MI HEALTH LINK

SOSWorks II
407 E. Fort St., Suite 407
Detroit, MI 48226

Customer Service: 313-965-0443 & 1-866-887-8424
TTY: 1-888-782-9082
Michigan Relay Service: 7-1-1
Administrative Fax: 1-313-221-9566
E-mail: enroll@sosworks.org
Web Site: sosworks.org

Employer of Record Enrollment Forms Packet

Dear Employer of Record:

Welcome! We have sent you this packet because you have been referred to the MI Health Link Dual Eligible Pilot Self Directed Program offered through the State of Michigan Department of Human Services. If you are enrolled in the MI Health Link program, and your services are provided through a Managed Care Organization. SOSWorks (SOS) is the Fiscal/Employer Agent (F/EA) supporting you by paying the Personal Care Provider (your employee) and managing tax filings on your behalf.

If you do not already have a scheduled enrollment appointment with a SOS Field Representative, please call 1-866-887-8424. This Welcome Packet contains important program information please read this packet and keep for your records. The forms in this packet, are referred to as the **Employer of Record Enrollment Forms Packet**. These are the required forms for both Employer of Record and the Employed Provider to enroll. Please do not use white-out or correction tape or cross out information on these forms. If you need a new form, you can call the SOS Customer Service team or print the forms from the SOS website.

To print forms from the SOS website, go to: www.sosworks.org. You will see a MI Health Link Program Menu Box on the right side of the screen. Click on it and you can print the Enrollment Documents.

Please bring these forms with you to your scheduled enrollment meeting. Prior to your scheduled enrollment meeting, you may also fax, email, or mail your completed forms to fax: 313-221-9566, email: enroll@sosworks.org or mail to SOSWorks, 407 E. Fort St., Suite 407, Detroit, MI 48226.

Once SOS receives correctly completed and signed forms from you and your prospective Provider(s), and after services have been authorized, SOS can begin paying your Providers(s) with Medicaid funds. SOS is committed to providing you with as much support as possible; however, we must follow federal, state, and local tax laws and Medicaid requirements.

☞ **NOTE: We will not be able to approve and begin paying your Provider until all the required forms for you and your Provider have been completed correctly.**

The Consumer-Directed Services Program does not discriminate against any person on the basis of race, religion, color, gender, sexual orientation, age, national origin, disability, veteran status or any other status or condition protected by law.

If you have questions, please call us toll-free at 1-866-887-8424 or email **enroll@sosworks.org**. Our Customer Service team is available Monday through Friday from 8:00AM until 8:00 PM ET and Saturday from 9:00 AM until 1:00 PM ET (excluding Federal Holidays).

We look forward to working with you!

EOR Welcome Packet

FORMS:

- ☐ Frequently Asked Questions
- ☐ Employer of Record Enrollment Forms
- ☐ Receipt of Employer Packet Information Acknowledgment
- ☐ Provider Employee Forms
- ☐ Instructions for Timesheets
- ☐ Timesheet
- ☐ Payroll Schedule
- ☐ Instructions for Contact Information Changes
- ☐ Employer of Record Contact Information Change Form
- ☐ Instructions for Notice of Discontinued Employment Form
- ☐ Notice of Discontinued Employment Form
- ☐ Worker's Comp

Frequently Asked Questions

General Program Questions

What is the purpose of the Michigan MI Health Link Consumer-Directed Services Program?

The Michigan MI Health Link Consumer-Directed Services Program is designed to allow people needing long- term care to receive authorized services in their home or community instead of a nursing home. The program allows those individuals to determine the services they will receive and select who will provide them according to their Service Plan and authorization.

How does this program work?

A Provider provides authorized services to a Consumer of the MI Health Link Program. The Employer of Record (EOR) is the person who employs the Providers. The EOR may be the Consumer or a different person selected by the Consumer.

What is SOSWorks?

SOSWorks (SOS) is a financial management services firm providing fiscal/employer agent (F/EA) services for you. SOS's services allow a Provider to work for you and be paid with program funds.

What types of services can Providers provide?

Providers can provide three types of service to Consumers through the Consumer-Directed Services Program. These are Provider services, Respite services, and Companion services. A person hired as a Provider can provide any of these types of services to a Consumer. The EOR will specify which service type is to be provided. Services must be authorized before providing the care.

- **Provider services** help individuals with their daily needs, such as dressing, bathing, eating, and assistance with self-administration of medication.

Frequently Asked Questions

What do I need to do as the Employer (EOR)?

As the Employer, you will

- Complete the Employment Agreement for each person you wish to have as a Provider.
- Review the Provider Employment Agreement with each Provider and ensure that both of you sign it.
- Complete and sign all Employer of Record Enrollment Forms.
- Sign all Provider Enrollment Forms and required paperwork.
- Establish schedules and tasks for each Provider in accordance with the Consumer's Service Plan.
- Monitor each Provider's work.
- Approve timesheets and submit signed timesheets to SOS for each Provider.
- Keep track of Service Authorizations and time used.
- Hire, supervise, and discontinue employment of the Providers.

SOS will:

- Perform a Criminal History Record Name Search on all Providers.
- Perform required state and federal background and employment eligibility checks on Providers.
- Issue wages using direct deposit to the Provider's checking or savings account.
- Withhold state and federal taxes and other withholdings for each Provider.
- File monthly, quarterly, and annual tax deposits and forms with state and federal agencies.
- Issue an IRS Form W-2 Wage Statement to each Provider in January every year.
- Provide the Quarterly Service Report (QSR) four times per year to review your Service Authorizations.
- Answer questions about enrollment, timesheets, and payments.
- Help you and your Provider with the enrollment process through SOS Customer Service.

What do I need to do first?

Review and sign all required forms. Once completed, fax or mail the EOR Enrollment Forms to SOS.

Does SOS have online resources to help me?

Yes, SOS maintains a website where you will find forms you can print on the SOS website.

Frequently Asked Questions

How do I access the SOS website, where there are forms?

1. Type www.sosworks.org into the computer's Internet browser address bar.

Where on the SOS Website will I find information for Employers?

Access the website using the information above. On the right side of this screen, under the heading MI Health Link you will find Employer and Employee forms you can print.

Must a Consumer's physical address change be reported?

Any changes in the Consumer's physical address **must** be reported.

Should SOS be notified of changes in the Consumer's phone number and email address?

Yes. There are several ways to notify SOS of phone number or email changes. You can:

- Call SOS Customer Service toll-free at 1-866-887-8424 or email at enroll@sosworks.org

Should the Employer of Record change their records on file with SOS?

Yes, the Employer of Record should notify SOS of any change in contact information. To update this information you can:

- Call SOS Customer Service toll-free at 1-866-887-8424 or email at enroll@sosworks.org

What if the Consumer loses Medicaid Eligibility?

The Provider can be paid through SOS only for services provided to a Consumer who is eligible for Medicaid and Waiver services.

What if the Consumer loses Waiver Eligibility?

Contact your Care Coordinator to be sure the Consumer is eligible for Waiver services.

The Consumer is in a nursing facility. Can the Provider be paid?

No, the Provider cannot be paid to provide care while the Consumer is receiving services in an in-patient setting such as a nursing facility or hospital.

Will I be required to pay for services out of my own pocket?

All authorized payroll related expenses are funded using program funds. These expenses include Provider wages, Employer payroll taxes, and unemployment insurance.

Services that do not meet requirements below will not be paid, including but not limited to circumstances such as:

- Medicaid or Waiver ineligibility
- Provider who has failed a Criminal History Record check due to a barrier crime
- Provider who is named in the federal List of Excluded Individuals/Entities database
- Provider working more than the number of Authorized Service hours.

What is the Provider Employment Agreement?

You must review the Provider Employment Agreement with each Provider. The agreement is found in the Provider Enrollment Forms Packet. This document needs to be signed and dated by both the Provider and you before SOS can issue a paycheck. The agreement will establish a hire date, program rules, and conditions of employment.

What if I do not understand how to complete the SOS paperwork?

You can contact SOS Customer Service for assistance with the paperwork 313-965-0443 or (866) 882-8424 (toll free).

Why do I need to sign the USCIS Form I-9 for my Provider?

The United States Citizenship and Immigration Services (USCIS) is a department within Homeland Security. Federal law requires all employers (you) to complete the I-9 for their employees, such as your new Provider. You must look at the Provider's identification before signing the form. The instructions for completing the form are in the Provider Welcome Packet. This form **must** be signed within three (3) days of employment. Providers should not start work without this form completed.

Can SOS email Provider Enrollment Packets and other program information to me?

Yes, if you request the Provider Enrollment Forms Packet and Provider Welcome Packet materials to be sent to you through email, SOS will send you a secure email. SOS may also send program communications by email.

What if I no longer want a Provider to work for me?

You can tell your Provider that you no longer wish to have services provided by him/her. Send SOS the completed Notice of Discontinuation of Employment form in this packet. Additional forms are available on the SOS website or by calling SOS Customer Service.

Frequently Asked Questions

Tax Questions

Will the IRS or Michigan Department of Treasury send me letters?

Now that you are an employer you may receive letters or forms. These letters may come from the IRS, Michigan Department of Treasury, and Michigan Unemployment Office. SOS asks for these letters to be sent to SOS but they may be sent to the address of the Employer. Most of the letters are for information only and you do not need to act. If you have questions, call SOS Customer Service; we may ask you to fax or mail the document to us.

What taxes are withheld for each of my Providers?

Most people must pay taxes. Taxes that are withheld include Social Security and Medicare (FICA), and income taxes (federal and state) for each paycheck. Withholding amounts are based on the tax exemption status the Provider selected on the tax paperwork. A list of payroll withholdings will be on the Provider's pay stub. SOS will mail the IRS Form W-2 Wage Statement to the Provider in January. SOS has until January 31st to mail the W-2 to your employees.

Does the Employer of Record handle payment of Employment taxes?

The program will pay the Employer's portion of taxes. As your agent, SOS will complete and submit all paperwork and payments.

Frequently Asked Questions

Payroll Questions

When can the Provider start receiving pay?

SOS can start paying your Providers when the following steps are complete:

1. The Consumer is approved to receive Authorized Services;
2. The Consumer is eligible for Medicaid and Waiver services;
3. The Employer of Record Enrollment Forms Packet has been received by SOS, all forms are complete, and an Employer Identification Number (EIN) has been issued.
4. The Provider Enrollment Forms Packet has been received by SOS and all forms are complete.

Who is responsible for approving and submitting timesheets to SOS?

As the Employer, you will approve and submit timesheets to SOS. You also will review, sign, and submit the Provider's final timesheet upon Discontinuation of Employment. You can select a responsible person to help you by completing and submitting the Signature Authority form.

What is a Payroll Schedule?

Payroll Schedules show pay periods and pay dates and are available at www.sosworks.org Click on the MI Health Link icon.

If you are unsure how to use the Payroll Schedules, call SOS Customer Service.

Frequently Asked Questions

Submitting Complaints

How can I submit a Complaint to SOS?

Complaints can be issued to SOS by phone; or in writing by fax, email, or mail.

- Call SOS Customer Service toll free at 1-866-887-8424
- Fax: 1-313-221-9566
- Email: www.enroll@sosworks.org
- Mail: SOSWorks
  407 E. Fort St. Suite 407
  Detroit, MI 48226

When should I hear from SOS regarding a complaint I submitted?

1. For a complaint you submit by phone, SOS will address your complaint immediately. If we can't resolve it during that call, we will contact you within three (3) business days with resolution.
2. For a complaint you submit in writing, SOS will attempt to contact you by phone or in writing within one (1) business day and take steps to resolve your complaint in that communication.
3. If we can't resolve your complaint at the time we acknowledge having received it, we will review and take steps to resolve your complaint within three (3) business days of having acknowledged it.

Frequently Asked Questions

Background Checks

What background checks are completed on Provider Employees?

SOS will complete the following background checks on Provider Employees:

- Criminal History Background. Criminal Background Checks means the State of Michigan Internet Criminal History Access Tool ("ICHAT") or other background checks that may be required by the State of Michigan. Criminal Background Checks includes a search of the OIG/GSA exclusion list to assure that the IPCP is not debarred or excluded from participating in government programs.

- List of Excluded Individuals/Entities (LEIE). The United States Department of Health and Human Services, Office of Inspector General (HHS-OIG) maintains the LEIE. This list contains names of people with findings of program-related fraud, patient abuse or licensing board actions.

What is the LEIE?

The List of Excluded Individuals/Entities (LEIE) is a database maintained by the United States Department of Health and Human Services, Office of Inspector General (HHS-OIG). This database contains names of people who have been convicted of crimes related to Medicare or Medicaid programs, patient abuse, and actions taken by a state licensing authority. These people cannot receive Medicaid funds for payment.

How often will SOS conduct LEIE background checks?

SOS will conduct an LEIE background check on all new Providers and on every Provider once a month to comply with federal law.

What happens if a Provider's name appears on an LEIE background check?

Medicaid payments cannot be made to an excluded person who is named in LEIE database.

How will I know if a Provider in my employ has been excluded from participation in federal health care programs?

SOS will mail you a letter if any Provider is denied employment due to being listed in the federal LEIE database.

Workers' Compensation

Workers' Compensation is a form of insurance required from employers that provides money as compensation for workers who are injured on the job or contract an occupational disease.

Are Your Employees Covered?
Your employees will automatically have Workers' Compensation coverage. This coverage is mandatory and is included in the employer burden that is paid out of the Individual Cost Plan. There are no forms you or your employee will need to complete.

How Do You Report an Injury?
Should an employee become injured while he/she is at work, please seek medical attention immediately in a life threatening situation. **Be sure to report the injury to SOSWorks 866-887-8424 within 24 hours of the incident.** SOSWorks designated Customer Service Workers' Compensation representative will help your employee throughout the claim filing process.

Please Note that you as the employer are required to post a copy of the Workers' Compensation flyer somewhere in your home where your employee(s) may see it, especially in an emergency. A copy of this poster has been included in your employer/ employee enrollment packet.

Unemployment Benefits

Your former employee may be eligible for unemployment benefits upon termination, depending on the reason for termination and several other factors. Unemployment Insurance is included in the employer tax that SOSWorks is paying on your behalf. However, the Michigan Unemployment Agency decides whether or not your employee qualifies to receive benefits. Refer your former employee to the Michigan Unemployment Agency wwww.mi.gov/UIA for more information or to apply for benefits.

