

Fiscal Agent Employee Checklist for Children’s Waiver Programs

#	Employee Start-up Forms	When Required
1	New Employee Set-up Form	For all Employees
2	Relationship Disclosure Form	For all Employees
3	IRS Form W-4 (current year)	For all Employees
4	IRS Form WT-4	For all Employees
5	Form I-9 Employment Eligibility Verification	For all Employees NOTE: Section 1 must be filled out by Employee, and Section 2 must be completed and signed by the Employer/Client.
6	Copy of Social Security Card	Optional but recommended
7	Wisconsin Medicaid Children’s Long-Term Support (CLTS) Waiver Program Provider Agreement and Acknowledgment of Terms of Participation for Sole Proprietor or Individual Waiver Service Providers (F-02364)	For all Employees
8	Background Information Disclosure Form (BID) for Entity Employees and Contractors (F-82064)	For all Employees
9	Employer/Client and Employee Agreement	For all Employees
10	Direct Deposit Authorization	Optional

	Resources	How to Use
	Employee Timesheet	To record days and hours worked
	Sample Employee Timesheet	For help completing Fiscal Agent Timesheet
	Employee Mileage Log	To record transportation services provided
	Employee Status Change Form	Optional; not required for start up. Only needed if Employee needs to submit changes during or after the application process.

⚠ IMPORTANT: Not submitting all documents or submitting incomplete and/or unsigned documents will delay the application process. Do not begin working until you receive official notification that you may begin working for the Employer/Client.

To process the application, iLIFE must receive documents numbered 1 – 5 and 7 – 9 on the list above. Documents 6 and 10 are optional. To be processed, all submitted documents must be complete and signed.



Fiscal Agent New Employee Set-up Form

- Instructions:** 1. Employee completes top half, and Employer/Client completes bottom.
2. Both Employee and Employer/Client sign at the bottom.
NOTE: Employee can work after Employee receives official notification to begin working.

Employee Section

Employee Name (print): _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: (_____) _____ - _____ Male Female

Email: _____

Birth Date: ____/____/____ Social Security Number: ____-____-____

Employer/Client Section

Program: _____

Employer/Client Name (print): _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: (_____) _____ - _____ Birth Date: ____/____/____

Email: _____

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

Employee Signature: _____ Date: _____

Employer/Client Signature: _____ Date: _____

Relationship Disclosure Form

Employee Name: _____

Employee Date of Birth: _____ / _____ / _____

Employer/Client Name: _____

Check one box to indicate your legal relationship to the Employer/Client. For example, if the Employer/Client is your grandmother, you are the Employer/Client's grandchild.

Relative (Biological)

- Parent*±
- Son/Daughter (over 21)*
- Son/Daughter (under 21) *±
- Grandparent *
- Grandchild *
- Adopted Child*
Adoption Date: _____

Other Relative (Biological)

- Brother/Sister
- Uncle/Aunt
- Nephew/Niece
- Cousin

Relative (By Marriage or Partnership)

- Spouse*±
- Domestic Partner*‡
Marriage Date: _____

Other Relative (By Marriage or P'ship)

- 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 Employer/Client and current legislation, you are exempt from payroll taxes for unemployment insurance (SUTA). If your employment with the Employer/Client is terminated, you will not receive unemployment benefits. Any applicable exemptions cannot be waived.

± Due to your relationship with the Employer/Client 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. Any applicable exemptions cannot be waived.

‡ Per Wis. Statute 770.05, Domestic Partnership means you and your same sex partner have filed for Domestic Partnership, and have a certified copy of your Declaration of Domestic Partnership.

Residency Disclosure

Yes No **Do the Employer/Client and Employee live in the same home?**

NOTE: It is the Employee's responsibility to notify iLIFE 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.

Employee Signature: _____ Date: _____

Employer/Client Signature: _____ Date: _____

Employee's Withholding Certificate

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

2026

Step 1:
Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at www.irs.gov/W4App.

