WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 9/1/98	Reviewed: 11/15/11 By: PE Last Revision: 11/18/11	Section: PROVIDER NETWORK	Policy No: 018	Pages: 1 of 5 (3 Attachments)
☒ Wraparound ☒ Wraparound-REACH ☐ FISS ☒ Project O-Yeah	Effective Date: 1/1/12	Subject: **FAMILY SUPPORT SERVICES (MCFI)**			

I. POLICY

Family Support is a category that covers the following types of services: Tutoring, Parent Assistant, Mentoring, daily and hourly Respite Services, Independent Living Skills, Child Care and Household Management Services. Family Support Services are provided to the youth and/or family through identified natural supports (relatives, neighbors, friends, community resources). The goal is to tailor informal/community-based services to meet the needs of each youth and family. It allows for the development of creative, non-traditional, innovative approaches to securing services that have been identified by the youth and family in response to their specific needs.

II. GENERAL INFORMATION

A. Provider /Employee

An individual employed as a Family Support Provider is the employee of the family/youth/client, **NOT** Wraparound/Milwaukee County. Payment of Family Support Providers is accomplished through the use of a fiscal intermediary – the Milwaukee Center For Independence (MCFI). Wraparound has initiated an application/screening process to assure the safety of our Wraparound clients/families and to assist the fiscal intermediary (MCFI). If a potential Family Support Provider is not approved through the application/screening process, and the family/youth/client continues to want that individual to provide services, then the family/youth has the right to appeal the administrative decision.

B. Recreational Activities

Recreational activity costs are the responsibility of the provider/family/client unless some type of exceptional activity is occurring which has been discussed in advance with the Child and Family Team and Care Coordinator/Transition Specialist. In these exceptional instances funding through discretionary funds could be sought on the Service Authorization Request (SAR).

C. Overnights

Wraparound Milwaukee **WILL NOT** fund or be liable for clients who go on overnight passes to Family Service Provider homes. A funded, overnight placement for a minor through Wraparound may occur **ONLY** within a licensed foster home with the parent's/legal guardian's authorization and Care Coordinator knowledge / approval.

NOTE: If the youth/client goes on an overnight with the Family Support Provider, per an independent agreement between the provider and the family/client, scheduled Wraparound activities that would be planned during that time may be acceptable for reimbursement. Again, this would have to be an exceptional activity and would have to be discussed with the Child and Family Team and the Care Coordinator/Transition Specialist.

D. Mandatory Reporting of Abuse

The Family Support Provider is a "Mandatory Reporter". It is the Family Support Provider's responsibility to immediately report to the Care Coordinator and/or the Police/Child Protective Services/State Bureau of Child Welfare Services any reported and/or witnessed neglect or physical, sexual or emotional abuse. The family and the Family Support Provider should be made aware from day one that this would be expected of him/her. **The number for Child Protective Services is 220-SAFE (7233).**

Any reported and/or witnessed physical, sexual or emotional abuse against a young adult (*age 18 or older)* should be report to the Transition Specialist and any appropriate legal party.

E. Confidentiality

The Family Support Services Provider agrees that all information about the youth/family/client they work with is strictly confidential and will not be discussed with any person outside the Child and Family Team or any person not associated with the Wraparound Milwaukee Program.

F. Provider Service Requirements / Training / Documentation

The Family Support Provider must be informed of and encouraged to be involved in all relevant meetings/sessions, i.e., Plan of Care meetings, family sessions as appropriate, etc. Communication and collaboration with the Care Coordinator/Transition Specialist/Family Team should be stressed. The Care Coordinator/Transition Specialist must provide guidance and support to the Family Support Provider regarding the client's care, strengths, needs, etc. The Family Support Provider must also be oriented to the Wraparound Milwaukee program and philosophy. The Family Support Provider must make a progress entry on the Family Support Services Provider Log (see Form C in packet) every time a child/family/client is seen. These Logs must be signed by the Care Coordinator/Transition Specialist, Provider and Parent/Guardian/Caregiver or client (*if over age 18)* and turned in to the Care Coordinator/Transition Specialist at the end of every month. If a session with a client is cancelled for any reason, this should still be indicated on the Log. If Logs are not submitted on time, the family/Wraparound has the right to terminate an employee.

G. Provider Hours

Family Support Services will generally not be approved for more than the maximum hours allowed per service per Wraparound standards. The reason for usage of services beyond these general parameters must be clearly documented in the Plan of Care.

Family Support Services Providers can only bill for actual "face-to-face" contact. Reimbursement is not available for travel time, phone contact and/or if there is a "no show" situation with a client. The Family Support Provider can bill for the time spent attending POC meetings, Child & Family Team meetings and other client related treatment-focused meetings when the youth/family/client is present. Billing for attendance at these meetings will occur at the same hourly rate of reimbursement.

H. Requests for Additional Units of Services

Any requests for additional units of service for the month beyond those authorized on the Service Authorization Request (SAR) form must be discussed with the Care Coordinator/Transition Specialist. The Care Coordinator/Transition Specialist must then have these additional hours/units approved by their Supervisor/Lead and the additional hours/units must be entered on-line through Synthesis (Wraparound Milwaukee's IT system).

I. Provider Monitoring

The Care Coordinator/Transition Specialist will assist the family/client with monitoring the services provided by the Family Support Provider.

J. Liability Issues

Wraparound will not be liable in the circumstance where a youth/family/client may steal from a Family Support Provider and/or cause damage to a Provider's property or person. Issues related to theft/damage must be dealt with between the employer and employee, meaning the Family Support Provider and the youth/family/client.

III. REQUIREMENTS.

Wraparound Milwaukee requires that the following guidelines be followed when the family hires a Family Support Provider.

A. **<u>Criminal History / Criminal Background Check / Caregiver Law / County Resolution</u>**

A statewide criminal background check must be done prior to hiring the individual and there must be adherence to the Wisconsin Caregiver Law/County Resolution. The Care Coordinator/Transition Specialist should have the prospective Provider complete the BACKGROUND INFORMATION DISCLOSURE FORM (s*ee Attachment 1)* and attach it to the Provider Application.

Individuals convicted <u>at any time</u> of the following offenses <u>cannot be hired</u> as a Family Support Services Provider: homicide (all degrees); felony murder; mayhem; aggravated and substantial battery; 1st and 2nd degree sexual assault; armed robbery; administering dangerous or stupefying drugs; and all crimes against children as identified in Chapter 948 of Wisconsin Statutes.

Individuals convicted <u>within the last five (5) years</u> of any crime under the Uniformed Controlled Substances Act under Chapter 961 of Wisconsin Statutes (excluding simple possession) **<u>cannot be hired</u>**.

Individuals convicted <u>within the last three (3) years</u> of any offenses including**,** but not limited to, criminal gang member solicitations; simple possession; endangering public safety; robbery; theft; or two (2) or more misdemeanors involving separate incidences **<u>cannot be hired</u>**.

If the family/client chooses to hire an individual with a past record (charges or convictions), additional character references are recommended and the family/client will need to state in writing that they understand the risks involved in hiring this individual and that they take full responsibility in doing so.

Note: Criminal background checks must be updated every four (4) years. If the Family Support Provider has lived in the State of Wisconsin for less than three years, an effort to get a background check from the last state of domicile must be made/documented.

B. **<u>Transporting a Youth/Family Member</u>**

If the Provider will transport the youth/family/client at any time, the parent/legal guardian or client (*if over age 18*), must sign a TRANSPORTATION CONSENT FORM that indicates permission for the Provider to do so *(see Attachment 2*). For youth under age 18, if the Family Support Services Provider is to pick up the youth at the youth's home for a session/activity, it is required that at least one parent/legal guardian/responsible adult be at home when the Provider arrives and when the youth is being dropped off *(unless otherwise indicated and approved by the Child & Family Team)*.

Please note: Schools, clinics, etc., will often request written permission and identification from the person picking the child up if it is not their parent/legal guardian.

IV. RECOMMENDATIONS

Wraparound <u>recommends</u> that the following guidelines be considered when the family/client hires a Family Support Provider.

A **<u>Driver's License</u>**

If a Family Support Provider is to transport a youth/family/client at any time in a motor vehicle, they must have verification of a valid Wisconsin Driver's License and current insurance. The Family Support Provider's motor vehicle should also have <u>working</u> seat belts and the client must be properly wearing the seat belt at all times during transport. The family/client may request that the Care Coordinator/Transition Specialist complete a Motor Vehicle Check to verify a safe driving record (i.e., no Driving Under the Influence offenses within the past 5 years, no lengthy history of multiple tickets/outstanding violations in the past 5 years). **A motor vehicle check can be done by calling the Department of Transportation in Madison at (608) 266-2353 or by contacting the Wraparound Milwaukee Quality Assurance Department.** It is recommended that a copy of a Certification of Insurance from the Provider's insurance company and a copy of a valid Driver's License also be obtained and kept in the client's chart. The family/client has the discretionary right when viewing the Family Support Provider's Motor Vehicle Check to determine whether or not the driving violations will potentially endanger the safety of their child/themselves and can then make the decision as to if they feel comfortable using that Family Support Provider.

B. **<u>Non-Paid Volunteers / Family Providers</u>**
Wraparound recommends that all **<u>Non-Paid</u>** volunteers working with a client be subject to the same screening procedures as a paid Provider. **<u>Non-Paid</u> volunteers would <u>not</u>** need to complete the MCFI specific paperwork. (The W-4 Form, the Employer Appointment of Agent Form - #2678, the MCFI Fiscal/Agent Authorization Form, the U.S. Department of Justice - Employment Eligibility Verification Form I-9 and the Application for Employer Identification Number – Form SS-4). They **<u>only</u>** need to complete a Provider Application.

