CONSUMER DIRECT CARE NETWORK

MEMBER DATA FORM

Member/FEIN Holder Information

Name on Social Security Card _____ _____ _____
First *Middle* *Last*

Name in Payer Program _____ _____ _____
First *Middle* *Last*

Street Address _____ *(Physical address where services will be provided, No PO Box)*

City _____ **State** _____ **Zip** _____ **County** _____

Phone (_____) _____ (_____) _____ (_____) _____ **Email** _____
Home *Cell* *Fax*

Gender ☐ Male ☐ Female **Date of Birth** _____ **Social Security #** _____-___-_____ **ID #** _____

Managing Party Information *(if applicable)*

Name _____ _____ _____
First *Middle* *Last*

Street Address _____ ☐
☐

City _____ **State** _____ **Zip** _____

Phone (_____) _____ (_____) _____ (_____) _____ **Email** _____
Home *Cell* *Fax*

Relationship to Member _____

Approving Entity Information

MCO/Entity Name _____ **Program** _____

External Case Mgr/Care Coordinator Name _____ **Phone** (____) _____

Address _____ **Cell** (____) _____

City _____ **State** _____ **Zip** _____ **Email** _____

Prior Relationships/Business Accounts

1. ☐ Yes ☐ No – Has Member ever received services through another Fiscal Provider?

   If yes, Provider name: _____

2. ☐ Yes ☐ No – Is Member switching FEIN holders?

   If yes, previous FEIN holder name: _____

3. ☐ Yes ☐ No – Are Prior Business Accounts established?

   If yes, account information: ☐☐-☐☐☐☐☐☐ _____ _____
   FEIN **State Unemployment Tax Account #** **SUTA Rate**

   If previous FEIN, ☐ Yes ☐ No – does FEIN holder have employees other than caregivers?

4. ☐ Yes ☐ No – Will a Guardian sign enclosed Federal and State tax forms on the FEIN holder's behalf?

   If yes, *Guardian name: _____ ___ _____
   First *MI* *Last*

   **Attach court-appointed guardianship paperwork.*

5. **Budget/Auth Start Date or Reactivation Start Date** _____

CONSUMER DIRECT CARE NETWORK

MEMBER DATA FORM

Enrollment Questions

The Consumer Direct Care Network representative responsible for assisting the Member with enrollment must complete the questions below by interviewing the Member/FEIN holder. *If Member/FEIN holder does not know the answer to a question, please write "member doesn't know" on the line next to the question.*

1. What name is shown on your most recently received Social Security Card?

   _____

2. What number is shown on your most recently received Social Security Card?

   _____

3. Have you gone by any other name(s) in the past which aren't shown on your most recently received Social Security Card?

   ☐ Yes ☐ No

   a. If yes, please list your other name(s): _____

   _____

   b. Please list when your other name(s) were used: _____

   _____

4. Were you ever previously assigned an FEIN by the IRS for any business previously operated/owned?

   ☐ Yes ☐ No

   a. If yes and known:

      i. Please list the previously assigned FEIN:

      ii. What was the business for? _____

      iii. Is the business still active? ☐ Yes ☐ No

5. Were you ever previously enrolled with another Fiscal Agent/Provider?

   ☐ Yes ☐ No

   a. If yes and known:

      i. Please list the name of the Fiscal Agent/Provider: _____

      ii. Please list when you were with the Fiscal Agent/Provider? _____

Consumer Direct Representative Name: _____

Consumer Direct Representative Signature: _____ Date: _____

CONSUMER DIRECT CARE NETWORK

FISCAL EMPLOYER AGENT

MEMBER ENROLLMENT CHECKLIST

Member/FEIN Holder Name	Managing Party Name

Welcome to Consumer Direct Care Network (CDCN)!

Please complete all the forms in the list below including this Member Enrollment Checklist. Check off each item upon completion. Provide original signed documents to CDCN Wisconsin.

Member Enrollment Packet - Mandatory Forms:

1. ☐ Member Data Form
2. ☐ Member Enrollment Checklist (this form)
3. ☐ Fiscal Employer Agent Services Agreement
4. ☐ SS-4 Application for Employer Identification Number
5. ☐ Guardianship papers (submit if applicable)
6. ☐ 2678 Employer/Payer Appointment of Agent
7. ☐ A-222 Power of Attorney (WI Dept of Revenue)
8. ☐ UCT-8291 Employer Power of Attorney Assignment (U/I Division)
9. ☐ Employer Handbook (Receipt acknowledgement. Keep for reference.)

