



FISCAL EMPLOYER AGENT
EMPLOYEE DATA FORM

Employee Information					
Name: _____					
First	Middle	Last			
Physical Address: _____					
Street	Apt/Unit #	City	State	Zip Code	
Mailing Address: _____					
<i>(if different than physical)</i>					
Street/PO Box	Apt/Unit #	City	State	Zip Code	
Phone #: Home _____ Cell _____					
Email*: _____					
Date of Birth: _____ Social Security Number: _____ - _____ - _____					
Emergency Contact: _____					
Name		Phone		Relationship	

**Mandatory. The state of WI will send your unique ID for use with Electronic Visit Verification (EVV) to this email address. Email is also the most reliable and quickest way of communication between you and CDCN.*

Member/Employer Information	
Name of Member/Employer of Record: _____	
Name of Managing Party (Member's Parent/Guardian): _____	
Age of Member: ☐ Adult <i>(Employee submits Documentation of Training form F-20972)</i>	
☐ Minor under age 18 <i>(Employee submits Children's Long-Term Support (CLTS) Waivers Qualified Provider Standards of Training Verification)</i>	
Name of MCO or County Authorizing the Member's Services: _____	
Employee's relationship to the Member/Employer of Record: _____	

Please Read Carefully: Neither the acceptance of employee paperwork nor entry into any type of employment relationship or employment agreement with a Member/Managing Party for the consideration of employment shall serve to create an actual or implied contract of employment with Consumer Direct Care Network Wisconsin (CDCN). CDCN serves as the Member's Fiscal Agent. **The Member/Employer of Record listed above is the employer. CDCN is not the employer.**

Employment is conditional until the criminal background check has been received and approved – the results of which may be shared with the approving entity (MCO or county) and/or the Member/Managing Party.

As the Employee, I understand that I cannot begin work until I receive an "Okay to Work" authorization letter from CDCN. This confirms the background check is complete, and all enrollment paperwork has been received and approved by CDCN.



Signature of Applicant: _____

Date: _____







FISCAL EMPLOYER AGENT
NEW EMPLOYEE CHECKLIST

Employee Name	Member Name	Managing Party Name

Welcome to Consumer Direct Care Network (CDCN)!

*Please complete all the forms in the list below including this New Employee Checklist. Send originals to the CDCN Wisconsin office **before** the employee begins work. The Employee may not begin work until all forms are completed, and are received and **approved** by CDCN.*

The Member/Managing Party should check each item as it is completed. The Member/Managing Party should keep a copy of each document and **send the originals to the CDCN Wisconsin office.**

Mandatory Forms - All New Employees:

1. ☐ Employee Data Form
2. ☐ New Employee Checklist (this form)
3. ☐ Employee-Employer Relationship Determination
4. ☐ Employee-Member Live-in Determination
5. ☐ I-9 - Additional I-9 instructions are available on the CDCN WI website under the Forms tab
6. ☐ W-4 (federal withholding certificate)
7. ☐ WT-4 (state withholding certificate)
8. ☐ Pay Selection Form - Attachment may be required, see form instructions
9. ☐ Wage Memo
10. ☐ Employee Agreement
11. ☐ Kenosha County Waiver Agency Policies and Expectations for Providers paid by FMS
12. ☐ Wisconsin Medicaid Program Provider Agreement
13. ☐ CLTS Waiver: Kenosha County Waiver Agency Standards of Training Verification
14. ☐ Background Information Disclosure
15. ☐ County of Kenosha Request for Child Protective Services ACCESS Employee Search Request
16. ☐ Employee Health Questionnaire

We have reviewed and verified the above forms for completeness and all forms are readable.





EMPLOYEE-EMPLOYER RELATIONSHIP DETERMINATION

(Determine if employee is exempt from some payroll taxes)

Employee Name	Employer of Record Name (Member under 18 years old)	Member's Parent or Guardian Name

Background: Employees providing domestic services may be exempt from some payroll taxes. This is based on the Employee's age and relationship to the Employer of Record (Employer). Consumer Direct Care Network (CDCN) will apply any exemptions based on the relationships identified below. **Incorrectly filling this form out may result in inaccurate tax withholdings.**

Note: If the Employee and Employer qualify for tax exemptions, they must be taken. Exemptions cannot be waived. If the Employee's earnings are exempt from these taxes, they may not qualify for related benefits. An example is unemployment insurance.

Employee-Employer Relationship

Employee select one relationship below.

☐ I am the grandparent of the Employer. <i>Subject to FICA¹ and FUTA². Exempt from SUTA³.</i>
☐ I am not related to the Employer or my relationship is not described above. <i>Subject to FICA, FUTA, and SUTA.</i>

Acknowledgement: The Employee and Employer's representative agree the relationship selected above is accurate. If this information changes, the Employee must notify CDCN. If CDCN is not notified of changes, the Employee may have to pay back money that should have been withheld from pay.

CG

Employee Signature

Date

M

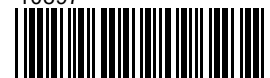
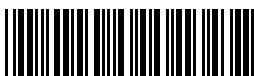
Parent/Guardian Signature

Date

¹FICA – Federal Insurance Contributions Act (Social Security and Medicare)

²FUTA – Federal Unemployment Tax Act

³SUTA – State Unemployment





EMPLOYEE-MEMBER LIVE-IN DETERMINATION

(Determine if employee is exempt from overtime pay and income tax)

Employee Name	Employer of Record Name (Member under 18 years old)	Member's Parent or Guardian Name

Domestic service workers may be exempt from overtime pay requirements and from paying income taxes. Consumer Direct Care Network (CDCN) will apply exemptions based on your answers below.

Employee-Member Live-in Status

Employee answers below with Yes or No

1. ☐ Yes ☐ No – Do you live permanently in the same home as the above-named Member?

If YES:

- You are exempt from submitting time through Electronic Visit Verification (EVV).

2. ☐ Yes ☐ No – Do you live temporarily, but for extended periods with the above-named Member (at least 120 hours per week or 5 consecutive days or nights per week)?

If YES to 1 or 2 above:

- Overtime hours worked are paid at the regular pay rate.
- Declare your Difficulty of Care income tax exemption status.
☐ Yes ☐ No – I declare under penalties of perjury that I am an individual care provider receiving payments under a state Medicaid Waiver program as defined in IRS Notice 2014-7. I provide care to the Member named above. The Member resides in my home. I am not required to report income earned under this Medicaid program. Federal and state income taxes should not be withheld from my pay. If non-taxable wages have been reported by CDCN in Box 1 of my Form W-2, I can deduct the nontaxable wages from my taxable income when I file my tax return. If I no longer qualify for IRS Notice 2014-7, I will notify CDCN. At that time, federal and state income tax withholding will resume. If the IRS deems I was not eligible for 2014-7 and taxes were not paid, I agree that I will be liable for any back taxes owed.

Note: IRS Notice 2014-7 directs that payments received under a Home and Community-based Medicaid Waiver program for providing Personal Care or Habilitation services are considered "Difficulty of Care" payments excludable from income taxation when the Medicaid recipient lives in the care provider's home. Respite and skilled services do not qualify. For more information please refer to <https://www.irs.gov/pub/irs-drop/n-14-07.pdf>.

If NO to both 1 and 2 above :

- Overtime hours worked are paid at 1.5 times the regular pay rate.
- You must submit time worked through an approved EVV method.

Acknowledgement: The Employee and Employer agree the declaration(s) above are accurate. If living arrangements change, the Employee must notify CDCN. Regardless of overtime status identified above, working overtime requires prior approval.