IV. PROCEDURE

A. Identify a potential Family Support Provider.

B. Get a Family Support Services Provider Application Packet from Wraparound Milwaukee or a copy from the Family Support Services (MCFI) Policy & Procedure (*see Attachment 3*).

C. Provide Orientation - Orientation Information (*see Form A in packet*), the Family Support Services Job Description (this job description focuses primarily on mentoring support services - *see Form B in packet*), the Family Support Services Provider Log (*see Form C in packet*), and this entire Family Support Services (MCFI) Policy & Procedure.

D. If the individual is interested in providing services for the potential youth/family/client, have the person fill out the Family Support Services Provider Application (*see Form D in packet*).

E. Obtain an Authorization For Release of Health Information form signed by the legal guardian (*see Form E in packet*). This enables the Care Coordinator/Transition Specialist to discuss the youth/family/client with the prospective Family Support Services Provider.

F. Orient Family Support Provider to youth/family/client (*i.e., share relevant history, coordinate first meeting with youth/family/client and Provider*). Youth/family/client and Provider must agree that this is a "good match" (*i.e., the youth/family and Family Support Provider will be able to have a positive, healthy relationship*).

G. If there is agreement between the youth/family/client and Family Support Provider, the Provider and the family should complete the remaining paperwork **<u>prior</u>** to beginning services, i.e. - Family Support Services Admissions Consent Form (*see Form F in packet*), the Provider Referral Form (*see Form G in packet*) and the MCFI papers **<u>if a paid Provider</u>** - see MCFI Fiscal Agent Program Procedure (*see Forms H-L in packet*).

H. The Care Coordinator/Transition Specialist discusses the youth/family/client Plan of Care goals/objectives and how the Provider will be integrated into the Plan. The Provider acknowledges their role/duties according to the Plan of Care.

I. Provider sets up future meetings/visits with the youth/family/client for activities/services as agreed upon by the Child & Family Team. The Care Coordinator/Transition Specialist assists the Provider in coordinating these services.

The Wraparound Milwaukee **Family Support Services (MCFI) Policy & Procedure** has been shared and explained to me by the Care Coordinator/Transition Specialist. By signing this document I am stating that I understand the above conditions and will abide by them. I relinquish the right to make a claim or file a lawsuit against Wraparound Milwaukee, their agents, owners, officers, employees, or other person or entity in any capacity on their behalf. Consent will expire with the termination of services of the Family Support Provider. Revocation of the consent prior to termination will be honored by written notification only.

Parent/Legal Guardian Signature *(for Minors)* or Client Signature (*Service Recipients age 18 or older)* Date

Family Support Provider Signature Date

Wraparound Milwaukee Care Coordinator/Transition Specialist Signature Date

Reviewed & Approved By: Bruce Kamradt

Bruce Kamradt, Director

DEPARTMENT OF HEALTH SERVICES
F-82064A (01/09)

STATE OF WISCONSIN
Chapters 48.685 and 50.065, Wis. Stats.
DHS 12.05(4), Wis. Admin. Code

BACKGROUND INFORMATION DISCLOSURE (BID)
INSTRUCTIONS

The Background Information Disclosure form (F-82064) gathers information as required by the Wisconsin Caregiver Background Check Law to help employers and governmental regulatory agencies make employment, contract, residency, and regulatory decisions. Complete and return the entire form and attach explanations as specified by employer or governmental regulatory agency.

CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Chapters 48.685 and 50.065, Wis. Stats., for persons who have been convicted of certain acts, crimes, or offenses:

1. The Department of Health Services (DHS) may not license, certify, or register the person or entity (Note: Employers and Care Providers are referred to as "entities");
2. A county agency may not certify a child care or license a foster or treatment foster home;
3. A child placing agency may not license a foster or treatment foster home or contract with an adoptive parent applicant for a child adoption;
4. A school board may not contract with a licensed child care provider; and
5. An entity may not employ, contract with or, permit persons to reside at the entity.

A list of barred crimes and offenses requiring rehabilitation review is available from the regulatory agencies or through the Internet at http://dhs.wisconsin.gov/caregiver/StatutesINDEX.HTM.

THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS / CARE PROVIDERS (Referred to as "Entities"):

Programs Regulated under Chapter 48, Wis. Stats.	Treatment Foster Care, Family Child Care Centers, Group Child Care Centers, Residential Care Centers for Children and Youth, Child Placing Agencies, Day Camps for Children, Family Foster Homes for Children, Group Homes for Children, Shelter Care Facilities for Children, and Certified Family Child Care.
Programs Regulated under Chapters 50, 51, and 146, Wis. Stats.	Emergency Mental Health Service Programs, Mental Health Day Treatment Services for Children, Community Mental Health, Developmental Disabilities, AODA Services, Community Support Programs, Community Based Residential Facilities, 3-4 Bed Adult Family Homes, Residential Care Apartment Complexes, Ambulance Service Providers, Hospitals, Rural Medical Centers, Hospices, Nursing Homes, Facilities for the Developmentally Disabled, and Home Health Agencies – including those that provide personal care services.
Others	Child Care Providers contracted through Local School Boards

THE CAREGIVER LAW COVERS THE FOLLOWING PERSONS:

- Anyone employed by or contracting with a covered entity who has access to the clients served, except if the access is infrequent or sporadic and service is not directly related to care of the client.
- Anyone who is a Child Care Provider who contracts with a School Board under Wisconsin Statute 120.13 (14).
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("nonclient resident").
- Anyone who is licensed by DHS.
- Anyone who has a foster home licensed by DHS.
- Anyone certified by DHS.
- Anyone who is a Child Care Provider certified by a county department.
- Anyone registered by DHS.
- Anyone who is a board member or corporate officer who has access to the clients served.

FAIR EMPLOYMENT ACT

Wisconsin's Fair Employment Law, Chapters 111.31 - 111.395, Wis. Stats., prohibits discrimination because of a criminal record or pending charge; however, it is not discrimination to decline to hire or license a person based on the person's arrest or conviction record if the arrest or conviction is substantially related to the circumstances of the particular job or licensed activity.

PERSONALLY IDENTIFIABLE INFORMATION

This information is used to obtain relevant data as required by the provisions set forth by the Wisconsin Caregiver Background Check Law. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches. For example, the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions. The Department of Health Services' Caregiver Misconduct Registry uses social security numbers as one identifier to prevent incorrect matches of persons with findings of abuse or neglect of a client or misappropriation of a client's property.

BACKGROUND INFORMATION DISCLOSURE (BID)

Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. Failure to comply may result in a denial or revocation of your license, certification, or registration; or denial or termination of your employment or contract. Refer to the instructions (F-82064A) on page 1 for additional information. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.

PLEASE PRINT YOUR ANSWERS.

Check the box that applies to you.

- ❑ Employee / Contractor (including new applicant)
- ❑ Applicant for a license or certification or registration (including continuation or renewal)
- ❑ Household member / lives on premises - but not a client
- ❑ Other – Specify:

NOTE: If you are an owner, operator, board member, or non client resident of a Division of Quality Assurance (DQA) regulated facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Name – (First and Middle)	Name – (Last)	Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)	
Any Other Names By Which You Have Been Known (Including Maiden Name)	Birth Date	Gender (M / F)	Race
Address Street, City, State, ZIP Code		Social Security Number(s)	
Business Name and Address - Employer or Care Provider (Entity)			

SECTION A - ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have any criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, local, military and tribal courts? ➢ If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgement of conviction, a copy of the criminal complaint, or any other relevant court or police documents.		
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.) ➢ If **Yes,** list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.		
3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked: ❑ (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.) ➢ If **Yes**, explain, including when and where it happened.		
4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? ➢ If **Yes,** explain, including when and where it happened.		

(continued on next page)

SECTION A (continued)	YES	NO
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.		
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.		
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.		

SECTION B – OTHER REQUIRED INFORMATION	YES	NO
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.		
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.		
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 3 years.		
4. Have you resided outside of Wisconsin in the last 3 years? ➢ If **Yes**, list each state and the dates you lived there.		
5. Have you had a caregiver background check done within the last 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.		
6. 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.		

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to $1,000.00 and other sanctions as provided in DHS 12.05 (4), Wis. Adm. Code.

SIGNATURE	Date Signed

FAMILY SUPPORT SERVICES TRANSPORTATION CONSENT FORM

Youth's Name ____ **DOB** __________________
(Print)

____ **has permission to pick up and transport my child**
(Name of Provider)

from ______________________________ **through the termination of services or in 12 months from the**
(Effective Date)

date signed, whichever is first.

Special Considerations / Medical-Medication Issues / Limitations:

____

____

____

____ ____________________ ___________________
Signature of Legal Guardian Relationship to Youth Date

____ ___________________
Signature of Youth Date

WITNESSED BY:

____
Print Name of Witness

____ __________________________
Signature of Witness Date Witnessed

EMERGENCY CONTACT:

Name ____ Phone _______________________

Address ____

City ____________________________ State ______________________ Zip Code ________________

Unless otherwise specified, this consent will expire <u>12 months</u> from the date it was signed. This consent or any part of this consent may be canceled at any time with <u>written</u> notification.

WRAPAROUND MILWAUKEE / REACH
Family Support Services

Provider Application Packet

To: Care Coordinator/Transition Specialist

Use the Wraparound Milwaukee Family Support Services (MCFI) Policy – # 018, Section IV – Procedure to guide you through this packet.