Step 2:
Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.
 Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; **or**
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate

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

Step 3:
Claim Dependent and Other Credits

If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):			
(a) Multiply the number of qualifying children under age 17 by \$2,200	3(a) \$		
(b) Multiply the number of other dependents by \$500	3(b) \$		
Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here		3	\$

Step 4:
Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here	4(b)	\$
(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027

Step 5:
Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

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



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

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

Step 4.

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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

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



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

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

 - a** Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) **4** \$ _____

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



See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

a **Qualified tips.** If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000 **1a** \$ _____

b **Qualified overtime compensation.** If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the “and-a-half” portion of time-and-a-half compensation **1b** \$ _____

c **Qualified passenger vehicle loan interest.** If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000 **1c** \$ _____

2 Add lines 1a, 1b, and 1c. Enter the result here **2** \$ _____

3 **Seniors age 65 or older.** If your total income is less than \$75,000 (\$150,000 if married filing jointly):

a Enter \$6,000 if you are age 65 or older before the end of the year **3a** \$ _____

b Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment **3b** \$ _____

4 Add lines 3a and 3b. Enter the result here **4** \$ _____

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information **5** \$ _____

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

a **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income **6a** \$ _____

b **State and local taxes.** If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately) **6b** \$ _____

c **Home mortgage interest.** If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) **6c** \$ _____

d **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income **6d** \$ _____

e **Other itemized deductions.** Enter the amount for other itemized deductions **6e** \$ _____

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here **7** \$ _____

8 **Limitation on itemized deductions.**

a Enter your total income **8a** \$ _____

b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** \$ _____

9 Enter: { • \$768,700 if you’re married filing jointly or a qualifying surviving spouse } **9** \$ _____
 { • \$640,600 if you’re single or head of household }
 { • \$384,350 if you’re married filing separately }

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here **10** \$ _____

11 **Standard deduction.**

Enter: { • \$32,200 if you’re married filing jointly or a qualifying surviving spouse } **11** \$ _____
 { • \$24,150 if you’re head of household }
 { • \$16,100 if you’re single or married filing separately }

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly) **12** \$ _____

13 Add lines 11 and 12. Enter the result here **13** \$ _____

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 **14** \$ _____

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 **15** \$ _____

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

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

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

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

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

Signature	Date Signed
-----------	-------------

EMPLOYEE INSTRUCTIONS:

• WHO MUST COMPLETE:

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

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

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

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

• UNDER WITHHOLDING:

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

• OVER WITHHOLDING:

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

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

• LINE 1:

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

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

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

• LINE 2:

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

• LINE 3:

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

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

Employer's Section

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

EMPLOYER INSTRUCTIONS for Department of Revenue:

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

EMPLOYER INSTRUCTIONS for New Hire Reporting:

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

Applicable Laws and Rules

This document provides statements or interpretations of the following laws and regulations enacted as of August 23, 2023: sec. 71.66, [Wis. Stats.](#), and sec. Tax 2.92, [Wis. Adm. Code.](#)

The address will be displayed appropriately in a left window envelope.

**DEPARTMENT OF WORKFORCE DEVELOPMENT
NEW HIRE REPORTING
PO BOX 14431
MADISON WI 53708-0431**



Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

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

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.		First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative
		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 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, sex, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document.</p>
<p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

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



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

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

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

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



Supplement B, Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) from Section 1 .	Middle initial (if any) from Section 1 .

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)	
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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)	
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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)	
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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			Check here if you used an alternative procedure authorized by DHS to examine documents.

Fiscal Agent Copy of Social Security Card (optional)

- To verify the Employee's identity and employment status, we recommend the Employee submit a copy of their signed Social Security card to iLIFE.
- Submitting a copy of the Social Security card helps prevent delays in paperwork processing and helps ensure correct tax reporting.
- Make sure copy of Social Security card is signed and has the Employee's current name.