CG

Employee Signature

Date

M

Member's Parent or Guardian
Signature

Date



Instructions for Completing Form I-9 Section 1

(On or before employee's first day of work for pay)

Employee: Complete Section 1 of Form I-9 no later than your first day of work for pay. Print clearly. Sign and date when you are finished. Numbered explanations below are shown in the pictured example.

- ① Print your full legal name: Last, First and Middle Initial. Provide any other last names used, such as maiden name. Enter "N/A" if you have never had another name.
- ② Print your physical address. A PO Box is not allowed. Enter "N/A" if you have no apartment number.
- ③ Print your Date of Birth.
- ④ Print your Social Security Number.
- ⑤ Print your Email Address or print "N/A" if you choose to not provide it.
- ⑥ Print your Telephone Number or print "N/A" if you choose to not provide it.
- ⑦ Check one box that describes your citizenship or immigration status in the United States. Enter additional information if you check box 3 or 4.
- ⑧ Sign and ⑨ date the form. **No later than first day of work for pay.**
- ⑩ Submit Supplement A (*Preparer and/or Translator Certification*) if a preparer or translator assisted you.

Employer: Review Section 1. Ensure your employee has completed it properly.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment , but not before accepting a job offer.						
Last Name (Family Name) ① <i>Doe</i>		First Name (Given Name) <i>Jane</i>		Middle Initial (if any) <i>R</i>	Other Last Names Used (if any) <i>N/A</i>	
Address (Street Number and Name) ② <i>123 Main St.</i>			Apt. Number (if any) <i>N/A</i>	City or Town <i>Anytown</i>		State <i>WI</i>
ZIP Code <i>55032</i>		Date of Birth (mm/dd/yyyy) ③ <i>03/13/1964</i>		U.S. Social Security Number ④ <i>1 2 3 4 5 6 7 8 9</i>		Employee's Email Address ⑤ <i>employee@email.com</i>
Employee's Telephone Number ⑥ <i>555-123-4567</i>		I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.				
Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):						
☒ 1. A citizen of the United States						
☐ 2. A noncitizen national of the United States (See instructions)						
☐ 3. A lawful permanent resident (Enter USCIS A-Number)						
☐ 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)						
If you check Item Number 4., enter one of these:						
USCIS A-Number		OR		Form I-94 Admission Number		OR
						Foreign Passport Number and Country of Issuance
Signature of Employee ⑧ <i>Jane Doe</i>					Today's Date (mm/dd/yyyy) ⑨ <i>09/15/2023</i>	
If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.						

Note: Refer to Form I-9 Instructions for detailed information.

Instructions for Completing Form I-9 Section 2

(After employee has accepted job offer, but no later than 3 days after employee's first day of work)

Employee: Present original, unexpired documents to your employer to verify your identity and authorization to work in the United States. See **LISTS OF ACCEPTABLE DOCUMENTS**.

Employer: Examine and record the documents your employee provides. The employee must be present while you examine them. Numbered explanations below are shown in the pictured example.

- ① Examine each document. Print the details in the appropriate List column(s). Only accept unexpired, original documents (no photocopies).
You may accept one document from List A **OR** one from List B and one from List C.
- ② Print the date of the employee's first day of work.
- ③ Print your last name, first name and title. Title is "Employer."
- ④ Sign and ⑤ date the form. **Must be completed and signed within 3 days of employee's first day of work.**
- ⑥ Print your first and last name.
- ⑦ Print physical address where services are provided (the Member's home).

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS , documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.			
List A		OR	List B AND List C
Document Title 1		①	Driver's License Social Security Card
Issuing Authority			State of Residence SSA
Document Number (if any)			0123456789abode 123-45-6789
Expiration Date (if any)			08/17/2027 N/A
Document Title 2 (if any)	Additional Information		
Issuing Authority	Example ⚡ Do not check. You must physically examine documents. ☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		
Document Number (if any)			
Expiration Date (if any)			
Document Title 3 (if any)			
Issuing Authority			
Document Number (if any)			
Expiration Date (if any)			
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.			First Day of Employment (mm/dd/yyyy): ② 09/15/2023
Last Name, First Name and Title of Employer or Authorized Representative ③ Smith, Ronald Employer		Signature of Employer or Authorized Representative ④ Ronald Smith	Today's Date (mm/dd/yyyy) ⑤ 09/15/2023
Employer's Business or Organization Name ⑥ Ronald Smith		Employer's Business or Organization Address, City or Town, State, ZIP Code ⑦ 500 Fictional Street, Anytown WI 55018	

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

Note: Refer to Form I-9 Instructions for detailed information.



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		☐ 1. A citizen of the United States				
		☐ 2. A noncitizen national of the United States (See Instructions.)				
		☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)				
		☐ 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)				
		If you check Item Number 4. , enter one of these:				
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee					Today's Date (mm/dd/yyyy)	

CG

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

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

List A		OR	List B	AND	List C	
Document Title 1						
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 2 (if any)		Additional Information				
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 3 (if any)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.						
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code			

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.



LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

Examples of many of these documents appear in the Handbook for Employers (M-274).

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

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.





Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) from Section 1 .	Middle initial (if any) from Section 1 .
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Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

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

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

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

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

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

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

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



Employee's Withholding Certificate

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

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) ☐ Single or Married filing separately ☐ Married filing jointly or Qualifying surviving spouse ☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works	Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs. Do only one of the following. (a) Reserved for future use. (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐
	TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$
	Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income (b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here (c) Extra withholding. Enter any additional tax you want withheld each pay period	4(a) 4(b) 4(c)

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)



General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.



Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

Step 4(b)—Deductions Worksheet (Keep for your records.)

- 1** Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$27,700 \text{ if you're married filing jointly or a qualifying surviving spouse} \\ \bullet \$20,800 \text{ if you're head of household} \\ \bullet \$13,850 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
\$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
\$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
\$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
\$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
\$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
\$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
\$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
\$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
\$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
\$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600



Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

Employee's legal name (first name, middle initial, last name)			Social security number	☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, check the Single box.
Employee's address (number and street)			Date of birth	
City	State	Zip code	Date of hire	

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

- Exemption for yourself – enter 1
 - Exemption for your spouse – enter 1
 - Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent
 - Total – add lines (a) through (c)
- Additional amount per pay period you want deducted (if your employer agrees)
- I claim complete exemption from withholding (see instructions). Enter "Exempt"

I CERTIFY that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming complete exemption from withholding, I certify that I incurred no liability for Wisconsin income tax for last year and that I anticipate that I will incur no liability for Wisconsin income tax for this year.

CG

Signature _____ Date Signed _____

EMPLOYEE INSTRUCTIONS:

• WHO MUST COMPLETE:

Effective on or after January 1, 2020, every newly-hired employee is required to provide a completed Form WT-4 to each of their employers. Form WT-4 will be used by your employer to determine the amount of Wisconsin income tax to be withheld from your paychecks. If you have more than one employer, you should claim a smaller number or no exemptions on each Form WT-4 provided to employers other than your principal employer so that the total amount withheld will be closer to your actual income tax liability.

You must complete and provide your employer a new Form WT-4 within 10 days if the number of exemptions previously claimed DECREASES.

You may complete and provide to your employer a new Form WT-4 at any time if the number of your exemptions INCREASES.

Your employer may also require you to complete this form to report your hiring to the Department of Workforce Development.

• UNDER WITHHOLDING:

If sufficient tax is not withheld from your wages, you may incur additional interest charges under the tax laws. In general, 90% of the net tax shown on your income tax return should be withheld.