Employer of Record Enrollment Forms

- ☐ Participant Information Sheet
- ☐ Employer of Record Information Form
- ☐ Self Determination Enrollment Form Copy
- ☐ Self Determination Agreement Copy
- ☐ Receipt of Privacy Notice and Grievance Policy
- ☐ SS-4 Application for Employer Identification Number
  - **SS-4 Form-** This form only needs your signature; we will fill out the rest of the information for you. There may be forms that will need to be filled out in the future.
- ☐ 8821 Tax Information Authorization
  - **IRS Form 8821-**Tax Information Authorization: The 8821 allows us to receive the employer's confidential payroll tax information from the IRS. IRS Form 8822-Change of Address: This changes the employer's mailing address for IRS payroll tax documents from the employer's address to ours. Having the address changed ensures that we will receive any IRS payroll tax notices.
- ☐ 2678 Employer/Payer Appointment of Agent
  - **IRS Form 2678-**Employer Appointment of Agent: This form authorizes us to act as the employer's payroll agent, which simply means it allows us to file payroll tax returns for the employer and to make payroll tax payments.
- ☐ MI 158 Registration for MI Taxes
- ☐ MI 151 Authorized Representative Declaration
- ☐ MI 3683 Payroll Service Provider/Power of Attorney
  - **MI Form 3683**-Payroll Service Provider Combined Power of Attorney Authorization: The 3683 performs the same functions as the four IRS forms above for the Michigan Department of Treasury. It allows us to file payroll tax returns, make payroll tax payments and receive confidential payroll tax information. In addition, it changes the Michigan Treasury mailing address from the employer's address to ours, ensuring that we receive any Michigan Treasury payroll tax documents.
- ☐ UIA 1488 Power of Attorney
  - **UIA Form 151**-Power of Attorney: This does the same as the 3683, but for the Unemployment Insurance Agency.
- ☐ Combined Budget Template
- ☐ Self Determination Backup Worker Plan
- ☐ Email Consent
- ☐ Informed Consent
- ☐ Workers Comp Info / Poster

Employer of Record Information Form

Complete this form as the Employer of Record

Employer of Record Information below is required for verification:
Employer of Record ID:
Employer of Record First Name & Middle Initial:
Employer of Record Last Name:
Employer of Record Date of Birth:
Provide information below:
☐ **Employer of Record's Phone Number: ( )_____-____**
☐ **Employer of Record's Email Address:**

_____

Employer of Record Signature **Date**

If you need assistance please contact SOSWorks (SOS).

➢ **Call SOSWorks Customer Service** ➢ **Email: enroll@sosworks.org** ➢ **Secure Email: sosworks@protonmail.com**	**Call**: 1-866-877-8424
Mail: SOSWorks II 407 E. Fort St., Suite 407 Detroit, MI 48226	**Fax**: 1-313-221-9566

Self-Determination Provider Agreement

The Self-Determination Provider is a provider directly employed by or contracted by a person using arrangements that support self-determination. The sole purpose of this agreement is to assure compliance with federal Medicaid requirements. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement.

Upon receipt of this agreement, the ICO will certify the Self-Determination Provider as available to provide services to individuals who receive services and/or supports in accordance with their Individual Integrated Care and Supports Plan (IICSP) developed in a person-centered planning process, authorized by the ICO or one of its subcontractors, and financed through the ICO.

The Medicaid Provider stipulates that it will do the following

1. Accept payment, in form of check(s) or direct deposit, from **SOSWorks II**, doing business in the State of Michigan.
2. No additional payments (beyond payment agreed to in the employment or purchase- of-service agreement and paid by the fiscal intermediary) will be accepted directly from individuals using arrangements that support self-determination.
3. Agree to keep records of the service(s) or purchase(s) provided as required by the individual(s) using arrangements that support self-determination or the ICO.
4. Provide only the service(s) or item(s) described in the employment or purchase-of- service agreement with the employer (as authorized in the person's IICSP) and do not exceed the hours set forth in the employment or purchase-of-service agreement except in emergency situations or with authorization from the ICO.
5. Accept the check(s) or direct deposit(s) as payment in full for service(s) or item(s) purchased.
6. Upon request, provide information regarding the service(s) or purchase(s) for which payment was made to and to provide such information and any related invoices or billings, upon request, to the individual using arrangements that support self- determination, ICO, the State Medicaid Agency, the Secretary of the Department of Health and Human Services or the State Medicaid fraud control unit.

_____ _____

Self-Determination Provider Agency/Individual Date

_____ _____

ICO Representative Date

SELF-DETERMINATION AGREEMENT

This agreement is made on ***[insert date]*** between ***[insert name of ICO]*** ("ICO") and [***insert name of enrollee***] ("enrollee"). The ICO authorizes supports and services to enrollees receiving Medicaid home and community-based supports and services and the enrollee is using arrangements that support self-determination to access those supports. These arrangements include using the person-centered planning process to determine the appropriate service and supports, develop an IICSP, and authorize an individual budget.

The purpose of this agreement is to define the responsibilities of the parties using arrangements that support self-determination. This agreement may be changed only through a written agreement by both parties. Termination of this agreement does not affect the enrollee's right to access supports and services through the ICO. The enrollee has the right to local dispute resolution, grievance, and/or appeals processes provided by the ICO.

Funds in the individual budget are the responsibility of the ICO and must be used consistently with Medicaid requirements. Providers must meet provider requirements and sign a Self-Determination Provider Agreement with the ICO. The authority over control and direction of the funds is delegated by the ICO to the enrollee to enable the enrollee to use his or her supports and services in a way that best meets his or her needs.

The individual budget will be administered by the fiscal intermediary (FI) **SOSWorks, 866-887-8424, enroll@sosworks.org, www.sosworks.org,** which will be responsible for completing and submitting paperwork for billing, payment for supports and services when authorized by the enrollee, and handling the employer agent function. The fiscal intermediary will provide a monthly spending report to the enrollee and the ICO Care Coordinator and/or LTSS Supports Coordinator.

ARTICLE I—ICO RESPONSIBILITIES

The ICO agrees to the following responsibilities:

1. Fund supports and services in the IICSP and the individual budget (see attachments A and B).

2. Inform the enrollee of the Medicaid requirements for providers (such as age, and relationship to enrollee).

3. Assist the enrollee with obtaining required agreements from each provider.

4. Provide information on the documentation and reporting requirements for supports and services obtained through arrangements that support self- determination.

5. Provide monthly assistance in monitoring expenditures and reviewing financial reports.

6. Provide the enrollee with information on applicable dispute resolution procedures.

7. The ICO Care Coordinator and/or LTSS Supports Coordinator will:
   a. Work with the enrollee to develop an IICSP and an individual budget through a person-centered planning process.
   b. Work with the enrollee to develop a backup plan for essential services in case of worker absences, emergencies or unforeseen circumstances.

ARTICLE II— PERSON'S RESPONSIBILITIES

The person (enrollee, guardian, or other legal representative) agrees to:

1. Directly manage a portion or all of his or her supports and services.

2. Directly hire or contract with workers or providers who meet provider requirements.

3. Use supports and services consistent with the goals in the IICSP.

4. Provide the ICO and/or the Fiscal Intermediary with all necessary documentation supporting expenditures of funds provided by the ICO pursuant to the individual budget.

5. Manage the use of funds so that expenses over the course of the year do not go over individual budget.

6. Let the ICO know of a change in circumstance or an emergency that may require a change in the IICSP or the individual budget.

7. When requested to do so, the person agrees to provide feedback to the fiscal intermediary or ICO to enable them to improve fiscal intermediary services.

The ICO and person agree to the terms and conditions of this agreement.

_____ _____

Person Date

_____ _____

ICO Date

FI- 2.13
Grievance Process Policy

POLICY

It is the policy of SOSWorks to follow all federal and state requirements regarding the grievance process. This policy ensures that all participants have access to grievance rights, options that are timely, objective, fair, accessible and understandable Enrollees/members are to be notified of grievance rights at the time of initial enrollment, annually, or as information is requested by enrollee/member or if there is change in policy.

Enrollees must be informed of the internal grievance procedure at the time of enrollment and any other time an enrollee expresses dissatisfaction by filing a grievance. All individuals involved with the enrollee/member's care will ensure that the recipients who file a grievance shall not be subject to discrimination or retaliation.

PURPOSE

The purpose of this policy is to define the process by which SOSWorks will address and resolve an enrollee/member's grievance in accordance with the applicable statutory, regulatory and contractual requirements.

APPLICATION

This policy applies to SOSWorks Fiscal Intermediary Services.

STANDARDS

A. SOSWorks will:

1. Ensure that all employees are trained on the grievance process within 30 days of hire and annually thereafter.
2. Provide information about the grievance procedures and forms upon enrollment.
3. Ensure persons who file a grievance shall not be subject to discrimination or retaliation.
4. Ensure staff that participates in the review or resolution of a grievance shall not be subject to discrimination or retaliation.
5. Ensure that the grievance process is:
    a. Timely
    b. Objective
    c. Fair to all parties
    d. Accessible and understandable to the member/enrollee/legal representative and service provider.
6. Ensure the member/enrollee or legal representative shall be:
    a. Informed orally and in writing of the grievance process available and methods to file a grievance.
    b. MI Health Link enrollee/members may file a grievance within sixty (60) Calendar days orally or in writing of the date of the adverse action notice and/or circumstance giving rise to the grievance.
    c. Provided interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
    d. Provide information regarding grievance rights in a format provided at the time of initial enrollment and at least annually thereafter.

PROCEDURE

- Upon receiving a request for review of grievance, the Grievance Coordinator shall:
    e. Document the grievance at the time in the SOSWorks, FI Tracking.
    f. Request any missing information from the enrollee/member/legal representative and enter any additional information the FI Tracker.
    g. Submit to the appropriate staff with the authority to require corrective action, none of whom shall have been involved in the previous review or decision-making.
    h. Ensure that the grievance resolution does not exceed thirty (30) days for **MI Health Link** enrollees/members/legal representatives.
- The Grievance Coordinator shall complete and forward an Acknowledgment Letter enrollee/member/legal representative within three (3) days of receipt of the grievance**.**
- The Grievance Coordinator is responsible for processing, investigating and responding to a grievance as expeditiously as the case requires, no later than thirty (30) days of receipt of the grievance. The thirty (30) day timeframe may be extended up to fourteen (14) days. If extension is granted, the enrollee/member/legal representative will immediately be notified of this delay in writing**.**
- The Grievance Coordinator shall ensure that corrective action occurs in a timely manner.
- The Grievance Coordinator shall review the grievance to ensure appropriate resolution.
- The Grievance Coordinator shall discuss the grievance resolution with the enrollee/member/legal representative.
- Once the Grievance Coordinator has obtained all pertinent information to resolve the issue, a Resolution Letter will be completed and mailed to the enrollee/member/legal representative**.**
- All grievances, whether they are received in writing or verbally, will be responded to in writing.
- All resolution letters will be carefully reviewed for content, spelling, and grammar to ensure that the communication is clear, concise, accurate, and at an appropriate level of understanding.
- The grievance is considered closed when:
    - The problem is resolved.
    - SOSWorks takes appropriate action to implement the decision.
    - The enrollee/member/legal representative withdraws the grievance.

INTERNAL CONTROLS

QUALITY ASSURANCE/IMPROVEMENT

SOSWorks shall review and monitor adherence to this policy as one element in its management of the program.

a. Tracking trends, patterns, and opportunities for improvement in the delivery of service utilizing the required forms.
b. Quarterly reports are provided to the Compliance and Quality Assurance Officer

Receipt of Privacy Notice and Grievance Policy

Participant Initials_____ Date: _____

Privacy / Confidentiality Policy

SOSWorks has procedures to protect the confidentiality of information about participants or persons seeking services collected in the conduct of its responsibilities. No information about a participant or person seeking services, or obtained from a participant or person seeking services by a service provider, is disclosed in a form that identifies the person without the informed consent of that person or of his or her legal representative. However, disclosure may be allowed by court order, or for program monitoring by authorized federal, state, or local agencies (which are also bound to protect the confidentiality of the client information) so long as access is in conformity with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. All client information written, electronic, or oral is maintained in a secure environment in controlled access files.

Participant Initials_____ Date: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (DHHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of DHHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Form **SS-4** (Rev. January 2010)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

▶ **See separate instructions for each line.** ▶ **Keep a copy for your records.**

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) _____
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ 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)

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 1-2010)

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Form **8821**

(Rev. March 2015)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶ **Information about Form 8821 and its instructions is at *www.irs.gov/form8821*.**

▶ **Do not sign this form unless all applicable lines have been completed.**

▶ **Do not use Form 8821 to request copies of your tax returns or to authorize someone to represent you.**

OMB No. 1545-1165

For IRS Use Only

Received by:

Name

Telephone

Function

Date

1 Taxpayer information. Taxpayer must sign and date this form on line 7.

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number	Plan number (if applicable)

2 Appointee. If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached ▶** ☐

Name and address	CAF No.
	PTIN
	Telephone No.
	Fax No.
	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

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

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters

4 Specific use not recorded on Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip lines 5 and 6 . . . . . ▶ ☐

5 Disclosure of tax information (you **must** check a box on line 5a or 5b unless the box on line 4 is checked):

a If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ▶ ☐

Note. Appointees will no longer receive forms, publications, and other related materials with the notices.

b If you do not want any copies of notices or communications sent to your appointee, check this box . . . . . ▶ ☐

6 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box is not checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 box and attach a copy of the Tax Information Authorization(s) that you want to retain. . . . . ▶ ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 6 instructions.

7 Signature of taxpayer. If signed by a corporate officer, partner, guardian, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ **IF NOT COMPLETE, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.**

▶ **DO NOT SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.**

Signature | Date

Print Name | Title (if applicable)

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.

✗ **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. ➡

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

6 **Agent's employer identification number (EIN)** ☐☐ – ☐☐☐☐☐☐☐

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

8 **Trade name** (if any)

9 **Address**

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

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

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

X **Sign your name here**

Print your name here

Print your title here

Date / /

Best daytime phone

Form **2678** (Rev. 8-2014)

Reset Form

Michigan Department of Treasury
Form 518 (Rev. 02-16)

Type or print in blue or black ink.

Registration for Michigan Taxes

Check the reason for this application. If more than one applies, see instructions.

- ☐ Started a New Business
- ☐ Reinstating an Existing Account
- ☐ Hired Employee / Hired Michigan Resident
- ☐ Incorporated / Purchased an Existing Business
- ☐ Acquired/Transferred All/Part of a Business
- ☐ Added a New Location(s)
- ☐ PEO: Client Level Reporting
- ☐ Report Wages After Total Transfer/Sale of Business
- ☐ Other (explain)_____

▸ 1. Federal Employer Identification Number, if known	▸ 2. Company Name or Owner's Full Name (include, if applicable, Corp, Inc, PC, LC, LLC, LLP, etc.). Required.
-	

▸ 3. Business Name, Assumed Name or DBA (as registered with the county)

Legal Address (Required)	▸ 4. Address for all legal contacts (street and number - no PO boxes)		Business Telephone
	City	State	ZIP Code
Taxpayer Mailing Address	▸ 5. Address, if different from Box 4, where all tax forms will be sent, unless otherwise instructed		**If this address is for an accountant or other representative, attach Form 1488, *Power of Attorney for UIA*.**
	City	State	ZIP Code
Physical Address	▸ 6. Address of the actual Michigan location of the business, if different from above (street and number--no PO boxes). If NO Michigan address, check this box ☐		
	City	State	ZIP Code

▸ 7. Enter the Business Ownership Type code from Page 4 (Required) ..... ▸ 7.
If your business is a limited partnership, you must name all general partners beginning on line 29.
If you are a Professional Employer Organization (PEO), give PEO License ID _____.