WRAPAROUND MILWAUKEE / REACH

Family Support Services

Provider Application Information and Requirements

Please note that a separate Application, including all MCFI paperwork (if applicable) must be completed on every Provider serving a youth/parent/client and for every youth/parent/client in that family, if the Provider serves more than one person in the family.

1. All information requested on the attached Application must be submitted along with MCFI paperwork (if applicable).

2. Send or drop off the Original complete Application to: **(Do Not Fax)**

   Theresa Randall, Provider Network
   WRAPAROUND MILWAUKEE
   9201 Watertown Plank Road
   Milwaukee, WI 53226

3. The necessary information will then be forwarded to the MCFI representative, if the Provider is a paid employee.

4. It is the Provider's responsibility to keep all information current. Any change in the ability of the Provider to provide services must be reported to the Care Coordinator/Transition Specialist. The Care Coordinator/Transition Specialist is responsible for forwarding any **address changes** to the Wraparound Milwaukee Finance Department.

5. No eligible client shall be unlawfully denied services or be subjected to discrimination because of age, race, religion, color, national origin, sex, sexual orientation, location, disability, physical condition or developmental disability as defined in 51.01 (s) Wisconsin Statutes.

WRAPAROUND MILWAUKEE / REACH
Family Support Services

Orientation Information

1. Wraparound Milwaukee History

In 1994, Milwaukee County was awarded a five-year Federal Grant from the Center for Mental Health Services to initiate a coordinated system of community-based care and resources, called "Wraparound Services" for children with severe emotional, behavioral and mental health needs. The system of care now established is called "Wraparound Milwaukee". Wraparound Milwaukee is operated by the Child & Adolescent Services Branch of the Milwaukee County Behavioral Health Division. Wraparound has evolved into a managed care system providing mental health and drug and alcohol treatment services to identified children and their families and young adults through the age of 24 (*O-YEAH program*). Our funding comes primarily from Medicaid, Juvenile Justice and the Bureau of Milwaukee Child Welfare.

Wraparound Milwaukee consists of a consortium of agencies providing family driven services to meet the complex needs of children, families and young adults.

2. What is Wraparound Milwaukee / REACH / O-YEAH Program

Wraparound is a strength-based approach to service delivery that is based on identifying what "Needs" a child/family/young adult has and what is required to care for that child/young adult with severe emotional or behavioral challenges; to identify natural supports, community supports, and professional resources to meet those needs, and to "wrap" services around the child/family/young adult. It is an approach that individualizes care rather than "fitting" an individual into an existing service that may not be what the individual needs.

Wraparound is designed to increase parent/caregiver/client choices in selecting services and service providers and promotes family/client independence rather than dependence by stressing that most often families/caregivers/clients know what is best for their child/themselves.

3. Target Group

The Wraparound Milwaukee/REACH/O-YEAH programs are targeted at serving children/young adults who meet the following qualifications:

- A current mental health disorder as defined in the DSM-IV – R.
- Functional impairments (i.e., psychotic symptoms, danger to self or others, impairment in community functioning).
- Involved in two or more service systems (i.e., mental health, child welfare, juvenile justice, social services, special education services).
- Are at imminent risk for out-of-home placement, inpatient psychiatric hospitalization or placement in a residential care center or juvenile correctional facility.

All areas of Milwaukee County are served.

WRAPAROUND MILWAUKEE / REACH

Family Support Services

Job Description

(Primarily focuses on mentoring, but applicable to other Family Support Service Providers also.)

Definition/Objective

To act as a positive role model and advocate for severely emotionally disturbed children and/or their families who are in need of guidance and opportunities for social growth. Mentoring is a trusting one-to-one relationship that focuses on developing youth and family strengths, interests and needs. The primary purpose in mentoring is role modeling and building supports and partnerships with youth and families in their communities.

Eligibility Criteria

Must be at least 18 years old. Experience in working with youth is preferred, but not required.

Working Hours

As determined by the needs of the client, family and/or program, and the availability of the Provider.

Desired Traits/Requirements

- Must be able to work as a member of a Child & Family Team.
- Must be dependable and responsible.
- Must be flexible.
- Must enjoy working with children/adolescents.
- Must be nurturing and patient.
- Must be supportive and objective.
- Must use good judgment.
- Must possess good written, verbal, listening and communication skills.
- Must be able to problem solve independently.
- Must be open to a variety of cultural experiences.
- Must be outgoing and active.
- Must be able to provide structure.
- Must be able to set limits and provide appropriate consequences for undesirable behavior.
- Must be able to provide praise and reinforcement when desirable behavior is evident.
- Must be receptive to direction and feedback from the Child & Family Team.
- Must have knowledge of wraparound philosophy and believe in the strength-based approach.
- Must be able to provide emotional support in order to help the child sort out feelings and channel them productively.
- Must be able to provide objective and unconditional care and acceptance.
- Must have a valid Wisconsin Driver's License and current auto insurance, if transporting youth and/or family members. If no Driver's License, Provider cannot transport.
- Must have a criminal background check completed and have met the requirements of the Wisconsin Caregiver Law and the Milwaukee County Caregiver Resolution.

Role Description

As a member of a Child & Family Team supported by the Wraparound / REACH program, a Family Support Provider would function as both a positive role model and advocate for a child or adolescent in his/her family system and community. Children would be matched with a Family Support Provider based on their needs and interests. A Family Support Provider could be involved in a variety of activities with the child and/or family with the focus including, but not limited to, recreation, school related projects, social skills and peer relationship building, personal care/hygiene/exercise, etc. Direction, consultation and support will be provided by the Wraparound / REACH Care Coordinator and Child & Family Team. The time commitment will vary depending upon the needs of the child/family. A Family Support Provider is a valuable link in assisting children and families in developing needed skills and relationships as they grow.

Responsibilities

1. Have knowledge of the Wraparound/REACH philosophy regarding providing services/care.

2. Have knowledge of the Wraparound Family Support Services Policy & Procedure, have signed off on the Policy and have completed the necessary MCFI paperwork if he/she is a paid provider.

3. Work as a member of the Child & Family Team in assisting children and families in skill development. Role models and teaches skills referred to in the Job Description and any other skills that may be identified in the Plan of Care.

4. Communicate routinely with the Care Coordinator (verbally and in writing) to assure comprehensive care.

   Reminder: The Family Support Provider is to immediately report to the Care Coordinator and/or Police or Child Protective Services any reported and/or witnessed neglect or physical, sexual or emotional abuse.

5. Documentation -- The work of the Family Support Provider must be documented routinely. This means that the Provider must fill out a Family Support Services Provider Log every time a child or family is seen (*see Form C in the Family Support Services Provider Application packet*). **The parent's/guardian's signature must be on every Log,** thus verifying that the contact/service did actually occur. These Logs must be turned in to the Care Coordinator at the end of every month. If a scheduled session with a client is cancelled for any reason, this should also be indicated on the Provider Log. Every Log must be signed by the Care Coordinator. The Logs must be reviewed by the Care Coordinator and feedback should be given to the Provider, as needed.

6. Participate in Child & Family Team/Plan of Care meetings led by the Wraparound / REACH Care Coordinator, in collaboration with the family and their support systems. Assist in the development of the Plan of Care and identifying the child's and family's strengths and needs.

7. Be accessible, if needed, to the child, family, and/or Care Coordinator according to the standards set by the Child & Family Team.

8. Complete the necessary paperwork as identified in the Family Support Services Policy & Procedure.

WRAPAROUND MILWAUKEE / REACH
Family Support Services

Provider Log

Youth's Name ____

Parent/Caregiver's/Guardian's Name ____

Provider's Name ____

Service Provided ____

Care Coordinator / Agency ______________________________ Phone ________________

For Services Provided During the Month / Year of ______________________________

Need(s) as Identified in the Plan of Care ______________________________

____

DATE	TOTAL Hours & Time Frame Seen	ACTIVITY / COMMENTS / PROGRESS
Example: 8/1/03	**2 hrs. – 2-4:00pm**	**Provider must make <u>ONE</u> entry for every time the client is seen.**

Care Coordinator's Signature ______________________________ Date ________________

Caregiver's/Guardian's Signature ______________________________ Date ________________

Provider's Signature ______________________________ Date ________________

Note: Submit this form with the Caregiver's/Guardian's Signature to the Care Coordinator at the end of every month. Pre-signing the Log is not permissible. The time identified on the Log must match the time of the Provider's Time Sheet.

WRAPAROUND MILWAUKEE / REACH

Family Support Services

FSS Provider
Application Packet
FORM D

Provider Application

Instructions: The Provider applicant is to complete this form and submit it to the family's Care Coordinator. The Care Coordinator and/or Agency representative should review, approve and sign the application and then forward to Theresa Randall, Provider Network.

SECTION A – General Information

Name of Provider ______________________________

Address ______________________________

City, State, Zip ______________________________

Telephone: Home ______________________ Work ______________________

Place of Employment ______________________ How Long? __________

Name of youth you will be working with ______________________________

Are you related to this youth/family? ____ Yes ____ No

If yes, how? ______________________________

Name of Family's Care Coordinator ______________________________

Care Coordination Agency ______________________________

Care Coordinator's Telephone Numbers:

Office ______________ Pager ______________ Cell Phone ______________

SECTION B – Identifying Provider Information

Name/Address/Telephone number of person to contact in case of emergency:

____

____

____

Social Security # ______________ Height ______________ Weight ______________

Birthdate ______________ Eye Color ______________ Hair Color ______________

Do you have a valid Wisconsin Driver's License? ____ Yes ____ No

If yes, Driver's License # ______________________________

Do you have current car insurance? ____ Yes ____ No If yes, please fill out the following:

Name of Insurance Company ______________________________

Insurance Agent's Name ______________________ Phone ______________

Policy # ______________________ Effective Date __________ Expiration Date __________

Have you been charged with Driving While Under the Influence within the last 5 years? ___Yes ___No

If yes, date of charge ______________

Does your driving record within the last 5 years reflect unsafe driving habits? _____ Yes _____ No

If yes, please explain ____

Have you ever been arrested for or convicted of a felony/criminal act/abuse or neglect/sexual abuse?