• OVER WITHHOLDING:

If you are using Form WT-4 to claim the maximum number of exemptions to which you are entitled and your withholding exceeds your expected income tax liability, you may use Form WT-4A to minimize the over withholding.

WT-4 Instructions – Provide your information in the employee section.

• LINE 1:

(a)-(c) Number of exemptions – Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will

be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1(a)-(c) or you may enter into an agreement with your employer to have additional amounts withheld (see instruction for line 2).

(c) Dependents – Those persons who qualify as your dependents for federal income tax purposes may also be claimed as dependents for Wisconsin purposes. The term "dependents" does not include you or your spouse. Indicate the number of dependents that you are claiming in the space provided.

• LINE 2:

Additional withholding – If you have claimed "zero" exemptions on line 1, but still expect to have a balance due on your tax return for the year, you may wish to request your employer to withhold an additional amount of tax for each pay period. If your employer agrees to this additional withholding, enter the additional amount you want deducted from each of your paychecks on line 2.

• LINE 3:

Exemption from withholding – You may claim exemption from withholding of Wisconsin income tax if you had no liability for income tax for last year, and you expect to incur no liability for income tax for this year. You may not claim exemption if your return shows tax liability before the allowance of any credit for income tax withheld. If you are exempt, your employer will not withhold Wisconsin income tax from your wages.

You must revoke this exemption (1) within 10 days from the time you expect to incur income tax liability for the year or (2) on or before December 1 if you expect to incur Wisconsin income tax liabilities for the next year. If you want to stop or are required to revoke this exemption, you must complete and provide a new Form WT-4 to your employer showing the number of withholding exemptions you are entitled to claim. This certificate for exemption from withholding will expire on April 30 of next year unless a new Form WT-4 is completed and provided to your employer before that date.

Employer's Section

Employer's name			Federal Employer ID Number	
Employer's payroll address (number and street)		City	State	Zip code
Completed by	Title	Phone number ()	Email	

EMPLOYER INSTRUCTIONS for Department of Revenue:

- If you do not have a Federal Employer Identification Number (FEIN), contact the Internal Revenue Service to obtain a FEIN.
- If the employee has claimed more than 10 exemptions OR has claimed complete exemption from withholding and earns more than \$200.00 a week or is believed to have claimed more exemptions than they are entitled to, mail a copy of this certificate to: Wisconsin Department of Revenue, Audit Bureau, PO Box 8906, Madison WI 53708 or fax (608) 267-0834.
- Keep a copy of this certificate with your records. If you have questions about the Department of Revenue requirements, call (608) 266-2772 or (608) 266-2776.

EMPLOYER INSTRUCTIONS for New Hire Reporting:

- This report contains the required information for reporting a New Hire to Wisconsin. If you are reporting new hires electronically, you do not need to forward a copy of this report to the Department of Workforce Development. Visit <https://dwd.wi.gov/uinh/> to report new hires.
- If you do not report new hires electronically, mail the original form to the Department of Workforce Development, New Hire Reporting, PO Box 14431, Madison WI 53708-0431 or fax toll free to 1-800-277-8075.
- If you have questions about New Hire requirements, call toll free (888) 300-HIRE (888-300-4473). Visit dwd.wi.gov/uinh/ for more information.





PAY SELECTION FORM

Employee Name: _____

Date of Birth: _____

Consumer Direct Care Network (CDCN) issues pay by direct deposit to a bank account or pay card. Pay stubs and W-2s are sent to you by mail to your address on file or electronically.

Please check one pay option below.

Note: You will be enrolled in the Wisely Pay card option if (1) you make no selection below, or (2) you select direct deposit to a bank account but provide invalid account information or your account is closed.

- ☐ **Direct Deposit to a Wisely Pay Card Account.** I authorize CDCN to issue me a Wisely Pay card. The card will be tied to my identification on file. CDCN will make payroll deposits to my card account. I will receive the card in 7 to 10 business days after initial processing.
- ☐ **Direct Deposit to an Existing Checking, Savings or Pay Card Account.** I authorize CDCN to initiate payroll deposits to my bank or financial institution.

The Name of my bank is: _____

The Account Type is (check one): ☐ Checking ☐ Savings ☐ Pay Card

AN ATTACHMENT IS REQUIRED.

For a Checking Account. Please attach a voided check. This is preferred. A bank-issued direct deposit form or bank letter* is ok too.

For a Savings Account or Pay Card. Please attach a bank-issued direct deposit form or bank letter.*

**Do not submit a deposit slip. The routing numbers differ from direct deposit routing numbers.*

Acknowledgement. I authorize CDCN to process my selected method of pay. I understand that:

- CDCN reserves the right to refuse any direct deposit request.
- I am responsible to confirm that each deposit has occurred. I must pay any fees caused by overdrafts on my account.
- All direct deposits are made through an Automated Clearing House (ACH). Processing is subject to ACH terms. The terms of my bank also apply.
- If funds are deposited to my account in error, or an improper payment is made, I authorize CDCN to debit my account to correct the error. If my account cannot be debited due to closure or insufficient balance, then CDCN may withhold future payments until the erroneous deposited amounts are repaid.
- I may receive a paper check while my selected method of pay is being set up.
- I must submit a new Pay Selection Form to CDCN if I wish to change my Direct Deposit option.

CG

Employee Signature

Date





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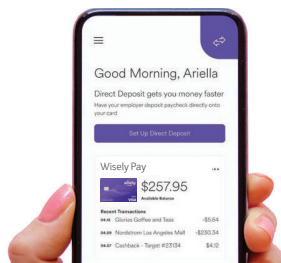


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² You must log in to the myWisely app or mywisely.com to opt-in to early direct deposit. Early direct deposit of funds is not guaranteed and is subject to the timing of payor's payment instruction. Faster funding claim is based on a comparison of our policy of making funds available upon our receipt of payment instruction with the typical banking practice of posting funds at settlement. Please see full disclosures on mywisely.com or the myWisely app. If you have a Wisely Pay or Wisely Cash card (see back of your card), this feature requires an upgrade which may not be available to all cardholders. Please allow up to 3 weeks after your initial setup of direct deposit for your pay to start loading to your card.

³ Amounts transferred to your savings envelope will no longer appear in your available balance. You can transfer money from your savings envelope back to your available balance at any time using the myWisely app or at mywisely.com.

⁴ The number of fee-free ATM transactions may be limited. Please log in to the myWisely app or mywisely.com and see your cardholder agreement and list of all fees for more information.

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**WAGE MEMO**

Employee Name	Member Name	Member CDCN ID #

MCO/Authorizing Entity:

Authorized Services:

Service Code	Wage or Reimbursement	Rate	
	\$_____	☐ hour ☐ day	☐ session ☐ mile
	\$_____	☐ hour ☐ day	☐ session ☐ mile
	\$_____	☐ hour ☐ day	☐ session ☐ mile
	\$_____	☐ hour ☐ day	☐ session ☐ mile
	\$_____	☐ hour ☐ day	☐ session ☐ mile
	\$_____	☐ hour ☐ day	☐ session ☐ mile

Overtime: ☐ Allowed ☐ Not Allowed

Effective Date:

CG

*Employee Signature*_____
*Date*_____
*CDCN Representative Name*_____
*CDCN Representative Signature*_____
Date



**FISCAL EMPLOYER AGENT
EMPLOYEE AGREEMENT**

I, _____, agree to and acknowledge the following:
(Employee Print Name)

_____ has elected to hire me to perform care services for the Member
(Member or Managing Party Print Name)

according to Wisconsin's self-directed services program. I understand Consumer Direct Care Network Wisconsin (CDCN) is the Fiscal/Employer Agency. CDCN assists the Member/Managing Party (MP) with employer related tasks. CDCN IS NOT my employer. The Member/MP is my employer.