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

Signatures:

CDCN Program Coord. Name	Signature	Date
Managing Party Name	Signature	Date

FISCAL EMPLOYER AGENT SERVICES AGREEMENT

This Fiscal Employer Agent Services Agreement ("Agreement") is made and entered into as of _____ ("Effective Date") between Consumer Direct for Wisconsin, LLC doing business as Consumer Direct Care Network Wisconsin (CDCN), and _____ ("Managing Party" or "Employer of Record") for the care of _____ (Member).

1. The Member is an individual who has a disability or is elderly and who receives services through _____, a managed care company (MCO). Members directing their own care services are also known as the Managing Party under this agreement.
2. The Federal Employer Identification Number (FEIN) Holder will be the Employer of Record and wishes to employ an individual(s) to provide services to the Member in the Member's home. A Managing Party will be designated to manage the day to day activities. A Managing Party may or may not be the FEIN Holder.
3. Consumer Direct Fiscal Vendor Agent for Wisconsin, LLC (working in conjunction with CDCN) serves as the Fiscal Vendor Agent as authorized under IRS Procedure Code 70-6 for the purpose of payroll and payroll reporting services filing on behalf of the Employer of Record under the Employer of Record's FEIN number.
4. The MCO has recognized that Consumer Direct Fiscal Vendor Agent for Wisconsin, LLC (working in conjunction with CDCN) will be the Fiscal Employer Agent to the Managing Party and will provide payroll service assistance to the Managing Party pursuant to a contract between the MCO and CDCN ("MCO Provider Contract").

Responsibilities of Member or Managing Party

1. Choose CDCN to serve as its payroll agent (Fiscal Employer Agency - FEA).
2. Complete all of the forms required by CDCN for its FEA services. This includes accurately filling out all required IRS and State Tax and unemployment forms. Failure on the part of the Member to provide required FEIN information or to submit a complete packet may result in a delay in caregiver payment, the Member paying out of pocket, or the Member paying for penalty charges.
3. Obtain a FEIN with the assistance of CDCN.
4. Follow all federal and state employee laws, regulations, and rules.
    a. Recruiting, interviewing, checking references, hiring, training, scheduling, managing, and dismissing each Employee who provides services. This includes directing the day-to-day care of the Member and working out conflicts between the Managing Party and Employees.
    b. Employee cannot be a paid guardian.
    c. Before an Employee can begin to work and be paid in this program, Managing Party must receive an "Okay to Work Form" for the Employee from CDCN.

d. Provide equal employment opportunities to all employees and interested employees without breaking discrimination law as to race, creed, color, national origin, sex, age, disability, marital status, sexual orientation, or any other status protected by law in all employment decisions, including recruitment, hiring, changing schedules and number of hours worked, lay off, and dismissal, and all other terms and conditions of employment. The Managing Party accepts full and specific responsibility for following equal opportunity laws and requirements regarding Employees. Each Employee is to be treated fairly and consistently. This means that if the member decides to do a criminal background check or reference checks on one Employee, it must be done on all Employees.

e. Direct Employees so that services are not provided while a Member is hospitalized or receiving any other Medicaid-reimbursed service.

f. Review and approve employee work-time records through online time entries (or paper time sheets by special authorization) which authorize the MCO to be billed. Records must be submitted in a timely manner according to the CDCN payroll schedule. The Managing Party can be held accountable for approving records that contain fraudulent information and result in over-billing Medicaid.

g. Managing Party has the responsibility for monitoring the monthly tracking reports provided by CDCN and to keep all expenditures within Member's authorized (by the MCO) amount.

h. Inform CDCN on a timely basis of any Member changes in name, address, telephone number or hospitalization.

i. Inform CDCN of the standard rate of pay for the Employee, including timely notification in any changes in the rate.

j. Maintain compliance with the MCO approved utilization amounts for the Member.

5. Make the payment of any wages and expenses that exceed the amount authorized in Member's authorized plan, and are the result of overtime worked by an Employee.

