Schedule ☐ New Hire Paperwork (NHP) ☐ Form W4 ☐ E-Timesheet Application

☐ Direct Deposit Application ☐ Debit Card Application ☐ Change Forms ☐ Other: _____

Change Form and Supply Request Instructions

Change Form

- Check who the change form is being submitted for (Consumer/Participant, PCA/Worker or Surrogate)

This Change Form is submitted to change information for **(check one):**	☐ Consumer/Participant	☐ PCA/Worker	☐ Surrogate

- Enter Consumer/Participant # and Participant/ Consumer Name
- Enter Last 4 of SSN and PCA/Worker Name (if applicable)
- Check Type of Change and Change Requested By

Type of Change (Required)	Change Requested By (Required)
☐ Consumer/Participant Address	☐ Consumer/Participant
☐ PCA/Worker Address	☐ Surrogate
☐ Surrogate Address	☐ PCA/Worker
	☐ PCM/CM

- Enter information to be updated
  - First Name
  - Middle Initial (if applicable)
  - Last Name
  - Address (Indicate Home or Mailing)
  - City, State and Zip Code
  - Phone Number
  - Cell Number
  - Email Address
  - Appropriate Individual should Print Name, Sign and Date the form

Signatures

- Only the signature of the requestor is required
- Only the Consumer/Participant/Surrogate or PCM Staff can update Consumer Information
- Only the Surrogate can update Surrogate Information
- Only the PCA/Worker can update PCA Information

Supply Request

- Check the forms you would like to be mailed to you (you can check more than one box).

Completed forms can be sent via Mail, Fax or Email (see top of page one). All requests will be processed in the order they are received

WHO MAY NOT BE A WORKER

EFF. 3/1/06

Spouse

Surrogate

Any Legally Responsible Relative
of the Waiver Participant

600 Technology Center Drive, Stoughton, MA 02072
Toll Free Phone #: 1-877-479-7577
Rev. 4/30/2025

www.tempusunlimited.org
Toll Free Fax #: 1-800-359-2884

Dear Consumer,

The Department of Industrial Accidents (DIA) has revised the Notice to Employees poster and has established new notice requirements.

We have provided the revised poster on the back of this notice for your convenience.

As an employer, you must:

- Fill out the Notice to Employees
- Post in a visible location utilized and accessible to all employees.
    - If no such location exists, the poster must be distributed to employees electronically or by mailing a copy.
- The posted must be updated, reposted, and redistributed whenever any of the information changes.

The revised poster is also available on the DIA website using the link or QR code below, in the following languages:

- English
- Arabic
- Cape Verdean
- Chinese
- Khmer
- Haitian Creole
- Portuguese
- Spanish
- Vietnamese

https://www.mass.gov/info-details/notice-to-employees-poster

Thank You,

Tempus Unlimited, Inc.

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-877-479-7577 | Email: MAFMS@tempusunlimited.org

NOTICE TO EMPLOYEES

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

IF YOU ARE INJURED ON THE JOB:

- **Immediately notify your employer that you have been injured.**

Employer HR/Workers' Compensation Contact Phone Number

- **Tell the medical provider that you have been injured at work and give the information below:**

Insurance Carrier	Address	Phone Number
Atlantic Charter Insurance Company	PCA, 25 New Chardon Street, Boston, MA 02114	(617) 488-6500

Employer Address

- **If the employer fails to report the injury to the insurer, the employee may file an Employee's Claim (Form 110).**
- **Additional information regarding your rights and eligibility for benefits pursuant the Workers' Compensation law may be obtained by contacting the Department of Industrial Accidents at 617.727.4900 or visiting www.mass.gov/dia.**

IF MEDICAL TREATMENT IS NEEDED:

Injured workers may select their own medical provider. Medical treatment costs that are reasonable, necessary, and related to the work injury will be paid by the above-named insurer.

If medical facility information is provided below, the above-named insurer has a preferred provider arrangement and the insurer has arranged for your initial treatment at:

Medical Facility: Address:

_____ _____

Phone Number:

_____

EMPLOYER: THIS NOTICE MUST BE FILLED OUT AND POSTED WHERE EMPLOYEES CAN READ IT PURSUANT M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). EMPLOYERS MAY NOT RETALIATE, DISCRIMINATE (IN ACCORDANCE WITH ANY APPLICABLE STATE OR FEDERAL LAWS WHICH INCLUDES IMMIGRATION STATUS), OR PROVIDE FALSE INFORMATION ABOUT THE WORKERS' COMPENSATION PROCESS TO THEIR EMPLOYEES. THIS NOTICE MUST BE UPDATED, POSTED AND REDISTRIBUTED WHEN THERE ARE CHANGES TO THE INFORMATION.