The "Approving Entity" authorizing the Member's services is _____.
(Managed Care Organization or County)

1. Effective Date

I can begin work when CDCN approves my enrollment materials and I receive an *Okay to Work* letter from CDCN.

2. Payment

- I am paid at an hourly rate as defined in the wage memo. My pay is subject to applicable tax withholding.
- CDCN offers two direct deposit pay options. I can specify a bank account or choose a pay card. If I change my direct deposit option, I must submit a new Pay Selection Form.
- CDCN issues pay every two weeks. CDCN sends pay stubs (summary of pay) and W-2s by first class mail to my address on file or electronically. A current CDCN Pay Schedule is available online at www.consumerdirectwi.com.
- Unless the Member is a child or I live with the Member, I agree to use an approved Electronic Visit Verification method to record each shift I work. The Member must approve each shift. If I make corrections, they need to be submitted using the EVV Time Correction Form. I will submit corrections by Monday at midnight following the two-week pay period, or pay may be delayed.
- If I live with the Member, or if the Member is a child, I will not use EVV. Instead, I agree to use a paper timesheet or the CDCN web portal to record each shift I work. I must submit my time records by midnight on Monday following the work week, or pay may be delayed.
- CDCN reserves the right to withhold wages for overpayment or alleged misrepresentation on time submitted.
- CDCN will file amended payroll tax returns in instances of over-collected Social Security and Medicare taxes from my pay (occurs when earnings are less than the IRS threshold published in Circular E). If this happens, I will receive a refund from CDCN in January. I agree to not file a claim for refund of over-collected Medicare or Social Security taxes with the IRS.
- CDCN is not responsible to pay me if:
 - The Member loses program eligibility.
 - The Approving Entity has not authorized the Member's services.
 - The Member/MP allows me to perform unauthorized tasks or work more hours than what is approved.

3. Trainings

I understand CDCN provides training materials available on the CDCN website and in the Employer Handbook left with the Member/Managing Party. It is my responsibility to review and understand the information provided on Infection Control; Lifting and Moving Patients; Abuse, Neglect and





**FISCAL EMPLOYER AGENT
EMPLOYEE AGREEMENT**

Exploitation; HIPAA (confidentiality); and Fraud Prevention. The Approving Entity and my employer may require additional trainings.

4. My Responsibilities

- Provide services according to authorized tasks and hours outlined in the Member's care plan.
- Use appropriate safeguards and universal health precautions to not spread communicable disease. I have received, reviewed and understand the "Infection Control Guidelines" training booklet provided by CDCN.
- Program compliance.
- Confidentiality of Member information.
- Status Change Notification (as necessary). I will notify CDCN within ten (10) days of any change in name, addresses, and telephone number. I must also disclose any criminal charges that may affect my employment within ten (10) days.
- Refusal of gifts and other forms of payments for services.
- Report workplace accidents, abuse and neglect, and Fraud as described below.
- Perform job duties in an ethical manner and respect the Member's rights and dignity.

5. Reporting Requirements

- All incidents, accidents, and work-place injuries involving the Employee to the CDCN Injury Hotline at 1-888-541-1701 within 24 hours.
- Possible Member neglect, abuse or exploitation to the county Adult or Elder Abuse reporting line.
- Suspected Medicaid Fraud must be reported to the appropriate authority. Reporting contact information is available on our website under the Resources/Fraud Prevention tab.

6. Member/MP Supervision

The Member/MP is responsible for training, managing, and supervising me. They will instruct me on how to perform services. They are solely responsible for hiring and dismissing all employees.

7. CDCN Contact Person

Employee and Member/MP may ask about compliance with program services and employment laws. Please direct inquiries to a CDCN Service Coordinator at 1-877-785-9991.

8. Medical Administration Procedures

I will learn all medical administration procedures necessary to perform my job from the Member/MP.

9. Insurance

- CDCN will provide worker's compensation insurance. I have reviewed and understand the Employee Injury Reporting procedures in the Employer Handbook.
- I will maintain a valid driver's license and I agree to work with the Member/MP to follow the State's minimum guidelines for maintaining auto insurance coverage on all vehicles used to provide services.

10. Non-Emergent Care

Services provided under this program are not meant to be emergency or acute medical services. Any potential risky health situations must be reported to the Member's attending physician and/or to local emergency services, such as 911, as appropriate.

Employee Signature

Date

Member/MP Signature

Date

11143





COUNTY OF KENOSHA

John T. Jansen, Director
Department of Human Services

Ron Rogers, Director
Division of Children & Family Services
Job Center / Human Services Building
8600 Sheridan Road, Suite 200
Kenosha, Wisconsin 53143-6512
(262) 697-4500
Fax: (262) 605-6570

Kenosha County Waiver Agency Policies and Expectations for Providers paid by a Financial Management Service

Re: _____
(CLTS Participant Name)

This document outlines policies and expectations for providers who are utilizing a Financial Management Service (FMS) agency and have agreed to provide services for a child funded through a Children's Long-Term Support (CLTS) Medicaid Waiver. Below is a summary of what must be agreed to before you can provide services. You must also complete all necessary tasks with the identified FMS agency.

1. The CLTS Waiver client and their parent/guardian is your employer, not the CLTS Waiver agency or Kenosha County.

- I agree to involve the participant and/or guardian in decisions about the participant's care and services s/he receives from me.

2. Providers are unable to restrain, isolate, or seclude a child while they are providing services to a client.

- I agree to provide care/services in the least restrictive manner and setting necessary, while still ensuring the safety of the participant. Any breach in this policy must be reported to the service coordinator within 24 hours of the incident

3. Providers must contact the appropriate service coordinator and the client's parent/guardian to report all critical incidents that occur during a service within 24 hours.

- I agree to report any injuries to the client, injuries to the provider, emergency situations, suspected abuse or neglect of the client, medications errors, significant property damage, and any other concerning incidents or accidents that cause harm to the service coordinator in a detailed report.
- I further acknowledge that I am a mandated reporter and will report all concerns of abuse/neglect which could include sexual abuse, physical abuse, neglect and sexual activity between minors. These concerns will be reported to the client's service coordinator and to Child Protective Services (CPS). CPS can be reached Monday through Friday 8 am to 5 pm via Kenosha County's Access Line at (262) 605-6582. Report after hours concerns to 262-657-7188.

4. You must keep records of when you worked with the client for 7 years.

- I understand that I may be asked to produce records by Kenosha County Waiver Agency.



11015



- I acknowledge that I may need to provide additional documentation as required for the service I am providing.

5. Providers' wages are based on the CLTS participant's needs and the rate standards created by Wisconsin Department of Health Services for each service performed.

6. Providers must engage with the client and their family in a professional capacity, should adhere to appropriate dress and language, and display a respectful demeanor toward the client and their family.

- I agree to be respectful of the family's cultural needs/preferences, rules of their home, and follow through on all required duties of the service I am performing.
- I agree to treat the participant, and their family members, with dignity and respect, free from any verbal, physical, emotional and/or sexual abuse.
- I agree to treat the participant fairly and will not discriminate based on race, national origin, gender, age, religion, disability, or sexual preference.

7. Providers should exercise a calm demeanor when in conflict with the client/family or other relevant providers the client engages with. Providers may contact the client's service coordinator for assistance with disputes between the provider and client/family or other relevant parties.