6. Immediately Report:

   a. Any possible Medicaid fraud to the CDCN Fraud Hotline 1-877-532-8530.

   b. Abuse, neglect and exploitation or impairment or health risk to the appropriate authorities, i.e., Adult Protective Services, MCO, and CDCN.

   c. Employee changes, including name, address or employment status within one working day.

7. Appoint a temporary Managing Party if the Member or current Managing Party is not capable or available to direct the care.

8. Maintain required Employee training for all employees.

Responsibilities of Consumer Direct Care Network

1. Provide the Member with a Member Packet, Employee Packets, and employee training materials.
2. Pay wages to Employee on a bi-weekly schedule, in accordance with the time records approved in writing by the Managing Party. CDCN has no obligation to advance wages.
3. Provide Workers' Compensation coverage as directed by state law for Employees.
4. Deposit Employer-Related Taxes in the aggregate using Member's individual FEIN.
5. Follow all IRS and State reporting guidelines.
6. Track the total number of budgeted service hours used and provide monthly (by mail or online) to the Managing Party and case manger, a "tracking report" detailing hours used and hours remaining. The Managing Party is responsible for monitoring monthly tracking reports and not using more service hours than approved for by the case manager.
7. Submit all claims for services to the MCO on behalf of the Managing Party.
8. CDCN will not pay for tasks that are not authorized on the care plan until approved by the case manager and reimbursement is received from the MCO.
9. Obtain Fiscal Employer Agency authorization pursuant to IRS procedure code 70-6 and follow all IRS guidelines including obtaining all proper Federal and State authorizations.
10. Follow all tax exemptions and withholdings as stated on Employee's W-4, and process all tax withholdings & filings including Federal and State income taxes, FICA, Medicare tax, FUTA, and SUTA, and any other mandated withholding, as appropriate, on behalf of the Member.
11. Inform Member of Customer Complaint Process and work to resolve any problem.
12. Track Employee training and inform Member of any expiration dates.

Limitations on Consumer Direct Care Network Payment Obligation

If Managing Party authorizes use of all hours before the end of the period, Managing Party will need to make other service arrangements.

Additional Agreement Terms and Conditions

Indemnification: Because the Managing Party is in a better position than CDCN to monitor, supervise and watch over the Employees in the performance of their duties, the Managing Party agrees to indemnify, which means to repay, defend and hold harmless CDCN from any claims, causes of actions, complaints, lawsuits claiming any damages or liability against CDCN, as the result of any actions, inactions, or any conduct by the Employee, while employed by the Managing Party. This indemnification agreement includes any claims for damage to the Member's property or person, or the property or person of any third party. The Managing Party understands that this means that the Managing Party will

be required to pay for damages caused by their Employee, while employed by the Managing Party, that are made against CDCN including the costs that CDCN develops in defending itself against such claims.

Partial Invalidity: If something in this Agreement does not apply or changes with time that does not mean the rest of the Agreement does not apply. If one part of this Agreement is broken, the rest of the Agreement remains in place.

Arbitration: CDCN and Managing Party agree that they will attempt to resolve any complaints, misunderstandings and other issues between themselves. If the Managing Party or CDCN decide that they cannot settle a disagreement by working together, they will choose someone together (known as an independent arbitrator) to work out the disagreement. This is called arbitration. The cost of arbitration will be paid equally by both the Managing Party and CDCN. The decision of the arbitrator may be given to a court judge.

State Law: If Managing Party cannot solve a problem through negotiation or talking about the problem, then Wisconsin laws will apply. Any legal action related to this Agreement must be done in the County where Member resides.

Duration and Modification of Agreement: This Agreement will go into effect on the date it is signed by both the Managing Party and CDCN. The Agreement can be changed. Any changes must be in writing, signed and dated by both the Managing Party and CDCN. The Agreement may be stopped as described in the Termination section.

Timely Notification: The Managing Party and CDCN agree that all contact should occur in a timely way. Any notice will be given immediately, so that the Managing Party or CDCN is not hurt by a delay.

Entire Agreement: This Agreement and other written materials together describe the complete understanding between Managing Party and CDCN. Any verbal agreements do not apply. All agreements must be put in writing by the Managing Party or CDCN.