_____ Yes _____ No If yes, please explain: ____

____

___

Please list one non-relative personal reference:

Name ____

Relation ____________________________________ Phone ________________________

Please list two professional references:

Name ____

Relation ____________________________________ Phone ________________________

Name ____

Relation ____________________________________ Phone ________________________

Please describe your specific skills/interest in providing services to children, adolescents and/or families:

____

____

____

What day(s) and time(s) would you be available each week? _______________________________

____

……………………………………………………………………………………………

SECTION C: Services

	Rate	Unit
☐ Respite Services *(Daily and Hourly only)*	_____	_____
☐ Mentor	_____	_____
☐ Tutor Services	_____	_____
☐ Independent Living Skills	_____	_____
☐ Crisis Home/Beds (must have a foster home license)	_____	_____
☐ Child Care	_____	_____
☐ House Management Services	_____	_____
☐ Parent Assistance	_____	_____

……………………………………………………………………………………………

The Provider certifies that the information provided on this application is true and correct. Any misrepresentation on the part of the Provider on this form may result in disqualification from participation in the Wraparound Milwaukee program and legal action or fiscal sanctions may be taken as determined appropriate by Milwaukee County or its designated representative(s).

____ ____________________

Signature of Applicant Date

____ ____________________

Care Coordinator / Agency Date

……………………………………………………………………………………………

For Wraparound Use Only: Date Received _______________ Approval Date ________________

Approved By ____

WRAPAROUND MILWAUKEE / REACH

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

PURPOSE OF INFORMATION RELEASE/EXCHANGE:

Release / exchange of mental health (Enrollment notification and information, Plan of Care – including diagnosis/prognosis, and Progress Reports) AODA (Alcohol and Other Drug Addiction), physical health and school progress information that will be used to plan and provide for the care, treatment and services for:

_______________________________ (Youth's Name) _______________ (Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and the Mobile Urgent Treatment Team to release and exchange information with staff at the agencies identified below. Information may be shared verbally or in writing.

Place your initials in the box next to the agency name to authorize information release/exchange.

	AGENCY NAME	ADDITIONAL INFO. TO BE RELEASED/EXCHANGED
☐	Insurance Carrier - Medicaid / Title 19	________
☐	Insurance Carrier – Other ________ (Insurance Company Name)	________
☐	Bureau of Milwaukee Child Welfare	________
☐	Milwaukee County Children's Court	________
☐	Wraparound Education Advocates Chris Shafer, Laverne Lunde, Shirley Fishman	________
☐	Families United of Milwaukee, Inc. *(Family Advocacy Agency)* ________	
☐	Milwaukee Public Schools ________ (School Name)	________
☐	Other Schools ________ (School Name)	________
☐	Primary Care Physician ________ (Physician ________	________
☐	(Clinic Name / Other-Name ________	________
	Address: ________	________
☐	Youth in Wraparound and REACH are also encouraged to participate in our **Wraparound Youth Council and Clubhouse** activities. By initialing here you authorize Youth Council representatives to contact your child directly regarding activities and events.	

CONSENT FOR INFORMATION TO BE USED IN RESEARCH

I give my consent for non-identifying data obtained during my enrollment to be used for research to evaluate the effectiveness of the program. No information that is presented will contain any identifying personal information.

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION

If not specified below, I understand that this Authorization to Release/Exchange Information EXPIRES 12 MONTHS from the date it is signed. I understand that I may cancel this authorization at any time (see back of sheet for instructions). This cancellation does not include any information that has been shared between the time I gave my consent to share information and the time that the consent was canceled.

This authorization expires on the ____________ day of ______________________, 20_____.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

_______________________________ _______________
Parent or Legal Guardian Signature — Date

_______________________________ _______________
Youth Signature (*age 14 and older should sign)* — Date

_______________________________ _______________
Witness Signature — Date

PARTICIPANT RIGHTS RELATED TO AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family. If my child is enrolled in Wraparound Milwaukee as part of a court order, I understand that failure to sign this form may result in a request to the courts to modify the court order that allows for enrollment in the Wraparound Milwaukee program.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be released/exchanged by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department.

HIV Test Results - I understand my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

Submit your written requests for withdrawal to:

Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608

WRAPAROUND MILWAUKEE

Family Support Services

FSS Provider
Application Packet
FORM F

Admissions Consent Form

Youth's Name ____

The following items needing consent are essential to the care and treatment of your child, please read each section and indicate your consent by initialing the appropriate line at the end of this form. If you do not consent, do not place your initials on the line.

Consent For Emergency Care

I authorize the Family Support Provider to act on my behalf in case my child is victim of major accident, injury or illness when immediate medical or surgical care is needed, provided that the Family Support Provider make diligent effort to get in touch with me are unsuccessful. I authorize the Family Support Provider to make such action and give such consent on my behalf as his/her judgment dictates. In the event of any such emergency, I can be reached at this telephone number: ______________________. Initials: __________

Consent or Participation in Activities

I hereby give consent for my child to participate in supervised sports and recreational activities which are scheduled as part of the Plan of Care recognizing that some of these activities may be provided outside of the home and require transportation outside of the county.

I understand and acknowledge that some of the activities may involve unanticipated risks that could result in injury to the child, to myself, to property or to third parties.

I expressly agree and promise to accept and assume all of the risks involved in activities within and outside my home. Initials: __________

Consent/Waiver of Responsibility for Personal Property

I give my consent for my child to possess certain items of personal property. I understand that the Wraparound Program/Service Provider is not responsible for the loss, theft or damage of personal property or money which your child may have in their possession while on outings. Initials:_____________

……..

I have read all the information pertaining to the above items needing consent and have indicated my approval by initialing the appropriate lines.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my son□s/daughter□s participation in any activity supervised the by Family Support Providers, I will have no right to make a claim or file a lawsuit against the Wraparound Milwaukee Agencies, their agents, owners, officers, employees or any other person or entity acting in any capacity on their behalf.

____

Date, Event or Condition upon which Consent will Expire

If not specified above, I understand that this Admissions Consent expires 12 months from the date it was signed. I also understand that I may cancel this consent at any time by stating so in writing with the date and my signature. This does not include any information which has been shared between the time I gave my consent to share information and the time that such consent was canceled.

____ ____________________

Parent or Guardian's Signature Date

____ ____________________

Care Coordinator / Witness Signature Date

____ ____________________

Family Service Provider Signature Date

FSS Provider
Application Packet
FORM G

WRAPAROUND MILWAUKEE

PROVIDER REFERRAL FORM

Reminder: Providers please assure that the initial visit is done with the Care Coordinator.

Referral Completion Date ____________________________

Referred by:

_______________________________ _______________________________
Name of Care Coordinator Name of Care Coordination Agency

Phone (___)_________________ Pager (____)_________________ Cell Phone (____)___________________

Name of Provider/Agency being referred to:____

Address ____

City ____ State_________________ Zip _________________

Name of Provider Contact Person ___________________________________ Phone (____)________________

1. **Service being requested**:____ Service Code _______________

   Frequency / Days & Times being requested: ____

2. **Service being requested**:____ Service Code _____________________

   Frequency / Days & Times being requested: ____

3. **Service being requested**:____Service Code _____________________

   Frequency / Days & Times being requested: ____

4. **Service being requested**:____Service Code _____________________

   Frequency / Days & Times being requested: ____

Name of Client being Referred:____ Phone (____)______________

Address ____

City____ State_________________ Zip______________

Name of associated WM Enrollee (if different than client being referred) ______________________________________

Relationship of Referred Client to WM Enrollee (if not the same – i.e., mother, sibling, etc.)______________________

Client Lives With:____ **Relationship:**__________________________

Ethnicity: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Asian ☐ Other _______________

Gender: ☐ Male ☐ Female **DOB**: _____________________ **SSN:** __________________________________

Special Accommodation Needs, if any *(i.e., physical and sensory disabilities, medical needs, limitations, etc):*

____

FAMILY/SCHOOL INFORMATION

Mother/Legal Guardian ____ Home Phone (____)__________________

Address ____ Work Phone (____)__________________

City____ State_________________ Zip _________________

Father/Legal Guardian ____ Home Phone (____)__________________

Address ____ Work Phone (____)__________________

City____ State _______________ Zip __________________

Other Emergency Contact _______________________________________ Home Phone (____)________________

Address ____ Work Phone (____)_________________

City____ State_________________ Zip _________________

Relationship to Client _______________________________

Siblings/Children: (*Not required for transportation services if only transporting identified client.*)

1. _______________________________________ **DOB** ______________________

2. _______________________________________ **DOB** ______________________

3. _______________________________________ **DOB** ______________________

4. _______________________________________ **DOB** ______________________

School ____ ☐ Not Attending ☐ Not Enrolled ☐ N/A

Grade ______________ **Special Education:** ☐ Yes ☐ No

GENERAL INFORMATION

Diagnosis: *(Required only if referring to medical or mental health providers.)*

____

Currently on Medication? ☐ **Yes** ☐ **No** **If yes, what type?** ___________________________________

Strengths/Interests*:* (*Not required for transportation referrals.)*

____

____

____

Needs/Reason for Referral: (*Not required for transportation referrals.)*

____

____

____

Safety Concerns: ____

____

____

____

(For Provider Agency Use Only)

Date Referral was Received ______________________

WRAPAROUND MILWAUKEE / REACH

Family Support Services

MCFI FISCAL AGENT PROGRAM

(for Payments to Non-Agency Providers)

Procedure

Note: The Care Coordinator should assist the Provider with the completion of these forms. Please complete the forms using Black Ink only.