8. Providers must keep identifying information regarding the client you are working with confidential.

- I will keep the participant's information confidential, unless the law permits disclosure. I acknowledge this agreement remains in effect even after employment is terminated.
- I will not release any information regarding the participant without consent from the participant or his/her guardian. This includes taking pictures of the client without parent consent or posting client pictures/information online.
- This notice also serves as a release of information in order for me to discuss the participant with the CLTS Service Coordinator.

I, _____, understand that as a paid Children's Long-Term
(Print name)
Support (CLTS) Waiver provider, I am required to follow all policies and expectations as outlined in this document. I further acknowledge that failure to follow these policies may result in my termination or denial of payment.

CG

Provider Signature

Date

M

Parent/Guardian Signature

Date



**WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND
ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION
FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS**

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Phone Number	
Address – Street	City	State	Zip Code

The above-referenced provider of home and community-based waiver services under Wisconsin's Medicaid program, hereinafter referred to as the provider, hereby agrees and acknowledges as follows:

1. To provide only the items or services authorized by the managed care organization or IRIS program.
2. To accept the payment issued by the managed care organization or IRIS program as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the managed care organization or IRIS program.
5. To keep any records necessary to disclose the extent of services provided consistent with the provider's business type.
6. To provide, upon request by the managed care organization, the IRIS program, or the Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program including the caregiver background check law.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants **for a period of ten (10) years** and to furnish upon request to the DHS, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. This requirement includes retaining all records and documents according to the terms provided by Wis. Admin. Code § DHS 106.02(a)-(d); (f)-(g).
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the managed care organization and upon request, to the Department in writing:
 - a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;
 - b) The names and addresses of all persons who have a controlling interest in the provider;



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DEPARTMENT OF HEALTH SERVICESDivision of Medicaid Services
F-00180C (07/2017)**STATE OF WISCONSIN**

42 CFR 431.107 & 42 CFR 438.602(b)

- c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;
 - d) The names and addresses of any subcontractors who have had business transactions with the provider;
 - e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.
12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.
13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.
14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

Modifications to this agreement cannot and will not be agreed to. Altering this agreement in any way voids the Department of Health Services' signature. This agreement is not transferable or assignable.

Name – Provider (Typed or Printed)

SIGNATURE – Provider

Date Signed

CG

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)

SIGNATURE – Department of Health Services

Date Signed



8/14/17



**Children's Long Term Support (CLTS) Waiver: Kenosha County Waiver Agency
Standards of Training Verification for Parent/Guardian Hired Providers (Non-licensed/certified)**

Participants: Information:

Participant/Child's Name (First and Last)	Parent/Guardian Name: (First and Last)	Service Coordinator Name: (First and Last)

Service Type: (Check all that Apply)

☐ Daily Living Skills Training
 ☐ Mentoring
 ☐ Respite
 ☐ Specialized Childcare
 ☐ Specialized Transportation
☐ Supportive Home Care (SHC)-Supervision/Attendant
 ☐ SHC-Chores
 ☐ Training for Parents/Unpaid Caregivers

Provider/Employee Information

Name- Last:	First:	M.I.	Date of Hire:
Address. Street:	City:	State:	Zip:

Provider named above will complete background and other service qualification requirements. Additionally, providers will receive training with participant's parent/guardian and when necessary, county waiver agency support and service coordinator (SSC), on the following requirements, to ensure provider is qualified to deliver services to the participant through CLTS Waiver funding. All provider training must be completed within 3 months of hire date.

Date of Completion	Service Provision and/or Training Requirement
--------------------	---

1. _____ 1. Provider is not listed on the Wisconsin Misconduct Caregiver Registry; does not have a substantiated finding of abuse, neglect, or misappropriation, and has not committed a crime that is substantially related to the provision of care or supervision of this service.
2. _____ 2. Provider is trained to safely deliver services, so as not to endanger the participant. Additionally, provider understands how to administer first aid for the participant when necessary.

Participant's safety plan is:

3. _____ 3. Provider is trained to recognize and appropriately respond in the event of an emergency, including protocol for contacting local emergency response systems, and the prompt notification of the county waiver agency.

Any emergency situations or incidents where the participant's health or safety may have been compromised during a session, must be immediately reported to the participant's support and service coordinator (SSC)

SSC agency name, contact staff, and phone number: _____

4. _____ 4. Provider is trained on participant specific information, including individual needs, functional capacities, strengths, abilities, preferences, goals, and family/participant's culture. Additionally, provider has received in-depth training on the participant's individual daily living skills needs and level of assistance for bathing, grooming, toileting, eating, transfers, mobility, learning, communication, and other related tasks. If necessary, provider has also received training on using any adaptive aids or equipment the participant needs for day to day functions.

Detailed Information on the participant's specific information is outlined below:



11010



Participants strengths, interests, and hobbies:

If provider will be conducting mentoring sessions: list how the participant's and provider's interests are similar and how will those interests be incorporated into sessions.

Participant's and their family's relevant cultural needs and preferences:

Participant's cognitive abilities and concerns:

Participant's communication abilities, strengths, and concerns:

Participant's grooming, bathing, toileting, and dressing strengths and concerns:

Participant's dietary concerns, eating habits, and need for eating/feeding assistance:

Participant's mobility strengths and concerns and need for assistance with transfers within home and community:

Participant requires specialized equipment that will be utilized by provider during sessions

☐ No ☐ Yes, equipment includes:

11011



Participant's Goals:

☐ Provider reviewed a copy of participant's most recent CLTS Waiver Individualized Service Plan (ISP) Goals and Outcomes Page.

5. _____ 5. Provider is trained on the participant's specific positive behavioral support plan so provider is able to safely and appropriately respond to challenging and unexpected behaviors participant may display during services.

Current Positive Behavioral Supports and Strategies for Participant:

Participant has an active Behavior Intervention Plan through school, therapy service, or other agency?

☐ No ☐ Yes, and provider has reviewed this/these behavior intervention plan(s)

6. _____ 6. Provider acknowledges and agrees that the participant may not be put into isolation or seclusion and cannot be restrained in any way during sessions. Providers are prohibited from these actions except in cases where a specific participant behavior plan has received Department of Health Services (DHS) approval. All violations of this policy must be immediately reported to the county waiver agency.

Participant has an approved DHS restrictive measures plan

☐ No ☐ Yes: Provider has received comprehensive training on this plan by county waiver agency AND participant's parent/guardian.

7. _____ 7. Provider Is trained on county waiver agency/contract agency policies, procedures, and expectations for providers including confidentiality of participant information according to federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.

8. _____ 8. Provider received training on billing and payment processes, record keeping, incident and mandated reporting requirements, and name/contact information of the county waiver agency service coordinator as well as contract agency.

9. _____ 9. Provider will be providing transportation services to the participant

☐ No ☐ Yes

If Yes, parent/guardian has reviewed the following and copies are on file with the county waiver agency:

- ☐ Provider's has a valid driver's license
☐ Provider has valid car insurance coverage
☐ Parent/Guardian has reviewed the provider's vehicle and attests that it is in sound working order and provider will be able to safely and legally provide transportation services to the participant.

10. _____ 10. Provider has a professional license or meets Medicaid certification for personal care services or nursing

☐ No ☐ Yes and a copy of the _____ license/certification has been received by the county waiver agency.

11. _____ 11. Provider has prior training related to the participant's specific disability of _____ or general training in ☐ developmental disabilities, ☐ mental health, and/or ☐ physical disabilities.