▸ 8. If you are a Michigan entity and line 7 is 35-39, 40, OR 41, enter your Michigan Licensing and Regulatory Affairs (LARA) Corporate ID Number ..... ▸ 8.

☐ Check this box if you have applied for and not yet received your ID number.

Date of Incorporation _____ State of Incorporation_____

▸ 9. Enter Business Code (NAICS) that best describes your business ..... ▸ 9.
NAICS codes can be found at http://www.census.gov/eos/www/naics

10. Define your business activity	11. What products, if any, do you sell (sold to final consumer)?

Check the tax(es) below for which you are registering. At least one box (12-16) must be checked.	**Date that liability will begin for each box checked at left.** Month / Day / Year	**Estimated monthly payment for each tax Required if box at left is checked.**
▸ **12.** ☐ Sales Tax ..... ▸ **12a.**		▸ **12b.** ☐ Up to $65 ☐ Up to $300 ☐ Over $300
▸ **13.** ☐ Use Tax ..... ▸ **13a.**		▸ **13b.** ☐ Up to $65 ☐ Up to $300 ☐ Over $300
▸ **14.** ☐ Employer and Retirement Withholding (See line 23.) ... ▸ **14a.**		▸ **14b.** ☐ Up to $65 ☐ Up to $300 ☐ Over $300
▸ **15.** ☐ Annual Gross Receipts over $350,000 (CIT) ..... ▸ **15a.**		**Corporate Income Tax is required only if annual gross receipts in Michigan exceed $350,000 with the exception of insurance companies and financial institutions.**
▸ **16.** ☐ Flow-Through Withholding... ▸ **16a.**		

Check the box if these other taxes also apply:

▸ **17.** ☐ Unemployment Insurance Tax. Attach UIA Schedule A and UIA Schedule B. Corporations, LLCs, LLPs: Enclose a copy of your Articles of Incorporation or Organization. **You must complete all items on this form accurately and completely. Failure to do so may subject you to the penalties provided under the Michigan Employment Security (MES) Act.**

▸ **18a.** ☐ Motor Fuel. Treasury will review your registration and contact you for any additional information.

▸ **18b.** ☐ IFTA Tax. Apply for a license first at www.Michigan.gov/IFTA. You may contact IFTA at (517) 636-4580.

▸ **19.** ☐ Tobacco Tax. Complete line 28. Treasury will review your registration and will contact you for more information.

▸ **20.** Enter the number of business locations you will operate in Michigan (Required) ..... ▸ **20.**
If more than 1, attach a list and include each location's name, address, city, state and ZIP code.

▸ **21.** Enter the month, numerically, that you close your tax books (for example, enter 08 for August) ..... ▸ **21.**

▸ **22. Seasonal Only:** (Your business is not open continuously for the entire year) Seasonal filers are required to file monthly returns for the months that you are open.

a. Enter the month, numerically, this seasonal business opens ..... ▸ **22a.**

b. Enter the month, numerically, this seasonal business closes ..... ▸ **22b.**

Note: If you are registering to sell at only one or two events in Michigan per year, do not submit this registration form. Instead, file a *Concessionaire's Sales Tax Return and Payment* (Form 2271). This form can be obtained on Treasury's Web site at **www.michigan.gov/taxes, or by calling 1-517-636-6925**.

▸ **23.** ☐ Check this box if you use a payroll service that produces your payroll checks and sends income tax withholding payments to the State and Federal Governments. Access Michigan Treasury Online (MTO) at **www.michigan.gov/mtobusiness** or attach *Authorized Representative Declaration (Power of Attorney)* (Form 151). This form can be obtained on Treasury's Web site at **www.michigan.gov/taxes, or by calling 1-517-636-6925**.

Enter the name of your payroll service provider: _____

▸ **24.** If you are incorporating an existing business, or if you purchased an existing business, list previous business names, addresses, and FEINs, if known.

Previous Business Name and Address	FEIN
Previous Business Name and Address	FEIN

25. If you purchased an existing business, what assets did you acquire? Check all that apply.

☐ Land ☐ Building ☐ Furniture and Fixtures ☐ Equipment ☐ Inventory ☐ Accounts Payable ☐ Goodwill ☐ None

		Yes	No
26.	**Motor Fuel Tax: (if you answer Yes to any of the questions below, see Web site www.michigan.gov/taxes)**		
	a. Will you operate a terminal or refinery? ..... 26a.	☐	☐
	b. Will you transport fuel across Michigan's borders? ..... 26b.	☐	☐
27.	**IFTA Tax: (if you answer Yes to any of the questions below, see Web site www.michigan.gov/taxes)**		
	a. Do you own a diesel-powered vehicle used for transport across Michigan's borders with three or more axles or two axles and a gross vehicle weight over 26,000 lbs? ..... 27a.	☐	☐
	b. Will you transport fuel across Michigan's borders? ..... 27b.	☐	☐
28.	**Tobacco Tax: (if you answer Yes to any of the questions below, see Web site michigan.gov/tobaccotaxes) Do you intend to:**		
	a. Sell cigarettes or other tobacco products for resale to other businesses? ..... 28a.	☐	☐
	b. Purchase any tobacco products from an out of state unlicensed source? ..... 28b.	☐	☐
	c. Sell any tobacco products in a vending machine? ..... 28c.	☐	☐

Complete all the information for each owner (sole proprietor or member), partner, or corporate officer. For limited partnership you must list all general partners. For limited liability companies you must list all members. For corporations you must list all officers, but do not include shareholders who are not officers. A signature is **REQUIRED** for each person listed in boxes 29-32. Attach a separate list if necessary.

I certify that the information provided on this form is true, correct and complete to the best of my knowledge and belief.

▸ **29.** Name (Last, First, Middle, Jr/Sr/III)		Title	Date of Birth	Phone Number
Driver License / MI Identification No.	Social Security Number	Signature		
▸ **30.** Name (Last, First, Middle, Jr/Sr/III)		Title	Date of Birth	Phone Number
Driver License / MI Identification No.	Social Security Number	Signature		
▸ **31.** Name (Last, First, Middle, Jr/Sr/III)		Title	Date of Birth	Phone Number
Driver License / MI Identification No.	Social Security Number	Signature		
▸ **32.** Name (Last, First, Middle, Jr/Sr/III)		Title	Date of Birth	Phone Number
Driver License / MI Identification No.	Social Security Number	Signature		

Questions regarding this form should be directed to Treasury at 517-636-6925. Submit this form six weeks before you intend to start your business. MAIL TO: Michigan Department of Treasury, PO Box 30778, Lansing, MI 48909-8278 OR FAX TO: 517-636-4520.

UIA Schedule A - Liability Questionnaire

Issued under authority of the Michigan Employment Security Act of 1936, as amended, MCL 421.1 et seq. Filing is mandatory for all employers. **You must complete all items on this form accurately and completely. Failure to do so may subject you to the penalties provided under the MES Act.**

UIA Account Number, if already assigned

Federal Employer Identification No. (required)

An employing unit becomes liable to pay Michigan unemployment taxes when the employing unit meets any of the following criteria:

- Pays $1,000 or more in gross wages for covered employment in a calendar year.
- Employs one or more employees in 20 different weeks within a calendar year.
- Acquires all or part of an existing Michigan business.
- Pays at least $1,000 in cash, not including room and board, for domestic service within a calendar quarter.
- Pays at least $20,000 in cash, not including room and board, for agricultural service within a calendar quarter, ***OR*** Employs at least 10 agricultural workers in each of 20 different weeks in the current or preceding calendar year.
- Elects coverage under the terms of the Michigan Employment Security (MES) Act.
- Is subject to federal unemployment tax.

When any one of the above criteria is met, you must submit Form 518, *Registration for Michigan Taxes,* and UIA Schedule A - *Liability Questionnaire* and UIA Schedule B - *Successorship Questionnaire.* You must also begin quarterly filing of Form UIA 1028, *Employer's Quarterly Wage/Tax Report.* Unemployment taxes are due and payable beginning with the first calendar quarter in which you had payroll. Due dates for tax and wage reports are April 25, July 25, October 25 and January 25.

Providing inaccurate or incomplete information in this Registration, or UIA Schedules A or B, will be evidence of intentional misrepresentation and may subject you to the civil and/or criminal penalties provided in Sections 54 and 54b of the *Michigan Employment Security (MES) Act*.

On what date did/will you first employ anyone in Michigan? .....

Month	Day	Year

Complete the appropriate sections below according to the type of employer being registered.

SECTION 1

EMPLOYERS OTHER THAN AGRICULTURAL OR DOMESTIC/HOUSEHOLD

(See instructions to determine if applicable)

If Agricultural, skip to Section 2. If Domestic/Household,skip to Section 3.

If you have had a gross payroll of $1,000 or more within a calendar year, enter the date it was reached or will be reached. .....

Month	Day	Year

If you have had 20 or more calendar weeks in which one or more persons performed services for you within a calendar year, enter the date the 20th week was reached or will be reached. The weeks do not have to be consecutive nor the persons the same. .....

Month	Day	Year

If Employer is a NonProfit, a Governmental Agency / Indian Tribe/ Tribal Unit, a Federal Unemployment Tax Act (FUTA) Subjectivity, or is selecting Elective Coverage, then complete only one of the following four employer types below that best describes the business.

1. NONPROFIT EMPLOYERS

Nonprofit organizations finance their unemployment liability by either (1) paying unemployment taxes on the taxable wages of their employees (contributing) or (2) making a specific prior election to reimburse the UIA for any unemployment benefits paid to their former employees (reimbursing). A nonprofit organization that does not elect to be reimbursing will be, by default, contributing.

To elect contributing status, check this box: ☐ and skip paragraphs A – D below.

To elect reimbursing status, see paragraphs A – D.

A. Nonprofit employers electing reimbursing status must provide the UIA with a copy of the documentation from the Internal Revenue Service (IRS) granting 501(c)(3) status.

☐ Check this box if you elect to be a reimbursing employer. Attach a copy of your IRS 501(c)(3) documentation. Failure to check this box will result in the establishment of your liability as a contributing employer.

B. If you are a nonprofit employer electing reimbursing status, enter the amount (or estimate) of your gross annual payroll ..... $

C. **Bonding Requirements.** Section 13a of the *Michigan Employment Security (MES) Act* requires that **nonprofit** employers electing reimbursing status on or after December 21, 1989, and that have, or expect to have, a gross payroll of more than $100,000 during any calendar year must notify the UIA of that fact immediately and must provide a surety bond, irrevocable letter of credit, or other banking device approved by the UIA, in an amount to be determined by the UIA to secure the employer's obligations under the MES Act. If you exceed $100,000 in gross payroll in a later year, you are obligated to notify the UIA, and provide the bond at that time.

D. If your organization is funded more than 50 percent by a grant, list the source and duration of the grant.

Source	Start Date	End Date

2. GOVERNMENTAL AGENCIES, INDIAN TRIBES AND TRIBAL UNITS

Governmental entities generally reimburse unemployment insurance benefits paid to former employees on a dollar-for-dollar basis unless they elect to make quarterly "contribution" payments.

A. If you are a governmental agency, or Indian tribe or tribal unit, identify the type (i.e., city, township, commission, authority, tribe, etc.) .....

B. Enter your fiscal year beginning date ..... Month Day

C. ☐ Check this box if you elect to be a contributing employer. Leaving this box unchecked will result in the establishment of your liability as a reimbursing employer.

D. Indian tribes and tribal units are subject to the same bonding requirements as nonprofit employers (see Line 1C, above).and must provide the amount (or estimate of their gross annual payroll here:

3. FEDERAL UNEMPLOYMENT TAX ACT (FUTA) SUBJECTIVITY. Select this option ONLY if you are NOT liable for UIA taxes State under any of the other employer types.

If you are already subject to FUTA, enter the state, other than Michigan, where you became liable.....

Note: "Subject to FUTA" refers to filing Form 940 with the IRS. If you are required to file Form 940 (FUTA) with the IRS in other states, you are required to file and pay state unemployment taxes in Michigan.

4. ELECTIVE COVERAGE. For employers who would not otherwise be liable for unemployment taxes, such as churches.

☐ Check this box if you wish to elect coverage under the MES Act. Approval is subject to UIA review; some qualifiers apply. Your election, if granted, will apply to all your employees. Give your reason for electing coverage in the space provided below. If you are an individual owner or partnership electing to cover family members, specify their relationship to the owner or partners. You may not elect coverage for your parents or spouse, nor for your child under the age of 18. Individual owners and partners cannot elect coverage for themselves. You may not elect coverage for domestic employment below the statutory requirements stated above. Election of coverage remains in effect for a minimum of two calendar years.

SECTION 2

2. AGRICULTURAL EMPLOYERS ONLY

A. If you have had a total cash payroll of $20,000 or more for agricultural services performed within a calendar quarter in either the current or preceding calendar year, not including room and board, enter the date the $20,000 was reached or will be reached. ..... Month Day Year

B. If you have had at least 10 agricultural workers in each of 20 different weeks in the current or preceding calendar year, enter the date the 20th week was reached or will be reached. The weeks do not have to be consecutive nor the persons the same. ..... Month Day Year

SECTION 3

3. DOMESTIC/HOUSEHOLD EMPLOYERS ONLY

A. If you have had a cash payroll of $1,000 or more for domestic services within a calendar quarter in either the current or preceding calendar year, not including room and board, enter the date the $1,000 was reached or will be reached. ..... Month Day Year

SECTION 4

ALL EMPLOYERS

Print Name of Owner/Officer			Signature of Owner/Officer
Title	Telephone Number	Date	
Print Name of Owner/Officer			Signature of Owner/Officer
Title	Telephone Number	Date	

Attach this schedule to Form 518, *Registration for Michigan Taxes* and mail it to the Michigan Department of Treasury.

518 Schedule B (Rev. 11-07)

UIA Schedule B - Successorship Questionnaire

Issued under authority of the *Michigan Employment Security Act* of 1936, as amended, MCL 421.1 et seq. Filing is mandatory for employers.