**WISCONSIN MEDICAID
CHILDREN'S LONG-TERM SUPPORT (CLTS) WAIVER PROGRAM
PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION
FOR SOLE PROPRIETOR OR INDIVIDUAL WAIVER SERVICE PROVIDERS¹**

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

Name of Provider Agency (Typed or Printed)	Tax ID	Phone Number	
Email Address			
Line 1 Street Address (physical address)	Line 2 Street Address		
Mailing Address (if applicable)	City	State	Zip Code

The sole proprietor provider's name, as listed above, must exactly match the name on file with the Wisconsin Department of Health Services (DHS), the U.S. Internal Revenue Service (IRS) and/or Wisconsin Department of Revenue. The above-referenced provider hereby agrees and acknowledges it will:

1. Comply with certain federal and state Medicaid home and community-based services (HCBS) laws, regulations and policies, including those relating to § 1915(c) of the Social Security Act and Title XIX, those regulations pertinent to Wisconsin's Medicaid program, official written policy as transmitted to the provider through the CLTS Waiver Program's published memos, handbooks and other communicate, the standards for the specific CLTS waiver service the provider will deliver, and other requirements as defined in the Wisconsin Medicaid Home and Community-Based Waivers Manual. The provider acknowledges it is responsible for knowing the provisions of federal and state laws, regulations, the applicable CLTS Waiver Program policies, and for complying with all applicable federal and state laws as a condition of its participation as a provider of Wisconsin's Medicaid-funded CLTS Waiver Program.
2. Register and submit all required data to DHS, including its National Provider Identifier (NPI). The provider will submit information updates, as necessary, to ensure accurate data is on file with DHS. Re-registration and an updated signed *CLTS Waiver Program Medicaid Provider Agreement* form must be submitted every four years, at a minimum. The CLTS Waiver Program registration site is available at: <https://www.dhs.wisconsin.gov/clts/providers.htm>.
3. Comply with all federal and state laws regarding confidentiality and disclosure of personal health information (PHI) and personal identity information (PII) including the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for all services, transactions (including electronic transactions), privacy, and security regulations.
4. Retain any records necessary to fully document the services delivered to participants, in accordance with 42 CFR § 431.107 of the federal Medicaid regulations, for a **period of seven years**. See DHS 106.02, Wis. Administrative Code for state policy related to provider record retention.
5. Upon request the provider shall furnish to DHS, the Wisconsin Department of Justice Medicaid Fraud Control Unit, or the U.S. Department of Health and Human Services (DHHS) any information regarding CLTS Waiver Program services delivered and payments claimed by the provider.
6. Comply with the disclosure requirements of 42 CFR Part 455, Subpart B in effect now, or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, furnish to the county waiver agency (CWA) and upon request to DHS, the following in writing:
 - a. The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;
 - b. The names and addresses of all persons who own or have a controlling interest in the provider;
 - c. Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;
 - d. The names and addresses of any subcontractors who have had business transactions with the provider;
 - e. The identity of any person, named in compliance with (a) and (b) above, who has been convicted of a criminal

¹ Note: This agreement is intended for use by providers who are sole proprietors or individuals who are unaffiliated with a provider agency or service.

offense related to that person’s involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