Termination: This Agreement can be terminated in three ways:

a. **Mutual Agreement* -** At any time, with written agreement from both Parties.

b. **Termination Without Cause* -** By either Party, for any reason or no reason at all. The Party wishing to terminate must give written notice of its decision to terminate this Agreement at least 30 days prior to any such termination. If the MCO is terminated, this Agreement shall also terminate.

c. **Termination for Cause*** - If any Party to this Agreement does not do what is said in this Agreement or follow the policies and procedures established by the MCO, the other Party may provide written notice of the breach and terminate this Agreement.

   * In the event the Agreement termination is related to a switch to a different FEA, the switch must occur at the end of a calendar year or quarter so that the tax transition for employee records may be made accurately.

Assignment: Neither this Agreement nor any of the rights, benefits, duties or obligations provided for in this Agreement may be assigned by the Managing Party to someone else without the prior written consent of CDCN.

Relationship of Parties: The relationship of the Parties to this Agreement is that none of the Parties is or shall be deemed to be the employee, agent or representative of the other Party, except for the Fiscal Employer Agent services described in the Agreement. No Party shall have authority to bind the other Party to any contract, agreement, debt, liability, or obligation.

This Agreement between the Managing Party and CDCN is not a contract/guarantee of employment for the Employee. The Employee is selected and employed under terms established by the Managing Party: the Employer does not have to follow existing CDCN personnel policies. CDCN does not control or direct how the Managing Party or the Employees perform their duties and responsibilities.

Workers Compensation Program: If the Managing party and Employee do not follow CDCN's safety program policies, safety training requirements, and injury reporting procedures, the Member (and their Employees) may be removed from CDCN's Worker Compensation coverage.

CONCLUSION: The Managing Party is the direct (managing) employer and employer of record of the Employee(s). The Managing Party knows and accepts responsibility for recruiting, hiring, training and supervising the Employee(s). The Managing Party is responsible for the actions of their Employees when they are providing services.

Acceptance on this Agreement is shown by signing below:

CONSUMER DIRECT FOR WISCONSIN, LLC:

_____

(Print name)

_____ _____

(*Signature*) (Date)

MEMBER OR MEMBER'S MANAGING PARTY:

_____

(Print name)

_____ _____

(*Signature*) (Date)

00249

Form **SS-4**
(Rev. December 2017)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

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

OMB No. 1545-0003

EIN

Type or print clearly.

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

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

3 Executor, administrator, trustee, "care of" name

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

5a Street address (if different) (Do not enter a P.O. box.)

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

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

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? . . . . . ☐ Yes ☐ No

8b If 8a is "Yes," enter the number of LLC members . . . . . ►

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

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

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

Group Exemption Number (GEN) if any ►

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

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

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

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

12 Closing month of accounting year

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

Agricultural	Household	Other

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

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

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

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

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

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☐ No

If "Yes," write previous EIN here ►

Third Party Designee

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

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

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

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

Name and title (type or print clearly) ► — Applicant's telephone number (include area code)

Signature ► Date ► — Applicant's fax number (include area code)

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

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

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

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

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

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

For IRS use:

Part 1: Why you are filing this form...

(Check one)

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

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

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

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

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

3 Trade name (if any)

4 Address

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

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

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

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

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

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

X **Sign your name here**

Print your name here

Print your title here

Date / /

Best daytime phone

Now give this form to the agent to complete.

Wisconsin Department of Revenue

Power of Attorney

See instructions on reverse side

(Please print or type)

Form **A-222**

Part 1 Taxpayer Name	Spouse Name	Social Security Number(s)	Wisconsin Tax Account Number
Taxpayer Address *(number and street)*	Spouse Address *(if different from taxpayer)*	Federal Identification Number	Telephone Number – Daytime ( )
City, State, and Zip Code	City, State, and Zip Code	E-mail Address	

Part 2 Hereby appoint(s) the following individual(s) as attorney(s)-in-fact to represent the taxpayer(s) before the Department of Revenue for the tax matter(s) specified in Part 3.