1. **Provider Application** (for specific child/family) – Should be completed and signed by the individual Provider. The Care Coordinator should also sign the application. Be sure the Provider has indicated the agreed upon unit and rate on the form.
   Note: A separate application, including all the MCFI paperwork, must be completed on every youth/parent receiving Family Support Services.
2. **W-4 Form** – The Individual Provider should complete and sign. The Provider should indicate the number of exemptions they wish to claim for tax purposes. Deductions will be taken from each check based on the information from the W-4 Form (s*ee attached sample & blank form*).
3. **Employer/Payer Appointment of Agent Form (#2678)** – Should be signed by parent/legal guardian. This form authorizes MCFI to act as the fiscal agent for the parent/legal guardian, who is employing the individual Providers. MCFI will obtain an Employer Identification Number for the parent/legal guardian after this form is received (s*ee attached sample & blank form*).
4. **U.S. Department of Justice - Employment Eligibility Verification Form I-9**
   This form is required to verify that the potential Provider/Employee is eligible to work in the United States (*see attached sample & blank form*).
   Section One -- Employee Information and Verification are to be completed by the Provider/Employee, who must sign and date the form.
   Section Two -- Employer Review and Verification are completed by the Care Coordinator utilizing the guide entitled "Lists of Acceptable Documents" located on the back of the form. The Care Coordinator must get information from one document under List A or one document from both List B & C. The Care Coordinator should then sign and date Section Two.
   Section Three -- Updating and Reverification. DO NOT COMPLETE THIS SECTION.
5. **MCFI Fiscal Agent Authorization Form** – Should be completed by the Care Coordinator and signed by the parent/legal guardian. This simply lists the Provider(s) who will provide services for the child/family, and the specific rates/units approved for each service. The Care Coordinator should keep a copy of this form, as this form can be used to add and delete Providers or Clients.
   Note: This form should is submitted each time there is a change in Providers, service, rate, or authorized payroll signature (*see attached sample & blank form*).
6. **Tax Information Authorization Form #8821.**
7. SS-4 Form – should be completed and signed by the legal guardian or by the enrollee, if age 18 or older. This form allows MCFI to apply for an Employer Identifcation Number (EIN) with the Internal Revenue Service for the enrollee (*Wraparound client*), if they are going to employ a family support person (*family support staff*).
8. Care Coordinator to give Provider copies of the "MCFI – Fiscal Agent – Direct Deposit Informational Letter" and "Direct Deposit Authorization Form" (*see Samples in Packet).*

Once the forms have been completed and signed, the **Originals** should be submitted to Wraparound Milwaukee – Theresa Randall, who will approve the Application and then complete the paperwork and forward it to MCFI.

Note: The Care Coordinator should keep a copy of all the forms and provide the parent/legal guardian and Provider with copies, as requested.

Authorization / Payment Process Requirements

1. Once Wraparound has processed the paperwork, the Care Coordinator/Transition Specialist can request the identified approved services on the SAR through Synthesis.
2. Individual Providers will receive a monthly Employee Time Report from MCFI, along with an envelope addressed to MCFI (*see sample of Time Report attached*). Wraparound Milwaukee will send the initial Employee Time Report to all new Providers.
   Care Coordinator: Please share the sample with the Provider so that they are aware of how to complete the Employee Time Report. The Employee Time Report will inform them of the total number of units authorized for the month.
3. Providers will need to list, by date, the time services were provided, and the number of units provided each day. Providers will then need to total the number of units for the month. Providers will need to sign the Employee Time Report, which also **needs to be signed by the parent/guardian or client, if age 18 or older, as the employer verifying that the services occurred.**
4. Time Reports should be mailed directly to MCFI for payment. Payments will be processed on the 15th and 30th of the month.
5. Time Reports are due **<u>no later than 60 days after the end of the service period</u>.**

Responsibilities

<u>Individual Provider</u> (Employee)
1. With assistance from the Care Coordinator complete Wraparound Provider Application (for specific child), W-4 form, and Employment Eligibility Verification Form I-9.
2. Log services provided on the Employee Time Report; total for month.
3. Sign the Employee Time Report, and have the parent/guardian sign it verifying provision of services.
4. Mail Employee Time Report to MCFI for payment.
5. Notify Care Coordinator of any changes in address/phone number or other significant information. The Care Coordinator is then responsible for relaying this information to Theresa Randall in the Wraparound Milwaukee Provider Network Department.

<u>Parent/Guardian</u> (Employer)
1. With the assistance of the Care Coordinator, complete and sign the Employer/Payer Appointment of Agent (form #2678) and the Fiscal Agent Authorization form, the SS-4 Form and the Tax Information Authorization Form #8821.
2. Sign monthly Employee Time Report of the Provider verifying services occurred.

<u>Wraparound Milwaukee</u>
1. Forward all necessary paperwork to MCFI for processing.
2. Send confirmation of services being rendered, initial timecard and other paperwork to employee.
3. Enter all applicable information into Synthesis, enabling Provider to be entered onto a Service Authorization Request (SAR) and be paid through MCFI.

<u>MCFI</u>
1. Obtain Employer Identification Numbers for Parents.
2. Process W-4 forms for non-agency Providers.
3. Based on information provided by Wraparound, MCFI will handle the payroll for all non-agency Providers.
4. Access monthly client authorizations through Synthesis.

Form W-4 (2011)

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 2011 expires February 16, 2012. 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 cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not 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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 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. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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 are single and have only one job; or
- You are married, have only one job, and your spouse does not 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 $1,900 of **child or dependent care expenses** for which you plan to claim a credit . . . . F ______
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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 $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children . . . . . 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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 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.

Cut 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. 1545-2159

2011

1 Type or print 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 2011, 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** (2011)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions . . . 1 $______

2 Enter: { $11,600 if married filing jointly or qualifying widow(er); $8,500 if head of household; $5,800 if single or married filing separately } . . . 2 $______

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . 3 $______

4 Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919) 4 $______

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet* in Pub. 919.) . . . 5 $______

6 Enter an estimate of your 2011 nonwage income (such as dividends or interest) . . . 6 $______

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . 7 $______

8 **Divide** the amount on line 7 by $3,700 and enter the result here. Drop any fraction . . . 8 ______

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 . . . 9 ______

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 ______

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" . . . 2 ______

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . 3 ______

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . 4 ______

5 Enter the number from line 1 of this worksheet . . . 5 ______

6 **Subtract** line 5 from line 4 . . . 6 ______

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . 7 $______

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $______

9 Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000 -	0	$0 - $8,000 -	0
5,001 - 12,000 -	1	8,001 - 15,000 -	1
12,001 - 22,000 -	2	15,001 - 25,000 -	2
22,001 - 25,000 -	3	25,001 - 30,000 -	3
25,001 - 30,000 -	4	30,001 - 40,000 -	4
30,001 - 40,000 -	5	40,001 - 50,000 -	5
40,001 - 48,000 -	6	50,001 - 65,000 -	6
48,001 - 55,000 -	7	65,001 - 80,000 -	7
55,001 - 65,000 -	8	80,001 - 95,000 -	8
65,001 - 72,000 -	9	95,001 -120,000 -	9
72,001 - 85,000 -	10	120,001 and over	10
85,001 - 97,000 -	11		
97,001 -110,000 -	12		
110,001 -120,000 -	13		
120,001 -135,000 -	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$560	$0 - $35,000	$560
65,001 - 125,000	930	35,001 - 90,000	930
125,001 - 185,000	1,040	90,001 - 165,000	1,040
185,001 - 335,000	1,220	165,001 - 370,000	1,220
335,001 and over	1,300	370,001 and over	1,300

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 who claims no withholding allowances; 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 possessions 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.

Form W-4 (2011)

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 2011 expires February 16, 2012. 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 cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not 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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 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. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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 are single and have only one job; or
- You are married, have only one job, and your spouse does not 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 $1,900 of **child or dependent care expenses** for which you plan to claim a credit . . . F ______

(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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 $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children . . . . . 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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 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.

Cut 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. 1545-2159 — **2011**

1 Type or print your first name and middle initial. MARY A. — Last name MARKS — 2 Your social security number 999-99-9999

Home address (number and street or rural route) 99 S. 60th St.