REVISED JUNE 2024

TEMPUS UNLIMITED, INC.
Opportunities for Independence

IMPORTANT INFORMATION ON TAXES

While on the ABI MFP Waiver program, you may receive in the mail various forms from certain government agencies. For example: Massachusetts Division of Unemployment Assistance (DUA), the Internal Revenue Service (IRS) and the Massachusetts Department of Revenue (DOR), to name a few.

At no time, should there ever be any financial charges to a consumer personally, and we never expect you to remit any monies in response to these notices. If you receive anything stating money is owed, immediately fax or mail it to the Fiscal Intermediary office at the address on this stationery. We will take care of the situation.

Tempus Unlimited, Inc. pays your Unemployment Insurance, Social Security/Medicare and Worker's Compensation Insurance for your ABI MFP Waiver program, and also pays quarterly withholding taxes to the IRS on your behalf. Any paperwork you may receive regarding filing quarterly taxes should be disregarded **unless there is a monetary demand for payment of quarterly taxes.** In that case, please forward said forms directly to this office and we will resolve the issue.

You may receive blank forms at the end of each quarter (March, June, September and December) on which to file quarterly taxes. Since **WE FILE THESE ELECTRONICALLY** for you, you may throw them out. Again, if you do get a notice from the IRS that these taxes have not been paid, showing a dollar amount due, please mail or fax to us and we will research and resolve the problem.

I hope this will help to ease your mind regarding various notifications you may receive. If you have any questions, feel free to call Tempus Unlimited, Inc. or your Skills Trainer at your agency.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Office of Long Term Services and Supports
One Ashburton Place, 5th Floor
Boston, Massachusetts 02108

CHARLES D. BAKER
Governor

KARYN E. POLITO

AMANDA CASSEL KRAFT
Acting
Assistant Secretary for MassHealth

NOTICE: COVID-19 Vaccine Requirement for DCWs

October 4, 2021

Dear HCBS Waiver Participant,

On September 1, 2021, the Baker-Polito Administration announced a vaccine requirement for all staff at rest homes, assisted living residences (ALRs), hospice programs, and home care agency workers providing in-home, direct care services under a state contract or state program as part of a continued effort to protect older adults and more vulnerable populations against COVID-19. On September 8, 2021, the Massachusetts Department of Public Health (DPH) promulgated 105 CMR 159.000: *COVID-19 Vaccinations for Certain Staff Providing Home Care Services in Massachusetts,* which requires certain home care workers, including Direct Care Workers (DCWs) working in the MassHealth Home and Community-based Services (HCBS) Moving Forward Plan (MFP) Waivers Self-Directed Program, to receive the COVID-19 vaccine.

As a result, **all DCWs working in the MassHealth HCBS MFP Waivers Self-Directed Program are required to complete the full regimen of COVID-19 vaccine by October 31, 2021**, except for those DCWs who qualify for an exemption because:

1. The vaccine is medically contraindicated, meaning that administration of a COVID-19 vaccine to that individual would likely be detrimental to the individual's health, and the individual can provide documentation demonstrating their need for this exemption, and the individual is able to perform their essential job functions with a reasonable accommodation that is not an undue burden on you, their employer; or

2. The individual objects to vaccination on the basis of a sincerely held religious belief and the individual can provide documentation demonstrating their sincerely held religious belief and the individual is able to perform their essential job functions with a reasonable accommodation that is not an undue burden on you, their employer.

Please continue reading to learn more information about the vaccine requirement and what this means for you as an employer of DCWs under the MassHealth HCBS MFP Waivers Self-Directed Program.

Please continue reading on reverse side →

When is the deadline for my DCW to get a COVID-19 vaccine?

All DCWs are required to receive the full required regimen of vaccine doses, or document that they qualify for an exemption, by October 31, 2021. The full required regimen of COVID-19 vaccine doses means:

- Two doses of the Pfizer-BioNTech COVID-19 vaccine; or
- Two doses of the Moderna COVID-19 vaccine; or
- One dose of the Johnson & Johnson COVID-19 vaccine.

Does the vaccine requirement change my rights and responsibilities as a Waiver Participant Consumer-employer?

No, this vaccine requirement does not change your rights and responsibilities as the employer of your DCW(s). **As a Waiver Participant Consumer-employer, it is your choice whether to hire, terminate, or decline services from a DCW based on their individual vaccination status**.

Please speak with your Waiver Case Manager for more information about your responsibilities as a Waiver Participant Consumer-employer.