	Name	Firm Name/Address	Telephone Number
**			( )
			( )
			( )

** Designated Receiver

Part 3 Type of Tax	Tax Year(s) or Period(s) Covered
☐ Individual Income Tax	
☐ Corporation Franchise or Income Tax	
☐ Excise Tax	
☐ Sales or Use Tax	
☐ Withholding Tax	
☐ Other (list type of tax/matter) _____	
☐ All delinquent tax matters	

Part 4 Complete if Power of Attorney is limited to:

☐ Field/office audit matters ☐ Appeal of notice dated _____

☐ Other _____

Part 5 Send notices and other written communications to: ☐ Attorney-in-fact OR ☐ Taxpayer ► I understand, agree, and accept:

If the Attorney-in-fact box is checked, any notices and written communications will be sent to only the attorney-in-fact, except as required by statute. If the Taxpayer box is checked, any notices and written communications will be sent to only the taxpayer. Notice to the attorney-in-fact is notice to the taxpayer and vice versa. If no box is checked or both boxes are checked, any notices and written communications will be sent only to the taxpayer.

Part 6 The Power of Attorney revokes all prior Powers of Attorney on file with the Wisconsin Department of Revenue with respect to the same matters and years or periods covered by this instrument, except the following:

_____

(Specify to whom granted, date, and address, or refer to attached copies of prior powers of attorney)

Part 7 *I understand that the execution of this Power of Attorney does not relieve me of personal responsibility for correctly and timely reporting and paying taxes, or from the penalties for failure to do so, all as provided for under Wisconsin tax law. I understand a photocopy and/or faxed copy of this form has the same authority as the signed original.*

If signed by a corporate officer, partner, or fiduciary on behalf of the taxpayer, I certify that I have the authority to execute this Power of Attorney on behalf of the taxpayer.

Signature	Title	Date
Signature	Title	Date

This Power of Attorney is not valid unless signed by the individual(s), corporate officer, partner or fiduciary.
Refer to instructions on reverse side.

00518

EMPLOYER POWER OF ATTORNEY ASSIGNMENT

Department of Workforce Development
Unemployment Insurance Division
P.O. Box 7942
Madison, WI 53707
Fax: (608) 327-6158

Be Aware That:

_____ , _____ , _____ ,
(Employer Name) (UI Account #) (FEIN #)

having its main office located at _____ ,
(Street Address, City, State & Zip Code)

_____ appoints _____ ,
(Telephone Number with Area Code) (Name of Representing Company)

located at _____ , _____ ,
(Street Address, City, State & Zip Code) (Telephone Number with Area Code)

as its attorney or representative with full power to represent the employer before the Wisconsin Unemployment Insurance Division. This representation applies to all matters affecting unemployment insurance including, although not limited to, all benefit claims, contributions, refunds, experience rating, hearings and appeals.

The employer further understands the Wisconsin Unemployment Insurance Division maintains three (3) separate and distinct mailing groups* which include:

Group I	UCB-16	Separation Notice
	UCB-23	Wage Verification/Eligibility Report
	UCB-20	Determination
Group II	UCT-14384-1-E	Unemployment Insurance Benefit Charges and Adjustments
Group III	UCB-719	Urgent Request for Wages
	UCB-701	Computation of Unemployment Insurance Benefits
	UCB-708	Notice of Changed Liability for UI Benefits
	UCT-101-E	Quarterly Contribution Report
	UCT-14384-E	Unemployment Insurance Reserve Fund Balance Statement
	UC-7823-E	Quarterly Wage Reports
	UCT-14309-E	Reimbursable Employer Monthly Statement

*** Forms listed above must remain within the respective mailing group**

The employer authorizes group(s) _____ to be mailed to the representative's address listed above.
(List Group Number(s))

The remaining group(s) _____ will be mailed to the employer's main office.
(List Group Number(s))

By the signatures below, the employer known as _____ ,
(Employer Name)

approves the above directions and voluntarily enters into this assignment on _____ ,
(Date – mm/dd/yyyy)

at which time this assignment is effective and takes place of all previous assignments.

Authorized Signature: _____
(Employer Signature) (Date Signed – mm/dd/yyyy)

Printed Name & Title: _____
(Print Name) (Job Title)

Witnessed By: _____
(Witness Signature) (Date Signed – mm/dd/yyyy)

Printed Name & Title: _____
(Print Name) (Job Title)