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 WEST Allis, WI 53000

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 2011, 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.) ▶ Mary A. Marks — **Date** ▶ 10/17/11

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) John DOE 31 Flower St. Milw, WI 99999 — 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** (2011)

Youth's NAME & Address

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: $11,600 if married filing jointly or qualifying widow(er); $8,500 if head of household; $5,800 if single or married filing separately	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet* in Pub. 919.)	5	$
6	Enter an estimate of your 2011 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,700 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet ..... 4 ______		
5	Enter the number from line 1 of this worksheet ..... 5 ______		
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000 -	0	$0 - $8,000 -	0
5,001 - 12,000 -	1	8,001 - 15,000 -	1
12,001 - 22,000 -	2	15,001 - 25,000 -	2
22,001 - 25,000 -	3	25,001 - 30,000 -	3
25,001 - 30,000 -	4	30,001 - 40,000 -	4
30,001 - 40,000 -	5	40,001 - 50,000 -	5
40,001 - 48,000 -	6	50,001 - 65,000 -	6
48,001 - 55,000 -	7	65,001 - 80,000 -	7
55,001 - 65,000 -	8	80,001 - 95,000 -	8
65,001 - 72,000 -	9	95,001 -120,000 -	9
72,001 - 85,000 -	10	120,001 and over	10
85,001 - 97,000 -	11		
97,001 -110,000 -	12		
110,001 -120,000 -	13		
120,001 -135,000 -	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$560	$0 - $35,000	$560
65,001 - 125,000	930	35,001 - 90,000	930
125,001 - 185,000	1,040	90,001 - 165,000	1,040
185,001 - 335,000	1,220	165,001 - 370,000	1,220
335,001 and over	1,300	370,001 and over	1,300

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 who claims no withholding allowances; 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 possessions 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.

Form **2678** (Rev. June 2011)

Employer/Payer Appointment of Agent

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

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	For SOME employees/payees
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-PR, 944-SS, 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 taxes 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 taxes for you. See the instructions.

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

X Sign your name here ____________

Date / /

Print your name here ____________

Print your title here ____________

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

☐ 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

Date / /

Print your name here

Print your title here

Best daytime phone

Instructions for Form 2678

Section references are to the Internal Revenue Code.

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. You cannot use a prior version of this form. All prior versions are obsolete and will not be accepted.

• If you want to appoint an agent, check the box in Part 1 that says, "You want to **appoint** an agent for tax reporting, depositing, and paying," and complete Part 2.

Note. Generally you cannot appoint an agent to file an aggregate Form 940. Beginning with the 2010 tax year, if you are a home care service recipient you may request approval for an agent to report, file, and pay taxes on a Form 940, by checking the box in the footnote on line 5.

At the time this form went to print, proposed regulations REG-137036-08 were issued to modify Regulations section 31.3504-1 to allow home care service recipients to appoint an agent to report, file, and pay taxes on Form 940.

• If you are an agent and you want to accept an appointment, complete Part 3. If you are a corporate officer, partner, or tax matters partner, you must have the authority to execute this appointment of agent.

Note. If the employer/payer will be making payments not covered by the appointment, the employer/payer must file all related returns and deposit and pay taxes for those payments. When completing line 5, check the box(es) "For SOME employees/payees."

• If you are an employer, payer, or agent and you want to revoke an existing appointment of an agent, check the box in Part 1 that says, "You want to **revoke** an existing appointment," and complete Parts 2 and 3. However, only one signature is required. If an existing appointment is revoked, the IRS cannot disclose confidential tax information to anyone other than the employer/payer for periods after the appointment is revoked.

Filing Form 2678

Send Form 2678 to the address for your location in the *Where To File Chart* later. We will send a letter to the agent after we have approved the request. Until we approve the request, the agent is not liable for filing any tax returns or making any deposits or payments.

Filing Schedule R (Form 940) and Schedule R (Form 941)

An agent for a home care service recipient that files an aggregate Form 940 must complete Schedule R (Form 940), Allocation Schedule for Aggregate Form 940 Filers, and file it with the aggregate Form 940.

An agent that files an aggregate Form 941 must complete Schedule R (Form 941), Allocation Schedule for Aggregate Form 941 Filers, and file it with the aggregate Form 941.

What are the reporting, deposit, and payment requirements after the IRS approves the appointment?

Agents must follow the procedures in Revenue Procedure 70-6 for employment taxes (unless you are a subagent for a state agent under Notice 2003-70) and Revenue Procedure 84-33 for backup withholding. Agents for employers who are home care service recipients receiving home care services through a program administered by a federal, state, or local government agency may also use this form. These agents are often referred to as "fiscal/employer agents" and "household employer agents." All agents, employers, and payers remain liable for filing all returns and making all tax deposits and payments while this appointment is in effect. If an agent contracts 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 tax deposits or payments and the third party fails to do so, the agent, employer, and payer remain liable.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on Form 2678 to carry out the Internal Revenue laws of the United States. The principal purpose of this information is to permit you to appoint an agent to act on your behalf. You do not have to appoint an agent; however, if you choose to appoint an agent, you must provide the information requested on Form 2678. Our authority to collect this information is section 3504. Section 6109 requires you and the agent to provide your identification numbers. Failure to provide this information could delay or prevent processing your appointment of agent. Intentionally providing false information could subject you and the agent to penalties.

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 section 6103. However, section 6103 allows or requires the IRS to disclose or give the information shown on this form to others as described in the Code. For example, we may disclose your tax information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. 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.

The time needed to complete and file Form 2678 will vary depending on individual circumstances. The estimated average time is 2 hrs., 12 minutes. If you have comments concerning the accuracy of this time estimate or suggestions for making Form 2678 simpler, we would be happy to hear from you. You can send comments by email to **taxforms@irs.gov*. Enter "Form 2678" on the subject line. Or write to: Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave., NW, IR-6526, Washington, DC 20224. Do not send Form 2678 to this address. Instead, see the *Where To File Chart* later.

Where To File Chart

If you are in ...						Then use this address ...
Connecticut Delaware District of Columbia	Illinois Indiana Kentucky Maine	Maryland Massachusetts Michigan New Hampshire	New Jersey New York North Carolina Ohio	Pennsylvania Rhode Island South Carolina Vermont	Virginia West Virginia Wisconsin	Department of the Treasury, Internal Revenue Service, Cincinnati, OH 45999
Alabama Alaska Arizona Arkansas California	Colorado Florida Georgia Hawaii Idaho	Iowa Kansas Louisiana Minnesota Mississippi	Missouri Montana Nebraska Nevada New Mexico	North Dakota Oklahoma Oregon South Dakota Tennessee	Texas Utah Washington Wyoming	Department of the Treasury, Internal Revenue Service, Ogden, UT 84201
No legal residence or place of business in any state						Department of the Treasury, Internal Revenue Service, Ogden, UT 84201
Exempt organization or government entity						Department of the Treasury, Internal Revenue Service, Ogden, UT 84201-0046

Form **2678** (Rev. June 2011)

Employer/Payer Appointment of Agent

Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

For IRS use:

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.

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

(Check one)

- [x] 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)** MCFI TO FILL OUT ☐☐ - ☐☐☐☐☐☐☐

2 **Employer's or payer's name** (not your trade name) John Doe — need youths name here

3 **Trade name** (if any) ——

4 **Address** need youth address here

31 N. Flower St.

Number Street Suite or room number

Milwaukee WI 99999

City State ZIP 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	For SOME employees/ payees
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-PR, 944-SS, 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)	☐	☐

MCFI to complete

*Generally you cannot appoint an agent to report, deposit, and pay taxes 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 taxes 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.

NEED PRINTED NAME OF LEGAL GUARDIAN HERE

Sign your name here Mary Doe

Print your name here Mary Doe

Print your title here Employer — put in "Employer"

Date 10/17/11

Best daytime phone 414 999-9999 — put in legal guardians phone #

need signature of legal guardian here

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

☐ 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.

✗ Sign your name here		Print your name here	
		Print your title here	
Date	/ /	Best daytime phone	

MCFI will complete
this whole AREA
LEAVE BLANK

Instructions for Form 2678

Section references are to the Internal Revenue Code.

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. You cannot use a prior version of this form. All prior versions are obsolete and will not be accepted.

• If you want to appoint an agent, check the box in Part 1 that says, "You want to **appoint** an agent for tax reporting, depositing, and paying," and complete Part 2.

Note. Generally you cannot appoint an agent to file an aggregate Form 940. Beginning with the 2010 tax year, if you are a home care service recipient you may request approval for an agent to report, file, and pay taxes on a Form 940, by checking the box in the footnote on line 5.

At the time this form went to print, proposed regulations REG-137036-08 were issued to modify Regulations section 31.3504-1 to allow home care service recipients to appoint an agent to report, file, and pay taxes on Form 940.

• If you are an agent and you want to accept an appointment, complete Part 3. If you are a corporate officer, partner, or tax matters partner, you must have the authority to execute this appointment of agent.

Note. If the employer/payer will be making payments not covered by the appointment, the employer/payer must file all related returns and deposit and pay taxes for those payments. When completing line 5, check the box(es) "For SOME employees/payees."

• If you are an employer, payer, or agent and you want to revoke an existing appointment of an agent, check the box in Part 1 that says, "You want to **revoke** an existing appointment," and complete Parts 2 and 3. However, only one signature is required. If an existing appointment is revoked, the IRS cannot disclose confidential tax information to anyone other than the employer/payer for periods after the appointment is revoked.

Filing Form 2678

Send Form 2678 to the address for your location in the *Where To File Chart* later. We will send a letter to the agent after we have approved the request. Until we approve the request, the agent is not liable for filing any tax returns or making any deposits or payments.

Filing Schedule R (Form 940) and Schedule R (Form 941)

An agent for a home care service recipient that files an aggregate Form 940 must complete Schedule R (Form 940), Allocation Schedule for Aggregate Form 940 Filers, and file it with the aggregate Form 940.

An agent that files an aggregate Form 941 must complete Schedule R (Form 941), Allocation Schedule for Aggregate Form 941 Filers, and file it with the aggregate Form 941.

What are the reporting, deposit, and payment requirements after the IRS approves the appointment?