You must complete all items on this form accurately and completely. Failure to do so may subject you to the penalties provided under the *Michigan Employment Security (MES) Act*. Attach additional sheets if necessary.

Successorship Reporting Requirement. If you acquired any part of the Michigan assets, trade or business of another employer, as defined in Part 3 of this form, by purchase, rental, lease, inheritance, merger, foreclosure, bankruptcy, gift or any other form of transfer, you must provide the following information. If you made multiple acquisitions, you must file a separate UIA Schedule B for each acquisition (photocopies of this form are acceptable). **If you made no acquisitions, you are still required to complete this schedule.** If subsequent to completing this registration form, you transfer the assets (by sale or transfer), organization (payroll/employees), trade (customers/accounts), or business (products/services), in whole or in part, to a new or previously existing business in Michigan, it is **mandatory** that you notify this Agency **immediately** by completing an additional Schedule B.

UIA Account Number (if already assigned) | | | | | | | | | | |

Federal Employer Identification No. (required) | | | | | | | | | |

PART I: QUESTIONS ABOUT PRIOR OR CURRENT BUSINESS FORMATIONS, ACQUISITIONS OR MERGERS

For each of the following five business formation, acquisition or merger types, the employer must indicate the pertinent business name, address and UIA Account Number in the space provided.

1. In the past 6 years, have you formed, acquired or merged with a business by any means? If no, check box ☐ and continue. If yes, provide the following:

Business Name and Address	UIA Account Number

a. If you formed a new business, what did you acquire from the previously existing business? (check all that apply)
☐ Land ☐ Buildings ☐ Furniture/Fixtures ☐ Equipment ☐ Inventory ☐ Accounts Receivable ☐ Goodwill
☐ Employees ☐ Trade ☐ Customer Accounts ☐ None

b. If you purchased, acquired or merged with an existing business by any means (including lease), what assets did you acquire? (check all that apply)
☐ Land ☐ Buildings ☐ Furniture/Fixtures ☐ Equipment ☐ Inventory ☐ Accounts Receivable ☐ Goodwill
☐ Employees ☐ Trade ☐ Customer Accounts ☐ None

c. What was the business activity of the previous business?

_____

2. At the current time, are you forming or acquiring a business by any means? If no, check box ☐ and continue, If yes, provide the following:

Business Name and Address	UIA Account Number

a. If you formed a new business, what did you acquire from a previously existing business? (check all that apply)
☐ Land ☐ Buildings ☐ Furniture/Fixtures ☐ Equipment ☐ Inventory ☐ Accounts Receivable ☐ Goodwill
☐ Employees ☐ Trade ☐ Customer Accounts ☐ None

b. If you are purchasing or acquiring an existing business by any means (including by lease), what assets are you acquiring? (check all that apply)
☐ Land ☐ Buildings ☐ Furniture/Fixtures ☐ Equipment ☐ Inventory ☐ Accounts Receivable ☐ Goodwill
☐ Employees ☐ Trade ☐ Customer Accounts ☐ None

c. Will any owner or owners of the previous business continue to operate or manage the business being registered by this form?
☐ Yes ☐ No If yes, provide name, title and business address below.

_____

d. What was the business activity of the previous business?

_____

e. What will be the business activity, if any, of the previous business after the new business being registered is formed?

_____

f. What will be the business activity of the new business being registered by this form?

_____

PART I: QUESTIONS ABOUT PRIOR OR CURRENT BUSINESS FORMATIONS, ACQUISITIONS OR MERGERS (continued)

3. At the current time, are you incorporating an existing business entity? If no, check box ☐ and continue. If yes provide the following:

Business Name and Address	UIA Account Number

a. What was the business activity of the business entity you are incorporating?

b. What will be the business activity of the new business being registered by this form?

4. At the current time, are you merging, by any means, with one or more business entities? If no, check box ☐ and continue. If yes, provide the following:

Business Name and Address	UIA Account Number

a. If you are purchasing or acquiring an existing business by merger, what are you acquiring? (check all that apply)
☐ Land ☐ Buildings ☐ Furniture/Fixtures ☐ Equipment ☐ Inventory ☐ Accounts Receivable ☐ Goodwill
☐ Employees ☐ Trade ☐ Customer Accounts ☐ None

b. If you are forming a new business, what are you acquiring from a previously existing business? (check all that apply)
☐ Land ☐ Buildings ☐ Furniture/Fixtures ☐ Equipment ☐ Inventory ☐ Accounts Receivable ☐ Goodwill
☐ Employees ☐ Trade ☐ Customer Accounts ☐ None

c. Will any owner or owners of the merging business continue to operate or manage the business being registered by this form?
☐ Yes ☐ No If yes, provide name, title and business address below.

d. What was the business activity of the merging business?

e. What will be the business activity of the continuing business being registered by this form?

5. Are you intending to form a business at a future time, by any means?

☐ Yes ☐ No

If yes, please explain:

PART II: FORMER OWNER INFORMATION

Former Owner's Name	Former Owner's UIA Account Number or FEIN, if known.
Corporate Name or DBA	Area Code & Telephone Number
Current Street Address (not a P.O. Box)	
City, State, ZIP	

PART III: ACQUISITION INFORMATION

1. Did you acquire all, part, or none of the **assets** of any former **business?** ☐ All ☐ Part What Percent? % Date Acquired ☐ None

2. Did you acquire all, part, or none of the **organization** (employees/payroll/personnel) of any former business?

   a. If all or part, indicate the percent and date acquired. ☐ All ☐ Part What Percent? % Date Acquired ☐ None

   b. Did you acquire all or part of the employees/payroll/personnel of any former business by leasing any of those employee/payroll/personnel? ☐ Yes ☐ No (If yes, provide a copy of your lease agreement)

3. Did you acquire all, part, or none of the **trade** (customers/accounts/clients) of any former business? ☐ All ☐ Part What Percent? % Date Acquired ☐ None

4. Did you acquire all, part, or none of the former owner's Michigan **business** (products/services) of any former business? ☐ All ☐ Part What Percent? % Date Acquired ☐ None

5. Was the Michigan business described in 1-4 above being operated at the time of acquisition? If no, enter the date it ceased operation. ☐ Yes ☐ No Month Day Year

6. Are you conducting/operating the Michigan business you acquired? ☐ Yes ☐ No

7. Is your Michigan business substantially owned or controlled in any way by the same interests that owned or controlled the organization, business or assets of a former business? ☐ Yes ☐ No

8. Did you hold any secured interest in any of the Michigan assets acquired? ☐ Yes ☐ No If yes, enter balance owed $

9. Enter the reasonable value of the Michigan organization, trade, business or assets acquired? $

Providing inaccurate or incomplete information in this Registration, or UIA Schedules A or B, will be evidence of intentional misrepresentation and may subject you to the civil and/or criminal penalties in Sections 54 and 54b of the *Michigan Employment Securities (MES) Act.*

Print Name of Owner/Officer			Signature of Owner/Officer/Authorized Agent
Title	Telephone Number	Date	
Print Name of Owner/Officer			Signature of Owner/Officer/Authorized Agent
Title	Telephone Number	Date	

Attach this schedule to Form 518, *Registration for Michigan Taxes* and mail it to the Michigan Department of Treasury.

Reset Form

Michigan Department of Treasury
151 (Rev. 02-16)

Issued under authority of Public Act 122 of 1941.

Authorized Representative Declaration (Power of Attorney)

INSTRUCTIONS: Use this form to authorize the Michigan Department of Treasury to communicate with a named individual or entity acting on your behalf. Also use this form to designate a representative to receive copies of correspondence regarding a particular tax dispute (other than City Income Tax). All information designated as "required" must be supplied for this authorization to be effective.

PART 1: TAXPAYER OR DEBTOR INFORMATION

Taxpayer's Name and Address **(Required)** If a business, include any DBA, trade or assumed name. If filing joint return, include spouse's name.	FEIN, ME or TR Number **(Required for business taxes)**	
	Taxpayer's Social Security Number **(Required if no FEIN ME or TR Number listed)**	Spouse's Social Security Number
Taxpayer's E-mail Address	Daytime Telephone Number **(Required)**	Fax Number

PART 2: REVOCATION OF AUTHORITY

To revoke the authority of your current representative, check the applicable box in this section. **Check only ONE box.**

- ☐ I revoke all prior authorizations. I will represent myself.
- ☐ I revoke prior authorizations in the matter/dispute listed in Part 4 and/or Part 5. I will represent myself.
- ☐ I revoke prior authorizations in the matter/dispute listed in Part 4 and/or Part 5 and appoint a new representative in Part 3 who is authorized under Part 4 and/or 5.

PART 3: REPRESENTATIVE APPOINTMENT

Your representative may be an entity or an individual. If you designate an entity you must also provide an individual as a contact. If no start date is indicated the authorization is effective as of the date this form is signed. If no expiration date is indicated the authorization is effective until revoked.

Authorized Representative's Name and Address **(Required)**	Contact Name **(Required if an entity is named)**	
	Telephone Number **(Required)**	Fax Number
	Authorization Start Date (mm/dd/yyyy)	Authorization Expiration Date (mm/dd/yyyy)
	Authorized Representative's E-mail Address	

PART 4: TYPE OF AUTHORITY

If you check a box, you authorize your representative to act in that capacity.

- ☐ 1. Receive and inspect confidential information (upon request only). (**To have your representative receive copies of all future letters and notices involving a tax dispute [other than City Income Tax], you must complete Part 5.)**
- ☐ 2. Make oral or written presentation of fact or argument.
- ☐ 3. Sign returns.
- ☐ 4. Enter into agreements.
- ☐ 5. All of the above.

You may restrict authority in boxes 1-4 to a specific matter (Not required)	
Tax Type, Debt or Fee	Year(s) or period(s)

PART 5: REQUEST COPIES OF LETTERS AND NOTICES REGARDING A TAX DISPUTE (other than City Income Tax)

☐ By checking this box, you are directing Treasury to send a copy of all future notices and letters involving a particular tax dispute to your representative named in Part 3 under section 8 of the Revenue Act (MCL205.8). This dispute is for year(s) or period(s) _____ and Tax (income tax, sales tax, use tax, etc.)_____ (Tax and year(s) or period(s) are both **required** if this box is checked.)

PART 6: TAXPAYER OR DEBTOR AUTHORIZATION

By signing this form, I authorize Treasury to communicate with my representative consistent with the authority granted.

Signature **(Required)**	Print Name **(Required)**	Title **(Required if a business)**	Date **(Required)**
Spouse's Signature	Print Name	Title	Date **(Required if spouse signs)**

TREASURY USE ONLY

☐ Accepted ☐ Rejected	Division Name	Reviewer Initials

Michigan Department of Treasury
3683 (Rev. 8-09)

Reset Form 36

Payroll Service Provider Combined Power of Attorney Authorization and Corporate Officer Liability (COL) Certificate for Businesses

Issued under authority of the Revenue Act, P.A. 122 of 1941, as amended. Filing is voluntary.

Complete this form if you wish to appoint someone to represent your business to the State of Michigan for withholding tax matters.

Taxpayer Name	Account No./Federal Employer ID No. (FEIN)
Address (Street or RR#)	
City, State, ZIP Code	
Contact Person	Telephone Number
Payroll Service Name Paychex	
Address (Street or RR#) 29065 Cabot Drive Suite 100	
City, State, ZIP Code Novi, MI	
Contact Person Tax Center Representative	Telephone Number (800) 322-7292

Effective _____ (mo/day/yr), the above-named payroll service provider/individual is authorized to represent my business and receive information in reference to all Treasury income tax withholding matters until I notify the Michigan Department of Treasury in writing that this Power of Attorney is revoked.

Taxpayer's Power of Attorney Authorization

Must be signed by an authorized representative of the business. I certify that I have the authority to execute this Power of Attorney.

Signature	Date
Type or Print Name	Title

Please be aware of officer, member or partner liability as provided in Michigan Compiled Laws 205.27a(5):

> "If a corporation, limited liability company, limited liability partnership, partnership, or limited partnership liable for taxes administered under this act fails for any reason to file the required returns or pay the tax due, any of its officers, members, managers, or partners who the department determines, based on either an audit or an investigation, have control or supervision of, or responsibility for, making the returns or payments is personally liable for the failure....."

CERTIFICATION

Corporations, partnerships, LLP's or LLC's must complete this section before this form can be processed. This officer, member or partner certification must be resubmitted when there is a change in the individual responsible for filing and/or paying Michigan taxes.

Signature of Corporate Officer, Partner, or Member responsible for reporting and/or paying Michigan taxes	Date
Type or Print	Title

If you have any questions, please contact the Michigan Department of Treasury at (517) 636-4660. You may fax this form to (517) 636-4520, or mail to: Michigan Department of Treasury
P.O. Box 30778
Lansing, MI 48909-8278

ote: Taxpayers must fill-in all fields and must enter an effective date; if effective date is left blank, POA form ill be returned. Certification only required for Corporations, partnerships, LLP's or LLC's.

UIA 1488
(Rev. 6-15)

State of Michigan
Talent Investment Agency
Unemployment Insurance Agency

Power of Attorney (POA)

Complete this form if you wish to appoint someone to represent you with the State of Michigan Unemployment Insurance Agency, or if you wish to revoke or change your current Power of Attorney representation. Please read the instructions on page 2 before completing this form.

PART 1: EMPLOYER INFORMATION

Name and Address (If individual)	If a business, enter DBA, trade or assumed name.		
	Telephone Number (required)	Extension	Fax Number
	FEIN Number		UIA Account Number **
E-mail Address (If applicable)			

PART 2: REPRESENTATIVE INFORMATION AND AUTHORIZATION DATES

Your authorized representative may be an organization, firm, or individual. If your representative is not an individual, designate a contact person. Please ensure that you submit a separate form for each representative.

Representative Name and Address	Contact Name (If applicable)		E-mail Address (If applicable)
	Telephone Number (required)	Extension	Fax Number
	Beginning Authorization Date – Required (mm/dd/yyyy)		Ending Authorization Date – If applicable (mm/dd/yyyy) *
	Representative FEIN		Representative UIA Account Number

This representative is a(n): ☐ PEO ☐ CPA ☐ Human Resources ☐ Bookkeeper ☐ Other Service Provider

PART 3: TYPE OF AUTHORIZATION

☐ **GENERAL AUTHORIZATION**

Authorizes my representative to: (1) inspect or receive confidential information, (2) represent me and provide oral or written presentations of fact and/or argument, (3) sign quarterly reports or registration reports, (4) enter into agreements, and (5) receive mail from the UIA (includes forms, billings and notices.) This authorization applies to all tax related/non-tax related matters and all years or periods.

☐ **LIMITED AUTHORIZATION**

Select the type of authorization by checking the appropriate boxes to the right of each item listed below. You may check up to 4 boxes.
If 5 boxes apply, please complete the 'General Authorization' section above.