7. Affirm each employed and/or sub-contracted individual that delivers CLTS waiver services to eligible participants, hold current licenses, registrations, certifications and/or similar entitlements, and meets the qualifications specified in the [CLTS Waiver Manual, P-02256](#), as required by federal or state statute, regulation, or rule for the provision of the service. In addition, the provider has completed all required screening activities, including a search of the [U.S. DHHS Office of Inspector General's List of Excluded Individuals/Entities \(LEIE\)](#), and conducted Wisconsin caregiver background checks for all employees or sub-contractors with regular, direct access to CLTS waiver participants²
8. Consent to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the provider to the Medicaid program as a result of an investigation or audit conducted by DHS, the Department of Justice Medicaid Fraud Control Unit, the U.S. Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these entities.
9. Submit to the CWA or DHS any information it requests to ensure qualified providers delivered prior authorized CLTS waiver allowed services to eligible participants. Failure to supply the information requested by DHS result in denial of CLTS Waiver Program payment or sanctions related to the provider’s continued participation in the program.
10. Affirm any statement made in this document, or during the DHS registration and CWA qualified provider screening and verification process, constitutes a statement or representation of a material fact made in an application for a benefit or payment, or made for use in determining rights to such benefit or payment, that is knowingly and willfully made or caused to be made by provider, within the meaning of Wis. Stat. § 49.49 (1)(a) 1 and 2, which imposes criminal penalties for fraud committed in connection with a Medicaid Program.
11. Affirm claims are only submitted for allowable CLTS waiver services to participants, which were included on the eligible participant’s Individual Service Plan (ISP), are prior authorized by the CWA, and delivered to the participant. With the exception of supplemental CLTS covered child care expenses, the provider agency is prohibited from billing the CLTS Waiver Program participant, or the participant’s parent/guardian, for any portion of the cost of the prior authorized waiver service.
12. Accept as payment in full, amounts paid in accordance with the CLTS rate schedule established by DHS for in-scope services: <https://www.dhs.wisconsin.gov/publications/p02184.pdf>
13. Submit claims and receive direct payment from the DHS third party administration (TPA) CLTS claims processing vendor, Wisconsin Physician Services (WPS), pursuant to 42 CFR § 447.10(e). The service payment is based on the CWA’s prior authorization of specified waiver services for each eligible CLTS waiver participant.
14. Submit all claims to the TPA within 120 days from the date of service, or in the instance of services covered by a private insurance carrier or Medicare, submit the service claims within 120 days from the date of the third party’s explanation of benefit (EOB) statement.
15. Submit refunds to WPS for any overpayments identified by the CWA, WPS or DHS.
16. This agreement may be terminated as follows:
 - a. By the provider as set forth at s. DHS 106.05, Wisconsin Administrative Code.
 - b. By the Department upon grounds set forth at s. DHS 106.06, Wisconsin Administrative Code.
 - c. Pursuant to terms set forth in the Wisconsin Medicaid Home and Community-Based Waivers Manual.
17. Unless terminated earlier, this agreement shall remain in full force and effect for a maximum of four years. This agreement shall not extend beyond the due date of the four year re-registration requirements. DHS will issue notification when the four-year re-registration requirement is due.

MODIFICATIONS TO THIS CLTS WAIVER PROGRAM AGREEMENT ARE NOT PERMITTED. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE TO ANOTHER PARTY.

Name – Provider – Sole Proprietor (Typed or Printed)	Title – Owner/Operator
SIGNATURE – Provider	Date Signed

² Qualified provider screening and credential verification and approval is a local county waiver agency function, whereby every four years, at a minimum, the agency must assess and ensure the provider continues to meet all applicable CLTS Waiver Program service standards.

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

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

Refer to DQA form [F-82064A, Instructions](#), for additional information.

Reset

Check the box that applies to you.

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

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

Full Legal Name – First	Middle	Last
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Other Names (including prior to marriage)

Position Title (applied for or existing)	Birth Date (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Home Address	City	State	Zip Code
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Business Name and Address – Employer (Entity)

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

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

SECTION A – DISCLOSURES

- Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

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

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.
- Please note that Wis. Stat. § 48.981, *Abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.
Has any government or regulatory agency (other than the police) ever found that you committed **child** abuse or neglect?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Provide an explanation below, including when and where the incident(s) occurred.
- Has any government or regulatory agency (other than the police) ever found that you abused or neglected **any person or client**?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If **Yes**, explain, including when and where it happened.