Can I ask my DCW about their vaccination status?

Yes. In order to make the best decisions about your safety and personal care, you may ask your DCW(s) to verify if they have been vaccinated and/or whether they qualify for an exemption. As the employer, you are entitled to ask your DCW(s) to complete the attached COVID-19 Vaccine Attestation Form, which has important information about the COVID-19 vaccine and your DCW(s)' vaccination status. For information regarding the vaccine requirement, please go to: https://www.mass.gov/info-details/massachusetts-law-about-vaccination-immunization.

Should I ask my DCW for a copy of their vaccine card or medical information?

You may ask to *look at* your DCW(s)' vaccine card or an applicable doctor's letter explaining why they cannot receive a vaccine. It is strongly recommended that Waiver Participant Consumer-employers NOT keep copies of this information on file, but if a Consumer-employer chooses to do so, the Consumer-employer should ensure that any such documents are maintained in compliance with any applicable laws.

If you wish to keep a record of your DCW(s)' vaccination status, you may have them complete the attached COVID-19 Vaccine Attestation Form after viewing their verification documents.

What should I do if my DCW refuses to get a vaccine?

COVID-19 vaccination is the most effective method for preventing infection and serious illness from the virus. As the employer of your DCW(s), it is your decision whether to hire, schedule, or terminate someone who has not received a vaccine. You do not have to employ anyone who is not vaccinated unless they qualify for an exemption and can perform their essential job functions without undue burden on you, their employer.

The Massachusetts Executive Office of Health and Human Services (EOHHS) does not plan to monitor DCWs' vaccination statuses. Consumer-employers are responsible for monitoring their own employees' vaccination statuses.

COVID-19 Vaccine Attestation Form

MassHealth Home and Community-based Services MFP Waivers Self-Directed Program

This form will help your Waiver Participant Consumer-employer verify your vaccine status and make decisions about their safety and personal care. **Any Direct Care Worker who refuses to complete this form and/or comply with regulations promulgated, or regulations issued, by the Department of Public Health (DPH) pertaining to COVID-19 vaccination requirements may be subject to termination, as determined by their Waiver Participant Consumer-employer.**

By signing below, I acknowledge the following:

- I understand that Direct Care Workers (DCWs) working in the MassHealth Home and Community-based Services MFP Waivers Self-Directed Program are required to complete the full regimen of COVID-19 vaccine doses by October 31, 2021, per the Massachusetts Department of Public Health regulation 105 CMR 159.000: *COVID-19 Vaccinations for Certain Staff Providing Home Care Services in Massachusetts*;
- I have received information regarding the risks and benefits of receiving a COVID-19 vaccine, which includes information available at https://www.mass.gov/info-details/massachusetts-law-about-vaccination-immunization;
- I understand that under state and federal employment law, my Waiver Participant Consumer-employer has a legal right to require that I receive a COVID-19 vaccine as a condition of employment. **My Waiver Participant Consumer-employer can make hiring, termination, and scheduling decisions based on this requirement**;
- I can produce proof of my vaccination status or proof supporting a qualified exemption;
- I understand that if I qualify for an exemption or if I otherwise do not get the vaccine, I may be at greater risk of contracting COVID-19 and/or spreading it to others; and
- I understand that my Waiver Participant Consumer-employer may choose to terminate employment even if I qualify for an exemption if I cannot perform my essential job functions through a reasonable accommodation without creating an undue burden on my Waiver Participant Consumer-employer.

DCW Vaccine Status

By signing below, I attest to the following under the pains and penalties of perjury (please check one):

☐ I have completed the full regimen of COVID-19 vaccine doses. Specifically, I have received two doses of the Pfizer-BioNTech vaccine, or two doses of the Moderna vaccine, or one dose of the Johnson & Johnson vaccine.

☐ I am requesting a COVID-19 vaccine exemption based on one of the following (please check one):

- ☐ A licensed independent practitioner who has a practitioner/patient relationship with me has determined that administration of the COVID-19 vaccine is medically contraindicated, meaning the COVID-19 vaccine would likely be detrimental to my health, and I have documentation from said licensed independent practitioner demonstrating this determination; or
- ☐ I object to receiving a COVID-19 vaccine based on a sincerely held religious belief and I have documentation demonstrating this sincerely held religious belief.

☐ I am not currently vaccinated against COVID-19 and am not requesting (or do not qualify for) an exemption.

DCW Name	DCW Signature	Date Signed
Waiver Participant Consumer Name	Waiver Participant Consumer, Surrogate, or Legal Guardian Signature	Date Signed