1. Inspect or receive confidential information..... ☐
2. Represent me and make oral or written presentation of fact or argument..... ☐
3. Sign reports..... ☐
4. Enter into agreements..... ☐
5. Receive mail from the UIA (including forms, billings and notices)..... ☐

If the box for Line 5 above is checked, please select the category or categories of forms that you want mailed to this POA:

Tax ☐ Claims Control ☐ Contested Claims ☐ All ☐

UIA mail will be sent based on the selections above to the representative at the address indicated in Part 2.

☐ **WORK OPPORTUNITY TAX CREDIT (WOTC)**

Select this box if you have been appointed to represent the taxpayer before the IRS for the Work Opportunity Tax Credit.
Authorization Dates:_____ (Required Beginning Date) through _____ (Required End Date).

PART 4: CHANGE IN POWER OF ATTORNEY

☐ **CHANGE IN POWER OF ATTORNEY REPRESENTATION:** This form replaces all earlier Powers of Attorney except those attached on file for the same tax related/non-tax related matters and years, or periods covered by this Power of Attorney.

☐ **REVOKE PREVIOUS AUTHORIZATION:** I revoke all Powers of Attorney submitted and will represent myself in all tax and benefit matters.

PART 5: EMPLOYER'S SIGNATURE

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

Signature	Name or Title Printed or Typed	Date

* If no ending Authorization Date is provided, the above-named representative will be authorized to represent you until you notify the Unemployment Insurance Agency (UIA) in writing to revoke this Power of Attorney. ** Unemployment Insurance Agency is abbreviated throughout this form as UIA.

Personal Care Services

Consumer Directed Services Budget

Consumer Information & Budget Approval

Consumer Name:	
Consumer Medicaid Number:	
Consumer's Address:	
Consumer's City, State, Zip Code:	
Consumer's Telephone Number:	
Region:	
Does the Consumer Have a Designated Representative (DR) or Legally Authorized Representative (LAR)?	
LAR's Name:	
DR's Name:	
Effective / Coverage Period (This does not guarantee eligibility for the entire period):	

Budget Calculations are:	**VALID**

CERTIFICATION: By signature below I acknowledge that all calculations must fall within the allowable budget, and that all budget calculations are VALID, as indicated above. I acknowledge these budget calculations are not exact, and may need adjustment throughout the budget period. I also acknowledge receipt of a copy of the Budget. I agree to remain within the boundaries of the budget set forth. I understand that failure to follow this budget may result in removal from the program and I accept personal liability for expenses that may be incurred due to my failure to follow the budget or program requirements. The budget does not imply eligibility for the entire budget period.

Employer (Consumer or Legally Authorized Representative) _____ Date _____

Designated Representative (If Applicable) _____ Date _____

SOSWorks Representative _____ Date _____

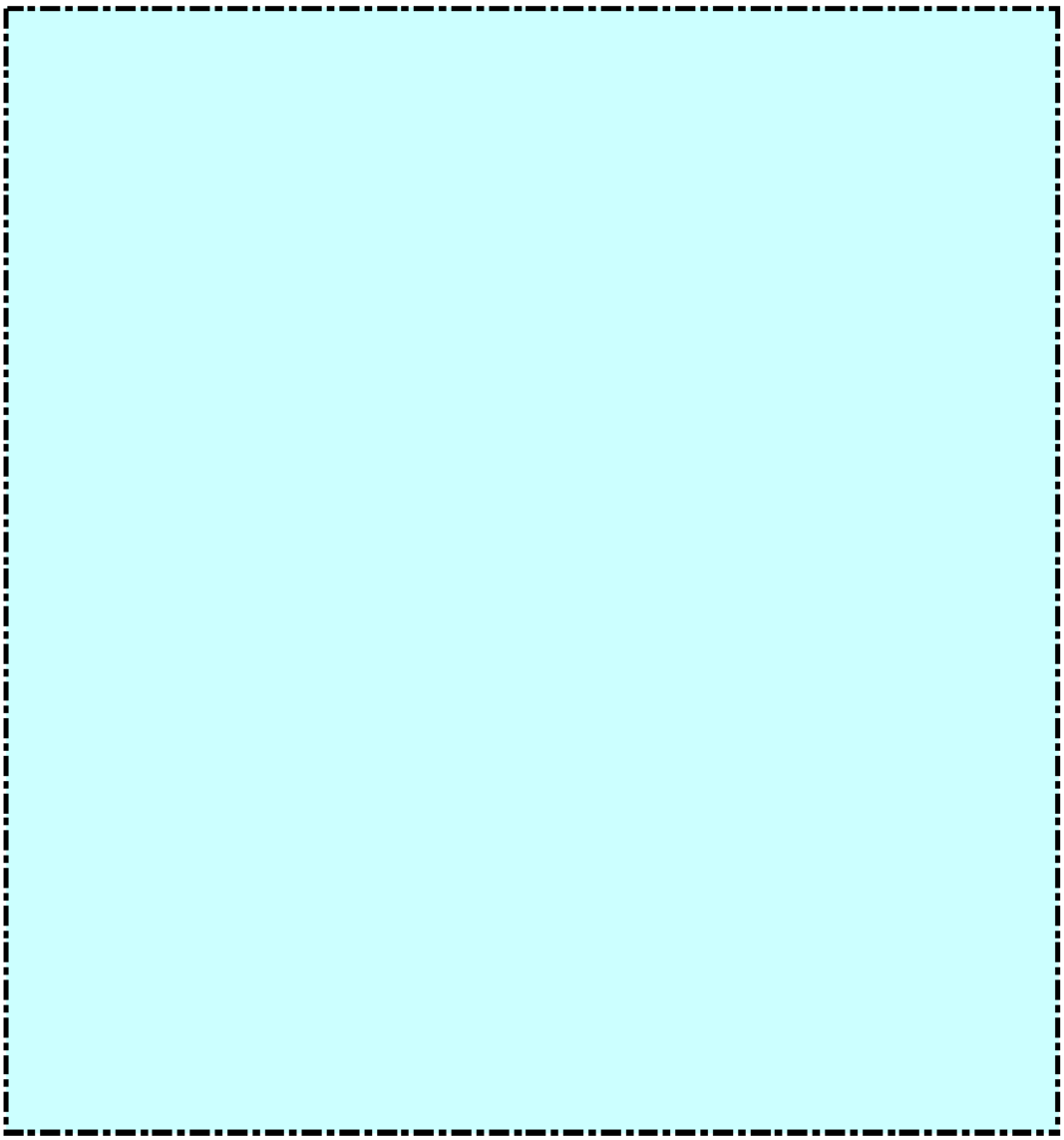
Personal Care Services

Consumer Directed Services Budget

Notes

0	0
Consumer Name	Medicaid Number

Coverage Period From: **1/0/1900** To: **1/0/1900**



Personal Care Services

Consumer Directed Services Budget

Authorized Units and Budget Calculations

0		0
Consumer Name		Medicaid Number

Coverage Period From: **1/0/1900** To: **1/0/1900**

Total Annual CDS Budget **$0.00**

Service	PCS/CFC Attendant Services
Weekly Authorized Hours	
*Hourly Rate	$8.92
Total PAS Dollars	$0.00

Service	PCS Behavioral Health/CFC Habilitation
Weekly Authorized Hours	
*Hourly Rate	$
Total PAS Dollars	$0.00

Personal Care Services

Consumer Directed Services Budget

Employer Support Services & Non-Taxable Costs

0		0
Consumer Name		Medicaid Number

Coverage Period From: **1/0/1900** To: **1/0/1900**

Total Annual CDS Budget:	**$0.00**

Estimated Employer Support Services Costs

Maximum Amount Available for Employer Support Services Costs: $0.00

	Amount:	Comments:
Advertising		
Equipment & Supplies		
Copies & Mailing		
Criminal History Check		
Other - Specify		
Other - Specify		
Total Estimated Employer Support Services Costs:		**$0.00**

Non-Taxable Employee Compensation Costs

Amount Available for Employee Compensation Costs: $0.00

	Amount:	Comments:
Worker's comp or liability insurance		
Other - Specify		
Other - Specify		
Total Estimated Non-Taxable Compensation Costs:		**$0.00**

Funds Available for Taxable Compensation Costs	***$0.00***

Personal Care Services

Consumer Directed Services Budget

Taxable Wage and Compensation Costs

0		0
Consumer Name		Medicaid Number

Coverage Period From: **1/0/1900** To: **1/0/1900**

Available Amounts

Total Available for Taxable Compensation:	$0.00	Dollars Needed to Meet Minimum Compensation:	$0.00
Total Taxable Compensation:	$0.00	**Dollars Left in Budget:**	**$0.00**

Taxable Wage and Compensation Validation

Do the Total Employee Compensation Costs Fall Within the Required Parameters for Employee Compensation?	Minimum Amount for Employee Compensation Costs met?	Yes
	Within Total Budget for Consumer?	Yes

Employee Hours, Pay Rates and Other Compensation

1

Employee Name	Begin Date	End Date	Weeks Employed	S.U.T.A. Rate	Total Annual Wages	Annual Taxes	Annual Total
			1.00		$0.00	$0.00	$0.00
Household exemption eligible							

Hourly Pay

	Hours per Week	Pay Rate	Weeks	OT Pay Rate	Wages
PCS/CFC Attendant Services			1.00		$0.00
PCS Behavioral Health/CFC Habilitation			1.00		$0.00
Overtime			1.00	$0.00	$0.00

NOTE - The consumer must not develop a regular employee schedule that contains fewer than or more than the weekly authorized units.

Other Compensation

	Amount	Number of Payments	Wages
Bonuses			$0.00
Paid Holidays			$0.00
Vacation Pay			$0.00
Sick Leave			$0.00
Other -Specify			$0.00

2

Employee Name	Begin Date	End Date	Employed	Rate	Wages	Annual Taxes	Annual Total
			1.00		$0.00	$0.00	$0.00
Household exemption eligible							

Hourly Pay

	Hours per Week	Pay Rate	Weeks	OT Pay Rate	Wages
PCS/CFC Attendant Services			1.00		$0.00
PCS Behavioral Health/CFC Habilitation			1.00		$0.00
Overtime			1.00	$0.00	$0.00

NOTE - The consumer must not develop a regular employee schedule that contains fewer than or more than the weekly authorized units.

Other Compensation

	Amount	Number of Payments	Wages
Bonuses			$0.00
Paid Holidays			$0.00
Vacation Pay			$0.00
Sick Leave			$0.00
Other -Specify			$0.00

Personal Care Services

Consumer Directed Services Budget

Quarterly Report

0	0
Consumer Name	Medicaid Number

Quarterly Report Coverage Period From: To:

Quarter Number:

NOTE - All Budgeted Amounts on the Quarterly Report are Estimates

Employee Compensation

Annual Dollars Budgeted for Employee Compensation:	$0.00
Minimum Dollars Required for Employee Compensation:	$0.00

Dollars

	Budgeted	Actual
Quarter 1 Dollars	$0.00	
Quarter 2 Dollars	$0.00	
Quarter 3 Dollars	$0.00	
Quarter 4 Dollars	$0.00	
Employee Compensation Totals (Dollars):	**$0.00**	**$0.00**

PCS/CFC Attendant Services

	Authorized	Actual
Quarter 1 Units	0.00	
Quarter 2 Units	0.00	
Quarter 3 Units	0.00	
Quarter 4 Units	0.00	
Employee Compensation Totals (Units):	**0.00**	**0.00**
	Remaining Units	**0.00**

PCS Behavioral Health/CFC Habilitation

	Authorized	Actual
Quarter 1 Units	0.00	
Quarter 2 Units	0.00	
Quarter 3 Units	0.00	
Quarter 4 Units	0.00	
Employee Compensation Totals (Units):	**0.00**	**0.00**
	Remaining Units	**0.00**

Employer Support Services

	Budgeted	Actual
Quarter 1 Dollars	$0.00	
Quarter 2 Dollars	$0.00	
Quarter 3 Dollars	$0.00	
Quarter 4 Dollars	$0.00	
Employee Compensation Totals (Dollars):	**$0.00**	**$0.00**

Dollars Remaining (negative indicates the consumer has overspent):	**$0.00**
Percent of Budgeted Dollars Spent (negative amount indicates the consumer has overspent):	

NOTE - The consumer must not develop a regular employee schedule that contains fewer than or more than the weekly authorized units.

CERTIFICATION: By signature below I certify that the numbers entered into this quarterly report are accurate as reported to me.

SOSWorks Representative Printed Name	Phone Number (with Area Code)
SOSWorks Representative Signature	Date

Self Determination Backup Worker Plan

Emergency Information & Back-up Plans

A. **Emergency Contacts & Procedures** – The CONSUMER and the PROVIDER/ EMPLOYEE are responsible to provide each other with at least one emergency contact person that may be easily contacted in the event of an emergency. Emergency contact information should be readily available to both parties.

B. It is highly recommended that both parties store emergency contact information on their phones or in their purse/wallet. ***In the event of an emergency, calling 9-1-1 is the safest solution if there is any question with regard to any emergency situation.***

C. CONSUMERS must inform employees of any medical/fire/weather emergency or accident procedures for their working environment.

D. **Emergency Staffing** - *SOSWORKS* does not provide any back-up or emergency PROVIDER staff and is not responsible to contact any parties in the event of a PROVIDER/ EMPLOYEE absence. The consumer's Back-Up Plan must be followed.

E. **Back-up Plans** – The consumer is responsible to create and maintain a Back-up Plan that addresses who will be contacted in the event of a PROVIDER/ EMPLOYEE call-in/absence. The back-up plan should list at least one individual who has agreed to be available by phone at the time of scheduled shifts.

F. The back-up plan may consist of family members, neighbors or other PROVIDER/ EMPLOYEES and must include a name, cell phone number and indicate the personal or employment relationship to the consumer. It is highly recommended to have more than one person listed on the back-up plan, as it is critical to the health and safety of the consumer.

G. In the event of a last minute absence, the best practice is to call (not txt) and keep calling until you speak with the contact person.

H. The consumer needs to maintain a back-up plan with valid contact information, have it readily available to each PCA and update them on an on-going basis.

***SOSWORKS* has created a sample Emergency Information Form** that may be used by the consumer to share with their PROVIDER/ EMPLOYEE, please visit our web site www.sosworks.org to obtain sample forms.

Emergency Backup Plan for Personal Care Services

In the event that (INSERT PRIMARY PROVIDER NAME), the personal care provider for critical services for (INSERT PARTICIPANT's NAME) is unable to provide services [1915(j) Medicaid State Plan Amendment], (INSERT PARTICIPANT's NAME) has identified two individuals that have completed all required pre-employment screening and enrollment paperwork and have accepted the responsibility to provide 24/7 emergency services if needed.