Agents must follow the procedures in Revenue Procedure 70-6 for employment taxes (unless you are a subagent for a state agent under Notice 2003-70) and Revenue Procedure 84-33 for backup withholding. Agents for employers who are home care service recipients receiving home care services through a program administered by a federal, state, or local government agency may also use this form. These agents are often referred to as "fiscal/employer agents" and "household employer agents." All agents, employers, and payers remain liable for filing all returns and making all tax deposits and payments while this appointment is in effect. If an agent contracts 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 tax deposits or payments and the third party fails to do so, the agent, employer, and payer remain liable.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on Form 2678 to carry out the Internal Revenue laws of the United States. The principal purpose of this information is to permit you to appoint an agent to act on your behalf. You do not have to appoint an agent; however, if you choose to appoint an agent, you must provide the information requested on Form 2678. Our authority to collect this information is section 3504. Section 6109 requires you and the agent to provide your identification numbers. Failure to provide this information could delay or prevent processing your appointment of agent. Intentionally providing false information could subject you and the agent to penalties.

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 section 6103. However, section 6103 allows or requires the IRS to disclose or give the information shown on this form to others as described in the Code. For example, we may disclose your tax information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. 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.

The time needed to complete and file Form 2678 will vary depending on individual circumstances. The estimated average time is 2 hrs., 12 minutes. If you have comments concerning the accuracy of this time estimate or suggestions for making Form 2678 simpler, we would be happy to hear from you. You can send comments by email to **taxforms@irs.gov*. Enter "Form 2678" on the subject line. Or write to: Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave., NW, IR-6526, Washington, DC 20224. Do not send Form 2678 to this address. Instead, see the *Where To File Chart* later.

Where To File Chart

If you are in ...						Then use this address ...
Connecticut Delaware District of Columbia	Illinois Indiana Kentucky Maine	Maryland Massachusetts Michigan New Hampshire	New Jersey New York North Carolina Ohio	Pennsylvania Rhode Island South Carolina Vermont	Virginia West Virginia Wisconsin	Department of the Treasury, Internal Revenue Service, Cincinnati, OH 45999
Alabama Alaska Arizona Arkansas California	Colorado Florida Georgia Hawaii Idaho	Iowa Kansas Louisiana Minnesota Mississippi	Missouri Montana Nebraska Nevada New Mexico	North Dakota Oklahoma Oregon South Dakota Tennessee	Texas Utah Washington Wyoming	Department of the Treasury, Internal Revenue Service, Ogden, UT 84201
No legal residence or place of business in any state						Department of the Treasury, Internal Revenue Service, Ogden, UT 84201
Exempt organization or government entity						Department of the Treasury, Internal Revenue Service, Ogden, UT 84201-0046

OMB No. 1615-0047; Expires 08/31/12

Form I-9, Employment Eligibility Verification

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

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3.**

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last | First | Middle Initial | Maiden Name

Address *(Street Name and Number)* | Apt. # | Date of Birth *(month/day/year)*

City | State | Zip Code | Social Security #

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):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) ____________
- ☐ An alien authorized to work (Alien # or Admission #) ____________
  until (expiration date, if applicable - *month/day/year*)

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature | Print Name

Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* ____________ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative | Print Name | Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)* | B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: ____________ Document #: ____________ Expiration Date *(if any)*: ____________

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 | Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the 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

LIST B

Documents that Establish Identity

1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Authorization

1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
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. Native American tribal document
6. U.S. Citizen ID Card (Form I-197)
7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
8. Employment authorization document issued by the Department of Homeland Security

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

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last | First | Middle Initial | Maiden Name

PROVIDER

Address *(Street Name and Number)* | Apt. # | Date of Birth *(month/day/year)*

COMPLETES SECTION ONE

City | State | Zip Code | Social Security #

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):

- [ ] A citizen of the United States
- [ ] A noncitizen national of the United States (see instructions)
- [ ] A lawful permanent resident (Alien #) ______
- [ ] An alien authorized to work (Alien # or Admission #) ______ until (expiration date, if applicable - *month/day/year*)

Employee's Signature: Providers Signature | Date *(month/day/year)*: Date Signed

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature | Print Name

Complete this section if Section 1 above is

Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

filled out by someone other than provider.

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

(EXAMPLE)

	List A	OR	List B	AND	List C
Document title:	US Passport		Drivers License		Social Security Card
Issuing authority:	US Govt.		Dept. of Motor Vehicles		S.S. Administration
Document #:	6666789		#7895032106		#035-11-1111
Expiration Date (if any):	1/1/12		1/1/12		
Document #:					
Expiration Date (if any):					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* ______ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative | Print Name | Title

CARE COORDINATOR SIGNS &

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

COMPLETES THIS AREA

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)* | B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: ______ Document #: ______ Expiration Date *(if any)*: ______

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 | Date *(month/day/year)*

MCFI FISCAL AGENT PROGRAM
FISCAL AGENT AUTHORIZATION

WRAPAROUND MILWAUKEE
Effective Date: ____________________

CASE STATUS:

Care Coordinator's Name ____________________ Opening ________
Agency Name ____________________ Closing ________ Closing Explanation ____________________
Phone Number ____________________ Change ________ ____________________

Wraparound Enrollee Name and Address | Enrollee DOB | Enrollee Social Security No. | Case No.

____________________ ________ ____________ ________
____
____

****

Employer (Provider) Information:

Name and Address	Birthdate	Social Security No.	Service	Unit	Rate	Relationship to Enrollee
____________	______	______	______	____	____	______
____________						
____________						
____________	______	______	______	____	____	______
____________						
____________						
____________	______	______	______	____	____	______
____________						
____________						

______________________________ ____________________
Authorized Payroll Signature (*Parent/Legal Guardian or Enrollee, if age 18 or older*) Date

I have informed the employer and the provider(s) of their rights and responsibilities.
Care Coordinator's Approval ______________________________ Date ____________________

Wraparound Milwaukee Approval ______________________________ Date ____________________

MCFI FISCAL AGENT PROGRAM
FISCAL AGENT AUTHORIZATION

WRAPAROUND MILWAUKEE
Effective Date: 8/31/11

CASE STATUS:

Care Coordinator's Name: Bill Jones
Agency Name: Caring, Inc.
Phone Number: 999-0000

Opening: X
Closing:
Change:

Closing Explanation:

Wraparound Enrollee Name and Address	Enrollee DOB	Enrollee Social Security No.	Case No.
Sue Smith 111 W. North Ave. Milwaukee, WI 53111	8/1/85	222-33-4444	MH 000222

****

Employer (Provider) Information:

Name and Address	Birthdate	Social Security No.	Service	Unit	Rate	Relationship to Enrollee
Mary Marks 999 S. 60th St. West Allis, WI 53000	3/5/60	999-00-9999	5524	Hour	$10.00	Mentor

Robert Smith
Authorized Payroll Signature (*Parent/Legal Guardian or Enrollee if age 18 or older*)

Date: 7/25/11

I have informed the employer and the provider(s) of their rights and responsibilities.

Care Coordinator's Approval ____________________ Date ____________

Wraparound Milwaukee Approval ____________________ Date ____________

Form **8821**
(Rev. August 2008)
Department of the Treasury
Internal Revenue Service

Tax Information Authorization

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

▶ **Do not use this form to request a copy or transcript of your tax return. Instead, use Form 4506 or Form 4506-T.**

OMB No. 1545-1165

For IRS Use Only
Received by:
Name
Telephone ( )
Function
Date / /

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

Taxpayer name(s) and address (type or print)	Social security number(s)	Employer identification number
	Daytime telephone number ( )	Plan number (if applicable)

2 Appointee. If you wish to name more than one appointee, attach a list to this form.

Name and address
MCFI- Fiscal Agent - IRIS
2020 W. Wells St.
Milwaukee, WI 53233

CAF No. 0307-57985R
Telephone No. 888-490-3966
Fax No. 414-937-2037
Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax matters. The appointee is authorized to inspect and/or receive confidential tax information in any office of the IRS for the tax matters listed on this line. Do not use Form 8821 to request copies of tax returns.

(a) Type of Tax (Income, Employment, Excise, etc.) or Civil Penalty	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s) (see the instructions for line 3)	(d) Specific Tax Matters (see instr.)
Employment	941	2010, 2011, 2012	

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 on page 4. 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 . . . . ▶ ☑

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

6 Retention/revocation of tax information authorizations. This tax information authorization automatically revokes all prior authorizations for the same tax matters you listed on line 3 above unless you checked the box on line 4. If you do not want to revoke a prior tax information authorization, you **must** attach a copy of any authorizations you want to remain in effect **and** check this box . . . . ▶ ☐

To revoke this tax information authorization, see the instructions on page 4.

7 Signature of taxpayer(s). If a tax matter applies to a joint return, **either** husband or wife must sign. 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/periods on line 3 above.

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

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

Signature Date | Signature Date

Print Name Title (if applicable) | Print Name Title (if applicable)

☐☐☐☐☐ PIN number for electronic signature | ☐☐☐☐☐ PIN number for electronic signature

General Instructions

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

Purpose of Form

Form 8821 authorizes any individual, corporation, firm, organization, or partnership you designate to inspect and/or receive your confidential information in any office of the IRS for the type of tax and the years or periods you list on Form 8821. You may file your own tax information authorization without using Form 8821, but it must include all the information that is requested on Form 8821.

Form 8821 does not authorize your appointee to advocate your position with respect to the federal tax laws; to execute waivers, consents, or closing agreements; or to otherwise represent you before the IRS. If you want to authorize an individual to represent you, use Form 2848, Power of Attorney and Declaration of Representative.

Use Form 4506, Request for Copy of Tax Return, to get a copy of your tax return.

Use Form 4506-T, Request for Transcript of Tax Return, to order: (a) transcript of tax account information and (b) Form W-2 and Form 1099 series information.