☐ **Prior training**

☐ **No prior training:** Parent/Guardian exempts provider from needing prior training and feels provider can safely, ethically, and appropriately deliver services to the participant. Parent/Guardian has provided provider with training on participant's specific diagnosis by sharing the following information:

12. _____ 12. Provider has received prior training on professional ethics and interpersonal skills as well as understanding and respecting participant direction, individuality, independence, and rights. Additionally, Provider has received prior training on how to handle conflicts and complaints with participants, respecting personal property, and understanding cultural differences and family relationships.

☐ **Prior training:**

☐ **No prior training:** Parent/Guardian is exempting provider from needing this training. They feel that the provider will be able to safely, ethically, and appropriately provide services to the participant due to the following reasons:

13. _____ 13. Provider has prior training on providing quality homemaking and household services, including understanding good nutrition, special diets, and meal planning and preparation. Provider has been trained on how to maintain a clean, safe, and healthy home environment. The provider is able to respect the participant's preferences in housekeeping, shopping and home making tasks.

☐ **Prior training:**



☐ **No prior training:** Parent/Guardian has provided training on this topic to provider as it relates to the participant’s dietary needs and family’s household preferences. Expectations of provider for maintaining household needs during services includes: (*Chores to be done during SHC-Chores sessions must be explained in full)

Signatures

Our signatures below indicate the named employee has met all required provider standards for this service at this time.

Signature of Employee	Date
CG	
Signature of Participant’s Parent or Legal Guardian	Date
M	
Signature of Support and Service Coordinator representing CWA	Date

Training Review

All providers must review this training information with the participant’s parent/guardian every 4 years during the provider’s renewal background check process. Significant changes to the participant’s needs warrants a new verification of training form to be completed. Please indicate below dates of reviews and any minor updates to training that was warranted for the participant.

Date of Review	Additional Training Provided by Parent/Guardian	Initials for all parties

DEPARTMENT OF HEALTH SERVICES

Division of Quality Assurance
F-82064A (01/2022)

STATE OF WISCONSIN

Wis. Stat. § 50.065
Wis. Admin. Code § DHS 12.05(4)

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS: INSTRUCTIONS

PURPOSE

- The *Background Information Disclosure for Employees and Contractors* ([form F-82064](#)) gathers information required by Wis. Stat. § 50.065 and Wis. Admin. Code ch. DHS 12 for entities to conduct [caregiver background checks](#) for prospective and existing employees and contractors. This form may also be used by entities to conduct background checks for students and volunteers that are expected to have regular and direct contact with clients.
- NOTE:** Form F-82064 should not be used by applicants for *entity operator approval* or by entities requesting approval for an individual to reside in entity facilities as a *non-client resident*. Applicants for *entity operator approval* or for a *non-client resident* background check must request an [entity background check](#) from the Division of Quality Assurance.

CAREGIVER BACKGROUND CHECK LAW

[Entities](#) must conduct background checks to verify initial and renewal eligibility of employees and contractors to serve as [caregivers](#). Pursuant to Wis. Stat. § 50.065 and Wis. Admin. Code ch. DHS 12, an entity may not employ or contract with an individual to serve as a “caregiver,” if the individual has certain governmental findings or criminal convictions affecting eligibility. See [Offenses Affecting Eligibility for Employment or Contract in Roles with Client Contact](#).

APPLICATION

Caregiver Background Checks are required for prospective and existing employees and contractors of entities. The term [entity](#) includes, but is not limited to:

- | | |
|---|---|
| • Adult Day Care Centers | • Home Health Agencies |
| • Adult Family Homes | • Hospices |
| • Alcohol and Other Drug Abuse Treatment Programs | • Hospitals |
| • Ambulance Service Providers | • Mental Health Day Treatment Services for Children |
| • AODA Services | • Nursing Homes |
| • Community Based-Residential Facilities | • Outpatient Mental Health Clinics |
| • Community Mental Health Programs | • Personal Care Agencies |
| • Community Support Programs | • Residential Care Apartment Complexes |
| • Comprehensive Community Services | • Rural Medical Centers |
| • Corporate Guardianships | • Youth Crisis Stabilization Facilities |
| • Facilities Serving People with Developmental Disabilities | • Programs regulated by ch. DHS 75 |
| • Emergency Mental Health Service Programs | |

FAIR EMPLOYMENT ACT & ELIGIBILITY REQUIREMENTS

Wisconsin Stat. §§ 111.31 – 111.395, prohibits discrimination because of a criminal record or pending charge. However, it is not discrimination to decline to hire or license a person based on the person’s arrest or conviction record if the arrest or conviction is substantially related to the circumstances of the particular job or licensed activity. In addition, Wisconsin law establishes conditions of eligibility for employment or contract to work in roles with regular and direct client/patient contact.

Wis. Stat. § 50.065(4m)(b) reads:

Notwithstanding s. 111.335, and except as provided in sub. (5), an entity may not employ or contract with a caregiver or permit to reside at the entity a nonclient resident, if the entity knows or should have known any of the following:

1. That the person has been convicted of a serious crime.
2. That a unit of government or a state agency, as defined in s. 16.61 (2) (d), has made a finding that the person has abused or neglected any client or misappropriated the property of any client.
3. That a final determination has been made under s. 48.981 (3) (c) 5m. or, if a contested case hearing is held on such a determination, a final decision has been made under s. 48.981 (3) (c) 5p. that the person has abused or neglected a child.
4. That, in the case of a position for which the person must be credentialed by the department of safety and professional services, the person’s credential is not current or is limited so as to restrict the person from providing adequate care to a client.

See [Offenses Affecting Eligibility](#) for guidance.



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DEPARTMENT OF HEALTH SERVICES

Division of Quality Assurance

F-82064 (01/2022)

STATE OF WISCONSIN

Wis. Stat. § 50.065

Wis. Admin. Code § DHS 12.05(4)

Page 1 of 2

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

- PENALTY:** A person who provides false information on this form may be subject to forfeiture and sanctions, as provided in Wis. Stat. § 50.065(6)(c) and Wis. Admin Code § DHS 12.05(4).
- Completion of this form to verify your eligibility for employment/service as a “caregiver” is required by Wis. Stat. § 50.065 and Wis. Admin Code ch. DHS 12. Failure to complete this form may result in denial or termination of your employment, contract or service agreement.

Refer to DQA form [F-82064A, Instructions](#), for additional information.**Check the box that applies to you.**

- | | |
|--|---|
| ☐ Applicant / Employee
☐ Contractor | ☐ Student / Volunteer
☐ Other – Specify: |
|--|---|

NOTE: This form should NOT be used by applicants for *entity operator approval* (license, certification, registration or other DHS approval) or by entities requesting approval for an individual to reside in entity facilities as a *non-client resident*. Applicants for *entity operator approval* or for a *non-client resident* background check must request an [entity background check](#) from the Division of Quality Assurance.

Full Legal Name – <i>First</i>	<i>Middle</i>	<i>Last</i>
--------------------------------	---------------	-------------

Other Names (including prior to marriage)

Position Title (applied for or existing)	Birth Date (<i>MM/DD/YYYY</i>)	Sex ☐ Male ☐ Female
---	----------------------------------	--

Home Address	City	State	Zip Code
--------------	------	-------	----------

Business Name and Address – Employer (Entity)

Answering “NO” to all questions does not guarantee employment, a contract, or service agreement.

If more space is required, attach additional documentation to this form and indicate “see attached” in your answer.

SECTION A – DISCLOSURES

- Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

Yes	No
☐	☐
- Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?
If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.
You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.

Yes	No
☐	☐
- Please note that Wis. Stat. § 48.981, *Abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.
Has any government or regulatory agency (other than the police) ever found that you committed **child** abuse or neglect?
Provide an explanation below, including when and where the incident(s) occurred.