Contact information for the two pre-approved emergency providers:

Name: _____ Phone: _____ Email: _____

Name: _____ Phone: _____ Email: _____

This plan is reviewed and updated during the annual support planning process.

Effective date of plan: _____

Participant Employer: _____

Provider Employer: _____

Fiscal Intermediary SOSWorks

Client Email/Texting Informed Consent Form

1. Risk of using email/texting
   The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:
   a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
   c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
   d. Employers and on-line services have a right to inspect emails sent through their company systems.
   e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   f. Email and texts can be used as evidence in court.
   g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts
   SOSworks FI Services cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. SOSWorks is not liable for improper disclosure of confidential information that is not caused by SOSWorks intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:
   a. Email and texting is not appropriate for urgent or emergency situations. SOSWorks cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
   b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
   c. All email will usually be printed and filed into the client's file. Texts may be printed and filed as well.
   d. SOSWorks will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
   e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
   f. Provider is not liable for breaches of confidentiality caused by the client or any third party.
   g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

Client name: _____

Client signature: _____ Date:_____

Parent/Legal Guardian name: _____

Parent/Legal Guardian signature: _____ Date: _____

Provider name: _____

Provider signature: _____ Date: _____

Informed Consent
SOSWorks Fiscal/Employer Reporting Agent

SOSWORKS is the Fiscal/ Employer Agent (F/EA) for (Insert Health Plan) consumers participating in the MI Healthlink Program. The role of the F/EA is to assure that all wage and tax-related issues are in compliance with applicable state and federal laws and regulations on behalf of the Consumer; who is the employer of record of a household business. F/EA in coordination with Reporting Agent Paychex Inc. will assume all responsibilities relevant to Payroll, Tax Reporting, and Monthly Statements, Recoupment, and Reinvestment of Unexpended funds. Tasks performed by the F/EA include, but are not limited to:

- SOSWORKS will process Internal Revenue Service (IRS) Form SS-4 to obtain a Federal ID Number (FEIN) for the Consumer during participation in the MI Healthlink Wavier program.
- SOSWORKS will process a State of Michigan Application to request an unemployment account (SUI) number for each Consumer that will authorize the Consumer to report unemployment taxes and wages for his or her directly hired employees.
- SOSWORKS will review all timesheets, invoices and other claims for payment to ensure that they are consistent with the consumer's Purchasing Plan, that all documents are completed properly and that adequate funds are available to pay the claim.
- SOSWORKS will use a payroll company, Paychex Inc., to process payroll and distribute payments, including payroll, vendor payments, and reimbursement payments to consumers by check or electronic funds transfer (EFT). Paychex Inc., will also file appropriate tax returns and make appropriate tax payments on behalf of each consumer.

By your signature below, you delegate to SOSWORKS and its sub-agent, Paychex Inc., a limited power of attorney to perform these tax-related tasks on your behalf and discuss, if necessary, tax information with appropriate federal and state government agencies.

Questions about any of the F/EA functions being provided by SOSWORKS may be addressed to your consultant, or SOSWORKS Customer Service at 1-866-761-7043, or via email enroll@sosworks.org

I understand and agree to the F/EA and sub-agent functions stated above.

Consumer (PRINT NAME)	Consumer ID #
Signature of Consumer	Date
Signature of Witness	Date

Receipt of Employer Information Packet Acknowledgement

I,_____, am interested in being an employer on behalf of_____. I have received the Employer Information Packet which includes:

- ☐ Things to know before becoming an Employer
- ☐ Services Provided by SOSWorks Fiscal Intermediary
- ☐ Your Responsibilities in Working with a Fiscal Intermediary
- ☐ Hiring an Employee
- ☐ Paying Your Employee
- ☐ How to get paid ON TIME!

By signing below, I acknowledge that I:

1. Have been informed of what it means to be an employer and understand the requirements and responsibilities involved.

2. Understand that no caregiver or provider is to work for me without passing a Criminal History Records check, being approved to work in the United States, having received information on Mandatory Abuse Reporting and understanding confidentiality. *If an employee performs work for me before clearing a criminal history check and being qualified, I understand SOSWorks cannot pay for the work done.*

_____ _____

Employer's Signature Date

_____ _____

Witness by Title Date

Provider Employee Forms

☐ **Provider Information Form**

- The Employer of Record (EOR) and Provider must complete a Provider Information Form when a new Provider is to work for an Employer of Record enrolled in the Consumer-Directed Services Program, or when an existing Provider is applying to work for a new or additional Employer of Record.
- Why is this form important? SOSWorks (SOS) will use the information provided on this form, about the Provider and the Employer of Record he or she will be serving, to prepare and pre-fill Provider employment forms. SOS will send the Provider Enrollment Forms Packet and Provider Welcome Packet to the Employer once this has been processed by SOS.

☐ **Employment Application**

☐ **Criminal Record Check Consent Form**

SOS will complete the following background checks on Provider Employees:

- Criminal History Background. Criminal Background Checks means the State of Michigan Interne Criminal History Access Tool ("ICHAT") or other background checks that may be required by the State of Michigan. Criminal Background Checks includes a search of the OIG/GSA exclusion list assure that the IPCP is not debarred or excluded from participating in government programs.
- List of Excluded Individuals/Entities (LEIE). The United States Department of Health and Human Services, Office of Inspector General (HHS-OIG) maintains the LEIE. This list contains names of people with findings of program-related fraud, patient abuse or licensing board actions.

☐ **Employment Agreement**

☐ **Relationship Disclosure Form**

☐ **Job Description**

☐ **Relationship Disclosure Agreement**

☐ **W4 Federal Withholding Exemptions**

☐ **MI W4**

☐ **I-9 Employment Eligibility Verification**

☐ **Preferred Payment Form**

Instructions for the Provider Information Form

Item Description	How to
1. Type of Request	Is this a **new** Provider?
2. Date of Request	The date the Provider and the EOR are completing the form
3. Process Request as Follows	Choose whether SOS should email or mail the Provider Enrollment Forms Packet to the Employer. Give SOS the Employer's email address if you want us to send the packet by secure email.
4. Provider First Name	First name as it appears on the Provider's Social Security Card
5. Provider Middle Name	Middle name given at birth
6. Provider Last Name	Last name as it appears on the Provider's Social Security Card
7. Provider Maiden Name	Maiden name, especially if it is on the Provider's Social Security Card
8. Provider Date of Birth	Month, day, and year of the Provider's birth
9. Provider Social Security Number	Enter SSN as it appears on the Provider's Social Security Card; this is a nine digit number
10. Provider Street Address (Physical)	The address where the Provider lives. ☞ **NOTE:** This cannot be a post office box. The physical building number and street name are required.
11. Provider City, State and ZIP Code	The city, state and ZIP code where the Provider lives
12. Provider Telephone Number	The telephone number where the Provider can be reached if SOS has questions
13. Provider Alternative Telephone Number	Another telephone number where the Provider can be reached if SOS has questions
14. Provider Mailing Address	Where the Provider wants SOS to send mail, if different from his or her physical address
15. Provider City, State and ZIP Code	The city, state and ZIP code where the Provider wants to receive his or her mail
16. Provider Email address	Email address where SOS can send information to the Provider
17. Provider Gender	Optional: male or female
18. Provider Race	Optional:
19. Expected Start Date of Employment for the Provider	The date the Provider **plans** to begin work. ☞ **NOTE:** This date cannot be before the date the Employer of Record is authorized to receive services. ☞ **NOTE:** Providers cannot be paid for service dates that have not been authorized by Medicaid, or for services provided to ineligible Employer of Records. Providers also will **not** be paid until all Employer of Record
20. Employer of Record ID	Enter the identification number for the Employer of Record for whom the Provider will
21. Employer of Record First Name	The first name of the person who the Provider will serve
22. Employer of Record Last Name	The last name of the person who the Provider will serve
23. Employer First Name	The first name of the person who will be the Provider's Employer
24. Employer Last Name	The last name of the person who will be the Provider's Employer
25. Employer Phone Number	The telephone number of the Employer of Record
26. Employer Email Address	Email address where SOS can send information to the Employer

Provider Information Form

The EOR and Provider must complete a Provider Information Form when a NEW Provider is applying to work for a Consumer, or if an EXISTING Provider is applying to work for a new or additional Consumer. All Providers must provide a street address (IRS requirement for physical address), and a mailing address where correspondence, like employment packets, will be mailed. Please enter all information and submit by fax to SOSWORKS II (SOS) at **1-313-221-9566,** or by mail (see instructions)**.** To complete over the phone call the enrollment hotline at **1-866-887-8424**.

Type of Request (Select One) ☐ **New Provider** ☐ **Existing Provider (Provider ID Number:_____)** **Date of Request:_____/_____/_____**	**Process Request as Follows:** ☐ **Mail to the Employer of Record** ☐ **Email to the Employer of Record**

PROVIDER INFORMATION

Items marked with an asterisk (*) are required.

First Name*	**Middle Name***	**Last Name***	**Maiden Name**	**Date of Birth***	**SSN***

Street Address (physical address no P.O. Box)	**City / State / ZIP***	
	Phone Number*	
	Alternate Phone Number:	
Mailing Address:	**City / State / ZIP***	
Email Address:	***Optional – Used for Criminal Background Check*** **Gender:**	***Optional – Used for Criminal Background Check*** **Race:**
Expected Date of Employment for Provider: (MM/DD/YYYY):		

EMPLOYER OF RECORD INFORMATION Please complete the following information

Consumer ID:	
Consumer First Name:	**Consumer Last Name:**
Employer of Record First Name:	**Employer of Record Last Name:**
Employer of Record Phone Number:	**Employer of Record Email Address:**

Employment Application

Applicant Information									
Full Name					Date				
	Last		*First*			*I M.I.*			
Address									
	Street Address				*Apartment/Unit #*				
	City				*State*	*ZIP Code*			
Phone			Other Phone						
Emergency Contact			Phone		Relationship				
Date Available		Social Security No.			Desired Salary	$			
Referral Source	Newspaper ☐	Employee Referral (Name)			Web ☐	Other ☐			
Position Applied for:		Salary Expected		Date Available					
Are you presently employed?		If yes, may we contact your present employer?							
Are you a citizen of the United States?	YES ☐	NO ☐	If no, are you authorized to work in the U.S.?		YES ☐	NO ☐			
Have you ever worked for this company?	YES ☐	NO ☐	If yes, when?						
Reason for Leaving									
Have you ever been convicted, pled guilty, pled "no contest" (or nolo contendere), or had a court withhold adjudication for any crime, felony or misdemeanor?					YES ☐	NO ☐			
If yes, give details including the type of crime, date of conviction or plea, penalty imposed and any additional information that will provide a full understanding of what occurred. (A conviction will not necessarily disqualify you from employment.)									
Have you ever been arrested or charged with any misdemeanor or felony not disclosed above for which you are out on bail or free on your own recognizance pending disposition or trial?					YES ☐	NO ☐			
If yes, give the date(s) and details of the arrest or charge and any other circumstances you deem relevant to a full understanding of what occurred (attach additional sheets if necessary). Note: answering this question is not an automatic bar to employment. We will consider whether the circumstances of the arrest or charge substantially relate to the circumstances of the particular job sought, and other considerations allowed by law. Again, please be advised that a misstatement or omission in answering this question may be grounds for disciplinary action, including discharge.									
Have you ever been sued in a civil action with regard to the death of or personal injury or intentional damage to any person or to any property?					YES ☐	NO ☐			
If yes, give details concerning the nature of the claims and defenses raised by the parties, the outcome of the action (e.g. settlement, jury verdict, or other disposition), and any other circumstances you deem relevant to a full understanding of what occurred (attach additional sheets if necessary).									
Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status?					YES ☐	NO ☐			
Are you currently engaged in using illegal drugs?					YES ☐	NO ☐			

Education

High School				Address:				
From		To		Did you graduate?	YES ☐	NO ☐	Highest Grade Completed	
College				Address:				
From		To		Did you graduate?	YES ☐	NO ☐	Degree:	
Other				Address				
From		To		Did you graduate?	YES ☐	NO ☐	Degree:	

References

Please list three references.

Full Name		Relationship:	
Company		Phone	
Address			
Full Name		Relationship:	
Company		Phone	
Address			
Full Name		Relationship:	
Company		Phone	
Address			

Previous Employment

Please list all employment beginning with your present job or last job held.

Company ______ Phone ______

Address ______ Supervisor ______

Job Title ______ Starting Salary $ ______ Ending Salary $ ______

Responsibilities ______

From ______ To ______ Reason for Leaving ______

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company ______ Phone ______

Address ______ Supervisor ______

Job Title ______ Starting Salary $ ______ Ending Salary $ ______

Responsibilities ______

From ______ To ______ Reason for Leaving ______

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company ______ Phone ______

Address ______ Supervisor ______

Job Title ______ Starting Salary $ ______ Ending Salary $ ______

Responsibilities ______

From ______ To ______ Reason for Leaving ______

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Previous Employment (continued)

Company _____ Phone _____

Address _____ Supervisor _____

Job Title _____ Starting Salary $ _____ Ending Salary $ _____

Responsibilities _____

From _____ To _____ Reason for Leaving _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company _____ Phone _____

Address _____ Supervisor _____

Job Title _____ Starting Salary $ _____ Ending Salary $ _____

Responsibilities _____

From _____ To _____ Reason for Leaving _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Military Service

Branch _____ From _____ To _____

Rank at Discharge _____ Type of Discharge _____

If other than honorable, explain _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that if the results of such investigation are not satisfactory, any offer of employment made by may be withdrawn or my employment may be terminated. I understand that any misrepresentation, falsification, or omission of these documents shall be sufficient reason for dismissal of my employment. I also agree that this application and any other materials I may receive are not intended to be a contract of employment and that my employment and compensation may be terminated with or without cause or with or without prior notice.

Signature _____ Date _____

DISCLOSURE AND AUTHORIZATION FORM
TO OBTAIN CONSUMER REPORTS FOR EMPLOYMENT PURPOSES

Please Read Carefully Before Signing the Authorization

DISCLOSURE

In considering you for this contract care provider role and, if you currently providing care giver services, in considering you for assignment, reassignment, retention, or discipline, STRATEGIC OPERATION SOLUTIONS ("the Company") may request and rely upon one or more consumer reports or investigative consumer reports about you that we obtain from a consumer reporting agency, such as IntelliCorp Records, Inc.

IntelliCorp Records, Inc. can be contacted by mail at 3000 Auburn Dr, Suite 410; Beachwood, OH 44122; or phone: 1-888-946-8355; or website: www.intellicorp.net.