- 5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?
If **Yes**, explain, including when and where it happened. Yes No

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

- 7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?
If **Yes**, explain, including credential name, limitations or restrictions, and time period. Yes No

SECTION B – OTHER REQUIRED INFORMATION

- 1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services?
If **Yes**, explain, including when and where it happened. Yes No

- 2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility?
If **Yes**, explain, including when and where it happened and the reason. Yes No

- 3. Have you been discharged from a branch of the US Armed Forces, including any reserve component?
If **Yes**, indicate the year of discharge:
Attach a copy of your DD214, if you were discharged within the last three (3) years. Yes No

- 4. Have you resided outside of Wisconsin in the last three (3) years?
If **Yes**, list each state and the dates you resided there. Yes No

- 5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years?
If **Yes**, list each state and the dates you resided there. Yes No

- 6. Have you had a caregiver background check done within the last four (4) years?
If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check. Yes No

- 7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe?
If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision. Yes No

Read and initial the following statement.

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

NAME – Person Completing This Form

Date Submitted



Fiscal Agent Employer/Client and Employee Agreement

- Instructions:** 1. Employer/Client completes the form.
2. Employer/Client and Employee sign at the bottom.

_____ (Employer/Client), hereafter referred to as Employer/Client, and
 _____ (Employee), hereafter referred to as Employee, do hereby enter
 into the following agreement:

The Employer/Client requires the following tasks and duties to be performed by the Employee:

The Employee agrees to perform the tasks as outlined above according to the following schedule:

- Monday
 Tuesday
 Wednesday
 Thursday
 Friday
 Saturday
 Sunday
 Other: _____
 Mileage (miles per week): _____

✓	Service Type	Pay Rate	Unit Type (hour, day, etc.)	Units/Week
	Daily Living Skills (DLS)			
	Respite Care (R)			
	Mentoring (M)			
	Child Care (C)			
	Other:			

We understand that we may not charge in excess of the amount authorized on the Employer/Client's plan. After the Employee has performed the services per this agreement, timesheets are due to iLIFE according to the Payment Schedule. Both signers agree to only submit timesheets within the hours authorized. Without prior approval, excess hours claimed above the authorization may be rejected for payment.

Employee Signature: _____ Date: _____

Employer/Client Signature: _____ Date: _____

OPTIONAL

Fiscal Agent Employee Direct Deposit Authorization

Instructions: 1. Complete, sign and date this form.
2. Attach required documents.

NOTE: To be effective for the pay date, submit this form at least five business days before the pay date.

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____

Type of Account: Checking Savings

Required Documents

Attach either a voided check or a letter from the bank.

- Starter checks may not be used.
- Must have the routing and account numbers for the account.
- Must be typed.
- Letter must be printed on bank letterhead and state type of account (checking or savings) and account holder's name.

I hereby authorize iLIFE to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries in error to my bank account at the financial institution noted above.

This authorization is to remain in full force and effect until iLIFE receives written notice from me of its termination, in such time and manner as to allow iLIFE and the financial institution a reasonable opportunity to act on it.

Employee Name (printed): _____ Employee Number: _____

Signature: _____ Date: _____

Employer/Client Name (printed): _____



Fiscal Agent Employee Status Change Form

Instructions: This form is for Employee information only. Complete only the sections the Employee needs changed.

Employee Name: _____ Employee Number: _____

Last four digits of Employee's Social Security Number: _____

Employer/Client Name: _____

Completed by Employee	
<input type="checkbox"/>	New Name: _____ Please attach a copy of your updated, signed Social Security card.
<input type="checkbox"/>	New Address: _____ City: _____ State: _____ ZIP: _____
<input type="checkbox"/>	New Phone Number: (_____) _____ - _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
<input type="checkbox"/>	New Email Address: _____
<input type="checkbox"/>	Cancel Direct Deposit Effective Date: _____
Completed by Employer/Client or Employee	
<input type="checkbox"/>	Employment Termination Date: _____ <small>Write the last day the Employee worked.</small> Reason for Termination: _____ _____

Employee Signature: _____ Date: _____