Yes	No
☐	☐
- Has any government or regulatory agency (other than the police) ever found that you abused or neglected **any person or client**?
If **Yes**, explain, including when and where it happened.

Yes	No
☐	☐



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- | | | |
|--|--------------------------|--------------------------|
| 5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?
If Yes , explain, including when and where it happened. | Yes | No |
| | ☐ | ☐ |
-
- | | | |
|--|--------------------------|--------------------------|
| 6. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person ?
If Yes , explain, including when and where it happened. | Yes | No |
| | ☐ | ☐ |
-
- | | | |
|--|--------------------------|--------------------------|
| 7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?
If Yes , explain, including credential name, limitations or restrictions, and time period. | Yes | No |
| | ☐ | ☐ |

SECTION B – OTHER REQUIRED INFORMATION

- | | | |
|---|--------------------------|--------------------------|
| 1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services?
If Yes , explain, including when and where it happened. | Yes | No |
| | ☐ | ☐ |
-
- | | | |
|---|--------------------------|--------------------------|
| 2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility?
If Yes , explain, including when and where it happened and the reason. | Yes | No |
| | ☐ | ☐ |
-
- | | | |
|---|--------------------------|--------------------------|
| 3. Have you been discharged from a branch of the US Armed Forces, including any reserve component?
If Yes , indicate the year of discharge:
Attach a copy of your DD214, if you were discharged within the last three (3) years. | Yes | No |
| | ☐ | ☐ |
-
- | | | |
|---|--------------------------|--------------------------|
| 4. Have you resided outside of Wisconsin in the last three (3) years?
If Yes , list each state and the dates you resided there. | Yes | No |
| | ☐ | ☐ |
-
- | | | |
|--|--------------------------|--------------------------|
| 5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years?
If Yes , list each state and the dates you resided there. | Yes | No |
| | ☐ | ☐ |
-
- | | | |
|--|--------------------------|--------------------------|
| 6. Have you had a caregiver background check done within the last four (4) years?
If Yes , list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check. | Yes | No |
| | ☐ | ☐ |
-
- | | | |
|--|--------------------------|--------------------------|
| 7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe?
If Yes , list the review date and the review result. You may be asked to provide a copy of the review decision. | Yes | No |
| | ☐ | ☐ |

Read and initial the following statement.

CG I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

NAME – Person Completing This Form

Date Submitted





COUNTY OF KENOSHA

John T. Jansen, Director
Department of Human Services

Ron Rogers, Director
Division of Children & Family Services
Job Center / Human Services Building
8600 Sheridan Road, Suite 200
Kenosha, Wisconsin 53143-6512
(262) 697-4500
Fax: (262) 605-6570

Request for Child Protective Services ACCESS Employee Search Request

The purpose of this form is to gather information and authorization to complete Child Protective Services (CPS) background checks from the following and is not for re-release except to the subject of the record.

- Child Protective Services Background Check (includes the use of the State of Wisconsin's automated EWISACWIS system and/or CPS case files).

This completed form should be faxed to Kenosha County Division of Children and Family Services (KDCDFS), to fax number 262-697-4585. The form should be to the attention of Access.

A separate form must be completed for each individual background check request. You should receive a response within 10 business days of the date the request was received. If you haven't received a response within this time frame, please contact Access at 262-605-6582, and include the name of the person you submitted a request for.

The purpose of this request is a CPS background check of Wisconsin record for Children's Long-Term Support (CLTS) Waiver program providers.

Information for individual the request is on:

Name (Last, First, Middle): _____

Social Security Number: _____ Birthdate: _____

Provide all other legal names (maiden, married, hyphenated) and include names used that were not legal changes, alternate spellings and initials used.

Agency Requesting Contact Information (Information can be returned to):

CLTS Agency Contact Person: _____

Email: _____ Requesting CLTS Agency: _____

Telephone: _____ FAX: _____

My signature hereby authorizes KDCDFS to conduct the search and release the information to the above listed CLTS agency.

Signature of individual the request is on:

 _____ Date: _____

Printed name of individual the request is on: _____

FOR ACCESS OFFICE USE ONLY:

Individual background check is cleared and this individual can be hired:

☐ YES ☐ NO



11009





EMPLOYEE HEALTH QUESTIONNAIRE

Employee Name: _____
(please print)

Background: You have been conditionally hired to provide services for the service recipient in accordance with their authorized plan of care. You may be required to perform physical tasks. The purpose of this Health Questionnaire is to assess your ability to safely perform the authorized tasks. The information provided on this Questionnaire will be used to help manage your employment in a safe manner. Your responses are considered *Confidential*.

Instructions: Respond to each item as to whether you have a medical or physical activity restriction or limitation. **Please explain each "Yes" answer on the backside of this form and attach additional information as necessary.**

Return this completed form and other employment forms to the Consumer Direct Care Network (CDCN) office.

	Do you currently have a Physical Activity Restriction for:	NO	YES
1	Sitting		
2	Stationary Standing		
3	Walking		
4	Ability to be Mobile		
5	Crouching (bending at knee)		
6	Kneeling/Crawling		
7	Stooping (bending at waist)		
8	Twisting (knees/waist/neck)		
9	Turning/Pivoting		
10	Climbing		
11	Balancing		
12	Reaching overhead		
13	Reaching extension		
14	Grasping		
15	Pushing/Pulling		
16	Lifting/Carrying		
17	Whole/Partial Loss of Hearing		
18	Blindness (partial or complete) or Eye Problems		
19	Have you ever been advised by a health care professional to restrict your physical activities in any way?		
	Personal Medical History – In the past 5 years, have you had or been treated for:	NO	YES
20	Epilepsy		
21	Fainting/Dizzy Spells		
22	Hernia		
23	Muscular Strain		
24	Neck or Back Injury		
25	Ruptured Intervertebral Disc		
26	Joint Injury or Pain		
27	Fractures		
28	Tuberculosis or Non-Negative TB Test		
29	Lung Problems/Disease		
30	Head Injury		
31	Other Current Problems, Diseases, Conditions		
32	Have you been hospitalized or undergone surgery, other than for childbirth?		
33	Have you refused a recommended surgical procedure?		
34	Are you currently taking any medication or drugs, whether by prescription or not, that could impair your judgment?		





EMPLOYEE HEALTH QUESTIONNAIRE

Do you currently have, or have you ever been told by a health care professional that you have any physical limitations related to the list below?							
		NO	YES			NO	YES
A	Back			H	Arm		
B	Shoulder			I	Hip		
C	Neck			J	Knee		
D	Elbow			K	Ankle		
E	Wrist			L	Foot		
F	Hand			M	Leg		
G	Finger			N	Other		

CDCN does not discriminate in hiring, promotion, or other terms and conditions of employment. In addition, CDCN does not discriminate against persons who have, in good faith, filed a claim for or received benefits according to State Workers' Compensation Laws. Requests for Accommodations which allow employees to perform the essential functions need to be requested in writing and will be provided if they do not cause an undue hardship.

Please explain any "Yes" answers from page 1 and 2 in detail below and note the associated number or letter. Also, include the dates of injuries & surgeries. Use additional pages, if necessary:

[illegible]

I affirm that I have answered the above questions to the best of my knowledge. My answers are true and complete. I understand that knowingly providing false information is cause for dismissal and may result in denial of workers' compensation benefits.