For explanation purposes:

- a "consumer report" is a written, oral or other communication of any information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in making a care giver contractor-related decision about you. Such information may include, for example, credit information, criminal history reports, or driving records; and

- an "investigative consumer report" is a consumer report in which information on your character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with your prior contractors, employers, neighbors, friends, or associates, or with others who may have knowledge concerning any such items of information. In the event an investigative consumer report is requested about you, you are entitled to additional disclosures regarding the nature and scope of the investigation requested, as well as a written summary of your rights under the Fair Credit Reporting Act ("FCRA").

Under the FCRA, before the Company can obtain a consumer report or investigative consumer report about you for contract care giver purposes, we must have your written authorization. Before we take adverse action on the basis, in whole or in part, of information in that report, you will be provided a copy of that report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA.

AUTHORIZATION

I have read and understand the foregoing Disclosure, and authorize STRATEGIC OPERATION SOLUTIONS to obtain and rely upon consumer reports or investigative consumer reports in considering me for a contract care giver and, if I am a care giver, in considering me for, reassignment, retention, or discipline. By my signature below, I authorize the Company to obtain any such reports and to share the information received with any person involved in the employment decision about me.

I also agree that this Disclosure and Authorization in original, faxed, photocopied, or electronic (including electronically signed) form will be valid for any consumer reports or investigative consumer reports that may be requested about me by or on behalf of the Company.

_____
Printed Name

_____ _____
Applicant Signature Date

_____ _____
Parent or Legal Guardian Signature Date
(for searches conducted on minors under
the age of 18)

Personal Data

Last Name _____ First Name _____ Middle Name _____

Current Address _____ Dates Lived Here _____

Addresses for the Past Seven Years: (include street, city, state, zip code) Dates of Residence:

_____ _____

_____ _____

_____ _____

Date of Birth _____ Other Names Used (including maiden name) _____ Years Used _____

Social Security Number _____ Driver's License # _____ State _____

Email address (may be used for official correspondence) _____

I have the right to make a request to **IntelliCorp Records, Inc**, upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including sources of information, and the recipients of any reports on me which **IntelliCorp Records, Inc** has previously furnished within the two year period preceding my request.

I certify that all elements of the personal data I have provided are true, accurate and complete. I understand and agree that any omission, false statement, misleading statement, or answer made by me on my application or any supplements to it and in any interviews will be sufficient grounds for rejection of employment and my discharge after employment.

Printed Name _____ Applicant Signature _____ Date _____

EMPLOYMENT AGREEMENT

Notes in bold, italics and brackets are places where specific information must be inserted. To make the agreement clearer for the enrollee, his or her name and the employee's name should be used throughout the document.

This agreement is made on ***[Insert date]*** between ***[Insert name of enrollee directly employing the worker]*** ("employer") and ***[Insert name of employee]*** ("employee") to describe the supports that the employee will provide to the employer and the terms and conditions of employment.

ARTICLE I

EMPLOYEE RESPONSIBILITIES

I, ***[Insert name of employee]*** I am aware and agree that my employment is conditioned on my employer's use of arrangements that support self-determination administered by the ICO. If my employer stops using arrangements that support self-determination, my employment may end. I agree to the following terms of employment:

1. During the term of this Agreement, I shall provide support to my employer by performing the duties outlined in this agreement and any attachments to it.
2. I agree to assist my employer in maintaining the documentation and records required by my employer, SOSWorks or the ICO. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay. All records I may have or assist in maintaining are the property of my employer. I will keep these records confidential, release them only with the consent of my employer, and return them to my employer if my employment ends. In addition, I will complete illness and incident reports when necessary as required or requested by the ICO or my employer.
3. I shall immediately notify *(insert the name and contact information of the contact person chosen by the employer) if* my employer experiences a medical emergency or illness. I will also notify (*insert name of contact person*) before taking my employer to the physician, except in case of an emergency.
4. I agree to abide by all of my employer's rules and ICO regulations (described below) regarding my employment duties to the employer and I acknowledge receipt of the following rules and regulations
    a. Attachment A to this Agreement, which outlines the supports that I will provide to my employer.

Employee Worklogs/Timesheets: employee completes this form to document the provision of personal care services for each day in the time period(s) indicated. See attached Worklogs/ Timesheet.

PROVIDER EMPLOYEE

1. Check (X) each day on which an approved task was provided for each month in the service time period(s).
2. Sign/date the form at the end of service time period to certify provision of the approved tasks.
3. Have the client/employer review the form and sign/date it to verify the services were delivered as agreed.
4. Return the signed/dated form to the adult services specialist at the end of the service time period.

PARTICPANT EMPLOYER

1. Review the completed form to be sure all the approved tasks were done as certified by the provider.
2. Indicate if you are satisfied with the services.
3. Sign/date the worklog form and direct the provider to return it to SOSWorks monthly worklog fax, email or mail.

NOTE:

- Please make sure that the hours your Provider records **do not overlap** with those of another Provider or timesheet. If this happens, the timesheet will need to be corrected before you approve and submit it to payroll for processing.

- Failure to return the form by the **5th day of the month** after the last service date on the log will result in delay or termination of payments to the client/employer for these services.

5. I understand that this is an employment at will relationship, which can be terminated by me or by my employer at any time. However, my employer cannot terminate my employment on the basis of my race, religion, sex, disability or other protected status under federal or Michigan law. In addition, I agree to give 14 days, written notice to my employer if I terminate my employment.
6. I understand and acknowledge that my employer is my sole employer and that I am not an employee of the ICO, which authorizes the supports I provide, or the fiscal intermediary, which is the financial administrator of funds used to pay me.
7. I agree to assist my employer in filing complaints upon request. I also understand that I have a responsibility to report rights violations of which I am aware or any potential abusive or neglectful situations I observe. I understand that I may be requested to cooperate with an investigation and/or assist my employer with exercising his or her rights.

8. I agree to not sue the fiscal intermediary for its role as the financial administrator of my employer's individual budget and the ICO for its role in administering arrangements that support self-determination,

9. I agree to execute a Self-Determination Provider Agreement with the ICO and acknowledge that this agreement does not alter the fact that the ICO is only the administrator of the funds used through arrangements that support self-determination, and that my employer is *[insert name of employer]*. I understand that my employment is contingent on completing this agreement.

ARTICLE II EMPLOYER RESPONSIBILITIES

I, ***[insert name of Employer]*** ("Employer") agree to the following:

1. I will provide through my fiscal intermediary with the necessary documentation to assure timely compensation of my employee.

2. I will compensate my employee in the following manner: $8.92 /hr. for XX hours. Payroll will be handled by my fiscal intermediary ***SOSWorks,*** which will withhold all necessary tax, unemployment and other withholdings from the employee's paychecks.

3. I will assure my employee receives appropriate training.

4. I will evaluate the performance of my employee and provide appropriate feedback to assure that I am receiving quality supports.

5. I will assure that my employee executes a Self-Determination Provider Agreement with the ICO.

_____

Employee Signature **Date**

_____

Employer Signature **Date**

PARTICIPANT-HIRED WORKER RELATIONSHIP IDENTIFICATION

INSTRUCTIONS:

Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. Participant-hired worker may not begin working for participant employer until they have received a mailed start date letter.

Completed forms should be submitted to the participant's fiscal employer agent.

Name – Participant-Hired Worker (Last, First)	Name – Participant Employer (Last, First)
Date of Birth – Participant-Hired Worker	

Check your legal relationship to the participant. For example, if the participant is your grandmother, you are the participant's grandchild. Check one.

RELATIVE (BIOLOGICAL)

- ☐ Parent * ±
- ☐ Son/Daughter (over 21) *
- ☐ Son/Daughter (under 21) * ±
- ☐ Adopted Child *

Adoption date:

- ☐ Grandparent *
- ☐ Grandchild *
- ☐ Brother / Sister
- ☐ Uncle / Aunt
- ☐ Nephew / Niece
- ☐ Cousin

RELATIVE (BY MARRIAGE/PARTNERSHIP)

- ☐ Spouse * ±
- ☐ Domestic Partner *

Marriage date:

- ☐ Step Parent *
- ☐ Step Child *
- ☐ Step Grandchild
- ☐ Step Brother / Step Sister
- ☐ Parent-in-Law
- ☐ Child-in-Law
- ☐ Brother-in-Law / Sister-in-Law

NON-RELATED RELATIONSHIPS

- ☐ Friend
- ☐ Neighbor
- ☐ Worker
- ☐ Ex-Husband / Ex-Wife

Divorce date:

* Due to your relationship with the participant and current legislation, you are exempt from payroll taxes for unemployment insurance (SUTA). If your employment with the participant is terminated, you will not receive unemployment benefits.

± Due to your relationship with the participant and current legislation, you are exempt from payroll taxes for Social Security and Medicare (FICA). By not paying into Social Security and Medicare (FICA), it means you are not earning Social Security work credits.

☐ Yes ☐ No The participant receiving nonmedical care lives in the participant-hired worker's home.

NOTE: It is the participant-hired worker's responsibility to notify the participant's fiscal employer agent should their living situation change.

By signing below, you agree the information on this form is accurate and you have all supporting documentation in your possession.

SIGNATURE – Participant-Hired Worker	Date Signed
SIGNATURE – Participant Employer	Date Signed

Personal Care Assistant Job Description

WHAT DO PERSONAL CARE ASSISTANTS DO?

Personal care assistants, also known as caregivers, home health or personal care aides, give assistance to people who are sick, injured, mentally or physically disabled, or the elderly and fragile. They work in the home and help their clients with daily activities, such as bathing and bathroom functions, feeding, grooming, taking medication, and some housework. Personal care assistants help clients make and keep appointments with doctors, provide or arrange transportation, make and serve meals, make sure they take their medicine and serve as a companion for their clients.

They are either hired by a client or their family. They work long hours, often physically demanding on their feet.

PROVIDER CRITERIA

- **Age** The provider must be 18 years and older.

- **Ability**
  - To follow instructions and home help program procedures.
  - To perform the services required.
  - To handle emergencies.
  - The provider's health must be adequate to perform the needed services.
  - Stamina: Personal care assistants might need to lift clients into the bathtub, cars and into bed, and need strength.

- **Knowledge** The provider must know when to seek assistance from appropriate sources in the event of an emergency.

- **Personal Qualities** The provider must be dependable and able to meet job demands.

  - Attention to Detail: Some clients have specific rules or schedules that must be minded, or specific dietary or physical rules that must be followed.
  - Interpersonal Skills: Personal care assistants work in a very personal way with their clients. Some will be in pain or very sensitive to their fragility. They must be sensitive and compassionate with clients.
  - Time Management: Personal care assistants are schedule keepers. They have to be there to make sure clients get up on time, make sure medication is taken on schedule and clients get to appointments on time.

- **Criminal History Screen** All individual home help providers must undergo a criminal history screen prior to providing home help services.

- **Training** The provider must be willing to participate in available training programs if necessary. The training includes safety information, emergency response, and cooking special dietary foods if necessary.

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074
2017

1 Your first name and middle initial	Last name	**2** Your social security number	
Home address (number and street or rural route)		**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code		**4** If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**	
6 Additional amount, if any, you want withheld from each paycheck		**6** $	
7 I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►		**7**	

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

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2017)

Reset Form

MI-W4

(Rev. 8-08)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE
STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. You must file a revised form within 10 days if your exemptions decrease or your residency status changes from nonresident to resident. Read instructions below before completing this form.

Issued under P.A. 281 of 1967.

▶ 1. Social Security Number	▶ 2. Date of Birth
▶ 3. Type or Print Your First Name, Middle Initial and Last Name	4. Driver License Number
Home Address (No., Street, P.O. Box or Rural Route)	▶ 5. Are you a new employee? ☐ Yes If Yes, enter date of hire . . . . ☐ No
City or Town / State / ZIP Code	

6. Enter the number of personal and dependent exemptions you are claiming ..... ▶ 6.

7. Additional amount you want deducted from each pay (if employer agrees) ..... 7. $ .00

8. I claim exemption from withholding because (does not apply to nonresident members of flow-through entities - see instructions):
   - a. ☐ A Michigan income tax liability is not expected this year.
   - b. ☐ Wages are exempt from withholding. Explain: _____
   - c. ☐ Permanent home (domicile) is located in the following Renaissance Zone: _____

EMPLOYEE:
If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records.

INSTRUCTIONS TO EMPLOYER:
Employers must report all new hires to the State of Michigan. Keep a copy of this certificate with your records. If the employee claims 10 or more personal and dependent exemptions or claims a status exempting the employee from withholding, you must file their original MI-W4 form with the Michigan Department of Treasury. Mail to: New Hire Operations Center, P.O. Box 85010; Lansing, MI 48908-5010.

Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming exemption from withholding, I certify that I anticipate that I will not incur a Michigan income tax liability for this year.

9. Employee's Signature	▶ Date

Employer: Complete lines 10 and 11 before sending to the Michigan Department of Treasury.

10. Employer's Name, Address, Phone No. and Name of Contact Person

▶ 11. Federal Employer Identification Number

INSTRUCTIONS TO EMPLOYEE

You must submit a Michigan withholding exemption certificate (form MI-W4) to your employer on or before the date that employment begins. If you fail or refuse to submit this certificate, your employer must withhold tax from your compensation without allowance for any exemptions. Your employer is required to notify the Michigan Department of Treasury if you have claimed 10 or more personal and dependent exemptions or claimed a status which exempts you from withholding.

You MUST file a new MI-W4 within 10 days if your residency status changes or if your exemptions decrease because: a) your spouse, for whom you have been claiming an exemption, is divorced or legally separated from you or claims his/her own exemption(s) on a separate certificate, or b) a dependent must be dropped for federal purposes.

Line 5: If you check "Yes," enter your date of hire (mo/day/year).

Line 6: Personal and dependent exemptions. The total number of exemptions you claim on the MI-W4 may not exceed the number of exemptions you are entitled to claim when you file your Michigan individual income tax return.

If you are married and you and your spouse are both employed, you both may not claim the same exemptions with each of your employers.

If you hold more than one job, you may not claim the same exemptions with more than one employer. If you claim the same exemptions at more than one job, your tax will be under withheld.

Line 7: You may designate additional withholding if you expect to owe more than the amount withheld.

Line 8: You may claim exemption from Michigan income tax withholding ONLY if you do not anticipate a Michigan income tax liability for the current year because all of the following exist: a) your employment is less than full time, b) your personal and dependent exemption allowance exceeds your annual compensation, c) you claimed exemption from federal withholding, d) you did not incur a Michigan income tax liability for the previous year. You may also claim exemption if your permanent home (domicile) is located in a Renaissance Zone. Members of flow-through entities may not claim exemption from nonresident flow-through withholding. For more information on Renaissance Zones call the Michigan Tele-Help System, 1-800-827-4000. Full-time students that do not satisfy all of the above requirements cannot claim exempt status.