CG *Employee Signature:* _____ *Date:* ____/____/____

Office Use Only	
Reviewed by: [] Date ____/____/____	Date sent to Risk Mgr: ____/____/____
State Office/Location: _____	Risk Mgr Review: [] Date ____/____/____





2023 Payroll Calendar

Symbol Key:



Time Due



Pay Day



Postal and Bank Holiday

JANUARY							FEBRUARY							MARCH						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7					1	2	3	4			1	2	3	4
8	9	10	11	12	(13)	14	5	6	7	8	9	(10)	11	5	6	7	8	9	(10)	11
15	16	17	18	19	20	21	12	13	14	15	16	17	18	12	13	14	15	16	17	18
22	23	24	25	26	(27)	28	19	20	21	22	23	(24)	25	19	20	21	22	23	(24)	25
29	30	31					26	27	28					26	27	28	29	30	31	
APRIL							MAY							JUNE						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1		1	2	3	4	(5)	6					1	(2)	3
2	3	4	5	6	(7)	8	7	8	9	10	11	12	13	4	5	6	7	8	9	10
9	10	11	12	13	14	15	14	15	16	17	18	(19)	20	11	12	13	14	15	(16)	17
16	17	18	19	20	(21)	22	21	22	23	24	25	26	27	18	19	20	21	22	23	24
23	24	25	26	27	28	29	28	29	30	31				25	26	27	28	29	(30)	
30																				
JULY							AUGUST							SEPTEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1			1	2	3	4	5						1	2
2	3	4	5	6	7	8	6	7	8	9	10	(11)	12	3	4	5	6	7	(8)	9
9	10	11	12	13	(14)	15	13	14	15	16	17	18	19	10	11	12	13	14	15	16
16	17	18	19	20	21	22	20	21	22	23	24	(25)	26	17	18	19	20	21	(22)	23
23	24	25	26	27	(28)	29	27	28	29	30	31			24	25	26	27	28	29	30
30	31																			
OCTOBER							NOVEMBER							DECEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	(6)	7				1	2	(3)	4						(1)	2
8	9	10	11	12	13	14	5	6	7	8	9	10	11	3	4	5	6	7	8	9
15	16	17	18	19	(20)	21	12	13	14	15	16	(17)	18	10	11	12	13	14	(15)	16
22	23	24	25	26	27	28	19	20	21	22	23	24	25	17	18	19	20	21	22	23
29	30	31					26	27	28	29	30			24	25	26	27	28	(29)	30
														31						

2023 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

***New Year's Day** - Monday, January 2

***Martin Luther King, Jr. Day** - Monday, January 16

Presidents Day - Monday, February 20

***Memorial Day** - Monday, May 29

***Juneteenth** - Monday, June 19

***Independence Day** - Tuesday, July 4

***Labor Day** - Monday, September 4

Columbus Day - Monday, October 9

***Veterans Day** - Friday, November 10

***Thanksgiving Day** - Thursday, November 23

***Christmas Day** - Monday, December 25



For Live-In and Child Caregivers Only - Each pay period consists of two Sunday through Saturday work weeks. Paper timesheets or web portal time is due Monday by midnight following each work week. Late time or time with mistakes may result in late pay. Thank you!

Work Week 1	Timesheet Due	Work Week 2	Timesheet Due	Pay Date
Sunday through Saturday	Monday	Sunday through Saturday	Monday	
12/18/22 to 12/24/22	12/26/22	12/25/22 to 12/31/22	1/2/23	1/13/2023
1/1/23 to 1/7/2023	1/9/23	1/8/23 to 1/14/23	1/16/23	1/27/2023
1/15/23 to 1/21/23	1/23/23	1/22/23 to 1/28/23	1/30/23	2/10/2023
1/29/23 to 2/4/23	2/6/23	2/5/23 to 2/11/23	2/13/23	2/24/2023
2/12/23 to 2/18/23	2/20/23	2/19/23 to 2/25/23	2/27/23	3/10/2023
2/26/23 to 3/4/23	3/6/23	3/5/23 to 3/11/23	3/13/23	3/24/2023
3/12/23 to 3/18/23	3/20/23	3/19/23 to 3/25/23	3/27/23	4/7/2023
3/26/23 to 4/1/23	4/3/23	4/2/23 to 4/8/23	4/10/23	4/21/2023
4/9/23 to 4/15/23	4/17/23	4/16/23 to 4/22/23	4/24/23	5/5/2023
4/23/23 to 4/29/23	5/1/23	4/30/23 to 5/6/23	5/8/23	5/19/2023
5/7/23 to 5/13/23	5/15/23	5/14/23 to 5/20/23	5/22/23	6/2/2023
5/21/23 to 5/27/23	5/29/23	5/28/23 to 6/3/23	6/5/23	6/16/2023
6/4/23 to 6/10/23	6/12/23	6/11/23 to 6/17/23	6/19/23	6/30/2023
6/18/23 to 6/24/23	6/26/23	6/25/23 to 7/1/23	7/3/23	7/14/2023
7/2/23 to 7/8/23	7/10/23	7/9/23 to 7/15/23	7/17/23	7/28/2023
7/16/23 to 7/22/23	7/24/23	7/23/23 to 7/29/23	7/31/23	8/11/2023
7/30/23 to 8/5/23	8/7/23	8/6/23 to 8/12/23	8/14/23	8/25/2023
8/13/23 to 8/19/23	8/21/23	8/20/23 to 8/26/23	8/28/23	9/8/2023
8/27/23 to 9/2/23	9/4/23	9/3/23 to 9/9/23	9/11/23	9/22/2023
9/10/23 to 9/16/23	9/18/23	9/17/23 to 9/23/23	9/25/23	10/6/2023
9/24/23 to 9/30/23	10/2/23	10/1/23 to 10/7/23	10/9/23	10/20/2023
10/8/23 to 10/14/23	10/16/23	10/15/23 to 10/21/23	10/23/23	11/3/2023
10/22/23 to 10/28/23	10/30/23	10/29/23 to 11/4/23	11/6/23	11/17/2023
11/5/23 to 11/11/23	11/13/23	11/12/23 to 11/18/23	11/20/23	12/1/2023
11/19/23 to 11/25/23	11/27/23	11/26/23 to 12/2/23	12/4/23	12/15/2023
12/3/23 to 12/9/23	12/11/23	12/10/23 to 12/16/23	12/18/23	12/29/2023
12/17/23 to 12/23/23	12/25/23	12/24/23 to 12/30/23	1/1/24	1/12/2024

CDWITimesheets@ConsumerDirectCare.com

Consumer Direct Care Network Wisconsin
744 Ryan Drive, Suite 201
Hudson, WI 54016-7984

Phone: 877-785-9991
Fax: 877-785-9992
www.ConsumerDirectWI.com



Work Opportunity Tax Credits - Consumer Direct Care Network

Consumer Direct Care Network (CDCN) participates in the Work Opportunity Tax Credit (WOTC) program. ADP administers WOTC on behalf of CDCN. Please follow the steps listed below to screen for the WOTC program. We appreciate your cooperation.

Applicant Instructions

- Open <https://tcs.adp.com/consumerdirectcare> or scan the QR code below.
***Note: If using a shared screening device, ensure the device does not have an autofill/auto complete function enabled*
- Please answer each question to complete the voluntary screening.
- Eligible applicants will be asked to **Electronically Sign and click Submit** to complete the screening.
- Ineligible applicants will be asked to click **Submit** to finish the screening. You will not be asked to electronically sign.

****ADP will contact WOTC-eligible new hires via email or text to request proof of age or address documentation, when needed.***

*****If you are unable to screen via the Web Link please contact ADP at 1-800-237-3279 (1-800-ADP-EASY) available 6am-11 pm ET, 7 days a week and enter company code shown below to screen for Tax Credits.***

IVR CODE: 410849



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