Web Site
Visit the Treasury Web site at:
www.michigan.gov/businesstax

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date*(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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		**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		**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. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**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		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **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 alien's nonimmigrant status 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.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		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		
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				

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

PAYCHEX

Direct Deposit Enrollment/Change Form

Company Name_____ **Client Number**_____

Employee/Worker Name_____ **Employee/Worker Number**_____

EMPLOYEE/WORKER: Retain a copy of this form for your records. Return the original to your employer.

EMPLOYERS: Return this form to your local Paychex office. For clients using on-line services, please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS – *PLEASE PRINT IN BLACK/BLUE INK ONLY*

Type of Account	Bank Account Number*	Routing/Transit Number	Financial Institution ("Bank") Name	I wish to deposit (check one):
☐ Checking ☐ Savings				☐ _____ % of Net ☐ Specific Dollar Amount $ _____ ☐ Remainder of Net Pay
☐ Checking ☐ Savings				☐ _____ % of Net ☐ Specific Dollar Amount $ _____ ☐ Remainder of Net Pay

One of the following is required to process this enrollment (check one):

☐ Voided check with name imprinted (no starter checks)

☐ Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number)

☐ Bank letter or specification sheet (the signature of your local bank representative MUST be included)

☐ Other Bank Documentation from your Financial Institution – If this box is checked the employer must sign this confirmation:

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc.

Employer Signature:_____ **Date** _____

***Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

COMPLETE IF CHANGING EXISTING DEPOSIT AMOUNTS – *PLEASE PRINT IN BLACK/BLUE INK ONLY*

Bank Account Number*	Routing/Transit Number	Financial Institution ("Bank") Name	Change My Deposit Amount to:
			☐ From _____% to____% of Net ☐ From $ _____.00 To $_____.00 ☐ Remainder of Net Pay
			☐ From _____% to____% of Net ☐ From $ _____.00 To $_____.00 ☐ Remainder of Net Pay

EMPLOYEE/WORKER CONFIRMATION STATEMENT

PLEASE SIGN IN BLACK/BLUE INK ONLY

I authorize my employer to deposit my wages/salary into the bank accounts specified above. I agree that direct deposit transactions I authorize comply with all applicable law. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer to make direct deposits into the named account.

Employee/Worker Signature _____ **Date** _____

Note: Digital or Electronic Signatures are **not** acceptable.

DP0002 07/14

Instructions for Timesheet

SOSWorks (SOS) needs accurate and complete timesheets in order to pay your Provider.

☞ **NOTE: You or a person to whom you have given signature authority must approve, sign, date, and submit to SOS your Provider's timesheets.**

How are timesheets submitted to SOS?

You can submit timesheets to SOS in one of these two ways:

1. **Fax a paper timesheet** to the number printed on the timesheet, or
2. **Mail a paper timesheet** to the street address printed on the timesheet.
3. **Email a paper timesheet** to worklogs@sosworks.org.

Instructions for filling in each type of timesheet are included in the next few pages.

When does SOS need to receive the timesheet?

SOS Payroll Schedules are available in this packet and at www.sosworks.org**.** The schedules show dates when pay periods begin and end. Payments are made monthly.

☞ **IMPORTANT:** Please make sure that the hours your Provider records **do not overlap** with those of another Provider or timesheet. If this happens, the timesheet will need to be corrected before you approve and submit it to payroll for processing.

☞ **NOTE:** Keep track of the Consumer's Authorization for available hours. SOS cannot pay for more than the number of hours allowed by the Service Plan.

INSTRUCTIONS FOR COMPLETION
OF THE PERSONAL CARE SERVICES PROVIDER LOG

Provider Logs must be received by the Fifth Day of every month.

Fax: 313-221-9566 or Email worklogs@sosworks.org Provider Logs

The provider log is prefilled with an "X" to indicate the services approved by the specialist. The provider completes this form to document the provision of personal care services for each day in the time period(s) indicated.

PROVIDER EMPLOYEE

5. Check (X) each day on which an approved task was provided for each month in the service time period(s).
6. Sign/date the form at the end of service time period to certify provision of the approved tasks.
7. Have the client/employer review the form and sign/date it to verify the services were delivered as agreed.
8. Return the signed/dated form to the adult services specialist at the end of the service time period.

NOTE: Failure to return the form by the **5th day of the month** after the last service date on the log will result in delay or termination of payments to the client/employer for these services.

PARTICPANT EMPLOYER

4. Review the completed form to be sure all the approved tasks were done as certified by the provider.
5. Indicate if you are satisfied with the services.
6. Sign/date the form and direct the provider to return it to the adult services specialist.

NOTE: Failure to return the form within **5th day of the month** after the last service date on the log will result in delay or termination of payments to the client/employer for these services.

APPROVED PERSONAL CARE TASKS

1. **Eating/Feeding –** helping with use of utensils, cup/glass, getting food/drink to mouth, cutting up/manipulating food on plate, cleaning face and hands, as needed after a meal.
2. **Toileting –** helping on/off toilet, commode/bed pan, emptying commode/bed pan, managing clothing, wiping and cleaning body after toileting, cleaning ostomy and/or catheter tubes/receptacles, applying diapers and disposable pads; may include doing catheter, ostomy or bowel programs.
3. **Bathing –** helping with cleaning the body or parts of the body, shampooing hair, using tub or shower, sponge bathing, including getting a basin of water, managing faucets, soaping, rinsing and drying.
4. **Grooming –** helping to maintain personal hygiene and neat appearance, including hair combing, brushing, oral hygiene, shaving, fingernail and toe nail care (unless a physician advises no to do so).
5. **Dressing –** helping with putting on/taking off, fastening/unfastening garments/undergarments, special devices such as back/leg braces, corsets, artificial limbs or splints.
6. **Transferring –** helping to move from one position to another, such as from bed to or from a wheelchair or sofa, to come to a standing position and/or repositioning to prevent skin breakdown.
7. **Mobility –** helping with walking or moving around inside the living area, changing locations in a room, moving from room to room or climbing stairs.
8. **Medication –** helping with administering prescribed or over-the-counter medication.
9. **Meal Preparation –** helping with planning menus, washing, peeling, slicing, opening packages, cans and bags, mixing ingredients, lifting pots/pans, reheating food, cooking, operating stove/microwave, setting the table, serving the meal, washing/drying dishes and putting them away.
10. **Shopping –** helping to compile a list identifying needed items, picking up items at the store, managing cart/baskets, transferring items to home and storing them away.
11. **Laundry –** helping by getting laundry to machines, sorting, handling soap containers, placing laundry into machines, operating machine controls, handling wet laundry, drying, folding and storing laundry.
12. **Light Housework –** helping with sweeping, vacuuming, washing floors, washing kitchen counters and sinks, cleaning the bathroom, changing bed linen, taking out garbage/trash, dusting and picking up, bringing in fuel for heating/cooking purposes if necessary.

13-21. Complex Care tasks – require special techniques/knowledge; replace most/all 1-9 tasks when approved by specialist.

MI HEALTH LINK
Linking Medicare and Medicaid for you
SOS Works
STAFFING SOLUTIONS

Monthly Personal Care Provider Log

Provider Logs must be received by the **Fifth Day** of every month.
Fax: 313-221-9566 or Email worklogs@sosworks.org Provider Logs

Provider Name:	**Client ID Number:**
Client Name:	**Month: Year:**

Mark X to show on which days of the month you assisted this member with any of the approved personal care tasks.

Care Services	**Days of the Month**																														
Eating/Feeding	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Toileting																															
Bathing																															
Grooming																															
Dressing																															
Transferring																															
Mobility																															
Medication																															
Meal Preparation																															
Shopping																															
Laundry																															
Light Housework																															
Complex																															
Catheter/Leg																															
Colostomy Care																															
Bowel Program																															
Suctioning																															
Special Skin Care																															
Range of Motion																															
Dialysis																															
Wound Care																															

Client: Are you satisfied with the services provided to you? □Yes □
NO why not? Provider: I certify that I have provided all the services

Client Signature: Date:	**Provider's Signature: Date:**

SOS Works II

Fiscal Intermediary Services 407 E. Fort St., Suite 407 Detroit, MI 48226
Customer Service: 1-866-887-8424
Fax or Email Timesheet:

https://www.sosworks.org

Timesheet Fax: 1-313-221-9566
Timesheet Email: worklogs@sosworks.org

Payment Schedule Reminders:

- Payments are issued once a month.
- Timesheets that are received after the timesheet due date and time are considered late.
- Late timesheets will be processed in the next available pay period and paid on the next payment date.
- Training to submit timesheets online is available! Call **1-866-887-8424** for over the phone or in person training

2017 Pay Schedule - MI HEALTH LINK

Services Provided in this Pay Period	
Pay Period Start	**Pay Period End**
3/1/2017	3/31/2017
4/1/2017	4/30/2017
5/1/2017	5/31/2017
6/1/2017	6/31/2017
7/1/2017	7/31/2017
6/19/2017	7/2/2017
8/1/2017	8/31/2017
9/1/2017	9/30/2017
10/1/2017	10/31/2017
11/1/2017	11/30/2017
12/1/2017	12/31/2017

Timesheets due by 5:00PM (EST)

The 5th day of the Month.

FAX: 313-221-9566

EMAIL:
worklogs@sosworks.org

Checks will be in US mail or EFT issued on Wednesdays
D
3/15/2017
4/17/2017
5/17/2017
6/14/2017
7/17/2017
8/16/2017
9/18/2017
10/18/2017
11/15/2017
12/18/2017

Instructions for Contact Information Changes

Employer of Record Address Change

☞ ***IMPORTANT:*** *If the Employer of Record changes his or her* ***physical address****, the change must be reported to the SOSWorks.*

Employer of Record Phone Number or Email Change

Please notify SOS directly of any change in the Employer of Record's phone number and/or email address. You can fill out the **Employer of Record Phone or Email Change Form** of this packet, and follow the instructions below to submit the changes.

Employer of Record Contact Information Change

To comply with federal and state tax regulations, SOS must have the correct physical street address on file for the Employer of Record (EOR). To change your contact information on file with SOS, fill out the **Employer of Record Contact Information Change Form** found in this packet, and follow the instructions below to submit the changes.

Submit the changes noted above, in one of the following ways:

- Call SOS Customer Service toll-free at 1-866-877-8424 and give them the new information on the form(s); **or**
- Fax or mail the form(s) to SOS at the fax number or mailing address provided on each form; **or**

☞ **NOTE:** You can print copies of forms from the SOS website at www.sosworks.org.

Employer of Record Change Form

Complete this form to notify SOS of changes in the Employer of Record phone number or email address.

☞ ***IMPORTANT: If the or Employer of Record address changes, the Employer of Record must report the change.***

Check Boxes Only for the Information You Are Changing:
☐ Change in Employer of Record Phone Number ☐ Change In Employer of Record Email Address
Employer of Record Information below is required for verification:
Employer of Record ID:
Employer of Record First Name & Middle Initial:
Employer of Record Last Name:
Employer of Record Date of Birth:
Provide changes to information below:
☐ **Employer of Record's New Phone Number: ( )_____-____**
☐ **Employer of Record's New Email Address:**

_____

Employer of Record or Employer of Record Signature **Date**

Update your information with SOSWorks (SOS) one of the following ways:

➢ **Call SOSWorks Customer Service**	**Call**: 1-866-877-8424
Mail: SOSWorks II 407 E. Fort St., Suite 407 Detroit, MI 48226	**Fax**: 1-313-221-9566

Instructions for Notice of Discontinued Employment Form

Why is this form important?

This form lets you notify SOSWorks II (SOS) when a Provider stops working for you. We need to know this for the following reasons:

- To prevent incorrect payments
- To maintain up-to-date information about who is working for you
- To communicate to the Virginia Employment Commission the last date of employment and the reason for termination

What must I include on the form?

Complete all sections of the form:

- Write the Provider's last day of work,
- Circle the reason for discontinuation,
- Submit the last timesheet if you have not already sent it, and
- Sign and date the form.

Does the Provider need to sign the form?

Just complete and sign the form yourself. The Provider does not need to sign this form.

Can anyone else sign the form?

The Care Coordinator can sign the form if you are unable to do so.

If you have given someone else power of attorney, that person can also sign the form for you. A copy of the power of attorney must be included with the form.

Need more forms?

If you need additional forms you can call SOS Customer Service at 1-866-887-8424 to have more forms sent to you.

Where do I send the form?

Mail or fax the form to SOS:

Mail: SOSWorks II
407 E. Fort St., Suite 407
Detroit, MI 48226

Fax: 1-313-221-9566

Notice of Discontinued Employment Form

This form lets you notify SOSWorks II (SOS) when a Provider has stopped working for you. Please complete all sections and sign and date in the spaces provided.

Employer of Record Name	Phone	Employer of

Employer of Record (EOR)Name	Phone

Provider (Employee) Name	Phone	Provider ID

LAST DATE PROVIDER WORKED: _____

REASON FOR DISCONTINUATION: ***(Circle One)*** **Quit Fired Deceased Other**

The last timesheet for hours worked is: ☐ **Attached** ☐ **Filed Online**

This form can be completed by the EOR or both the EOR and Provider to document the reason(s) for ending employment. Briefly state the reason(s) why employment was terminated:

_____

_____

_____

☞ **Note***: If the Provider cannot or will not sign, the EOR should sign, date, and return this form without the Provider's signature.*

Employer of Record Signature:_____Date:_____

Provider Signature:_____Date: _____

☞ **Note***: An **Agent** authorized by power of attorney (POA), **an Executor of Estate,** or **Medicaid Service Facilitator** may sign the form when the EOR is unable to do so. (An Agent or Executor of the Estate **must provide a copy of the POA** to verify they have authority to terminate the employee.)*

Other Signature:_____Date:_____

(A copy of the power of attorney is attached: ☐ Yes ☐ No)

This form must be signed. Mail or fax the form to SOS:

Mail: SOSWorks II
407 E. Fort St., Suite 407
Detroit, MI 48226

Fax: 1-313-221-9566

Workers' Compensation Claim Reporting Guidelines for Employees

If there has been a workplace injury or accident, please take the following action:

- **If it a life-threatening emergency, seek medical attention immediately and inform the hospital that it is a workplace injury.**
- **Inform your employer of the injury.**
  - **Call our Workers' Compensation hotline at (877) 824-9356 within 24 hours of the injury to report the claim and begin the claims process.**

Timely reporting of accidents is important because:

- Early access to medical care may decrease recovery time!
- The claims adjuster will need ample time to investigate incidents and make the appropriate decision about your benefits.
- In most states, there is a waiting period seven (7) days before compensation is dispersed. The sooner you report the claim to Acumen, the sooner the clock starts on this waiting period.