Use Form 56, Notice Concerning Fiduciary Relationship, to notify the IRS of the existence of a fiduciary relationship. A fiduciary (trustee, executor, administrator, receiver, or guardian) stands in the position of a taxpayer and acts as the taxpayer. Therefore, a fiduciary does not act as an appointee and should not file Form 8821. If a fiduciary wishes to authorize an appointee to inspect and/or receive confidential tax information on behalf of the fiduciary, Form 8821 must be filed and signed by the fiduciary acting in the position of the taxpayer.

When To File

Form 8821 must be received by the IRS within 60 days of the date it was signed and dated by the taxpayer.

Where To File Chart

IF you live in . . .	THEN use this address . . .	Fax Number*
Alabama, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, or West Virginia	Internal Revenue Service Memphis Accounts Management Center PO Box 268, Stop 8423 Memphis, TN 38101-0268	901-546-4115
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin, or Wyoming	Internal Revenue Service 1973 N. Rulon White Blvd. MS 6737 Ogden, UT 84404	801-620-4249
All APO and FPO addresses, American Samoa, nonpermanent residents of Guam or the Virgin Islands**, Puerto Rico (or if excluding income under section 933), a foreign country, U.S. citizens and those filing Form 2555, 2555-EZ, or 4563.	Internal Revenue Service International CAF DP: SW-311 11601 Roosevelt Blvd. Philadelphia, PA 19255	215-516-1017

*These numbers may change without notice.

**Permanent residents of Guam should use Department of Taxation, Government of Guam, P.O. Box 23607, GMF, GU 96921; permanent residents of the Virgin Islands should use: V.I. Bureau of Internal Revenue, 9601 Estate Thomas Charlotte Amalie, St. Thomas, V.I. 00802.

Where To File

Generally, mail or fax Form 8821 directly to the IRS. See the *Where To File Chart* on page 2. Exceptions are listed below.

If Form 8821 is for a specific tax matter, mail or fax it to the office handling that matter. For more information, see the instructions for line 4.

Your representative may be able to file Form 8821 electronically with the IRS from the IRS website. For more information, go to *www.irs.gov*. Under the *Tax Professionals* tab, click on *e-services–Online Tools for Tax Professionals*. If you complete Form 8821 for electronic signature authorization, do not file a Form 8821 with the IRS. Instead, give it to your appointee, who will retain the document.

Revocation of an Existing Tax Information Authorization

If you want to revoke an existing tax information authorization and do not want to name a new appointee, send a copy of the previously executed tax information authorization to the IRS, using the *Where To File Chart* on page 2. The copy of the tax information authorization must have a current signature and date of the taxpayer under the original signature on line 7. Write "REVOKE" across the top of Form 8821. If you do not have a copy of the tax information authorization you want to revoke, send a statement to the IRS. The statement of revocation or withdrawal must indicate that the authority of the appointee is revoked, list the tax matters and periods, and must be signed and dated by the taxpayer or representative. If the taxpayer is revoking, list the name and address of each recognized appointee whose authority is revoked. When the taxpayer is completely revoking authority, the form should state "remove all years/periods" instead of listing the specific tax matters, years, or periods. If the appointee is withdrawing, list the name, TIN, and address (if known) of the taxpayer.

To revoke a specific use tax information authorization, send the tax information authorization or statement of revocation to the IRS office handling your case, using the above instructions.

Taxpayer Identification Numbers (TINs)

TINs are used to identify taxpayer information with corresponding tax returns. It is important that you furnish correct names, social security numbers (SSNs), individual taxpayer identification numbers (ITINs), or employer identification numbers (EINs) so that the IRS can respond to your request.

Partnership Items

Sections 6221-6234 authorize a Tax Matters Partner to perform certain acts on behalf of an affected partnership. Rules governing the use of Form 8821 do not replace any provisions of these sections.

Representative Address Change

If the representative's address has changed, a new Form 8821 is not required. The representative can send a written notification that includes the new information and their signature to the location where the Form 8821 was filed.

Specific Instructions

Line 1. Taxpayer Information

Individuals. Enter your name, TIN, and your street address in the space provided. Do not enter your appointee's address or post office box. If a joint return is used, also enter your spouse's name and TIN. Also enter your EIN if applicable.

Corporations, partnerships, or associations. Enter the name, EIN, and business address.

Employee plan or exempt organization. Enter the name, address, and EIN of the plan sponsor or exempt organization, and the plan name and three-digit plan number.

Trust. Enter the name, title, and address of the trustee, and the name and EIN of the trust.

Estate. Enter the name, title, and address of the decedent's executor/personal representative, and the name and identification number of the estate. The identification number for an estate includes both the EIN, if the estate has one, and the decedent's TIN.

Line 2. Appointee

Enter your appointee's full name. Use the identical full name on all submissions and correspondence. Enter the nine-digit CAF number for each appointee. If an appointee has a CAF number for any previously filed Form 8821 or power of attorney (Form 2848), use that number. If a CAF number has not been assigned, enter "NONE," and the IRS will issue one directly to your appointee. The IRS does not assign CAF numbers to requests for employee plans and exempt organizations.

If you want to name more than one appointee, indicate so on this line and attach a list of appointees to Form 8821.

Check the appropriate box to indicate if either the address, telephone number, or fax number is new since a CAF number was assigned.

Line 3. Tax Matters

Enter the type of tax, the tax form number, the years or periods, and the specific tax matter. Enter "Not applicable," in any of the columns that do not apply.

For example, you may list "Income, 1040" for calendar year "2006" and "Excise, 720" for "2006" (this covers all quarters in 2006). For multiple years or a series of inclusive periods, including quarterly periods, you may list 2004 through (thru or a hyphen) 2006. For example, "2004 thru 2006" or "2nd 2005-3rd 2006." For fiscal years, enter the ending year and month, using the YYYYMM format. Do not use a general reference such as "All years," "All periods," or "All taxes." Any tax information authorization with a general reference will be returned.

You may list the current year or period and any tax years or periods that have already ended as of the date you sign the tax information authorization. However, you may include on a tax information authorization only future tax periods that end no later than 3 years after the date the tax information authorization is received by the IRS. The 3 future periods are determined starting after December 31 of the year the tax information authorization is received by the IRS. You must enter the type of tax, the tax form number, and the future year(s) or period(s). If the matter relates to estate tax, enter the date of the decedent's death instead of the year or period.

In **column (d),** enter any specific information you want the IRS to provide. Examples of column (d) information are: lien information, a balance due amount, a specific tax schedule, or a tax liability.

For requests regarding Form 8802, Application for United States Residency Certification, enter "Form 8802" in column (d) and check the specific use box on line 4. Also, enter the appointee's information as instructed on Form 8802.

Note. If the taxpayer is subject to penalties related to an individual retirement account (IRA) account (for example, a penalty for excess contributions) enter, "IRA civil penalty" on line 3, column a.

Line 4. Specific Use Not Recorded on CAF

Generally, the IRS records all tax information authorizations on the CAF system. However, authorizations relating to a specific issue are not recorded.

Check the box on line 4 if Form 8821 is filed for any of the following reasons: (a) requests to disclose information to loan companies or educational institutions, (b) requests to disclose information to federal or state agency investigators for background checks, (c) application for EIN, or (d) claims filed on Form 843, Claim for Refund and Request for Abatement. If you check the box on line 4, your appointee should mail or fax Form 8821 to the IRS office handling the matter. Otherwise, your appointee should bring a copy of Form 8821 to each appointment to inspect or receive information. A specific-use tax information authorization will not revoke any prior tax information authorizations.

Line 6. Retention/Revocation of Tax Information Authorizations

Check the box on this line and attach a copy of the tax information authorization you do not want to revoke. The filing of Form 8821 will not revoke any Form 2848 that is in effect.

Line 7. Signature of Taxpayer(s)

Individuals. You must sign and date the authorization. Either husband or wife must sign if Form 8821 applies to a joint return.

Corporations. Generally, Form 8821 can be signed by: (a) an officer having legal authority to bind the corporation, (b) any person designated by the board of directors or other governing body, (c) any officer or employee on written request by any principal officer and attested to by the secretary or other officer, and (d) any other person authorized to access information under section 6103(e).

Partnerships. Generally, Form 8821 can be signed by any person who was a member of the partnership during any part of the tax period covered by Form 8821. See *Partnership Items* on page 3.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

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. Form 8821 is provided by the IRS for your convenience and its use is voluntary. If you designate an appointee to inspect and/or receive confidential tax information, you are required by section 6103(c) to provide the information requested on Form 8821. Under section 6109, you must disclose your social security number (SSN), employer identification number (EIN), or individual taxpayer identification number (ITIN). If you do not provide all the information requested on this form, we may not be able to honor the authorization.

The IRS may provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. 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.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is: **Recordkeeping,** 6 min.; **Learning about the law or the form,** 12 min.; **Preparing the form,** 24 min.; **Copying and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 8821 simpler, we would be happy to hear from you. You can write to Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. **Do not** send Form 8821 to this address. Instead, see the *Where To File Chart* on page 2.

Form **8821** (Rev. August 2008) Department of the Treasury Internal Revenue Service

Tax Information Authorization

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

▶ **Do not use this form to request a copy or transcript of your tax return. Instead, use Form 4506 or Form 4506-T.**

OMB No. 1545-1165

For IRS Use Only
Received by:
Name
Telephone ( )
Function
Date / /

SAMPLE

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

Taxpayer name(s) and address (type or print)	Social security number(s)	Employer identification number
Enrollees name & address goes here	Enrollees SS#	
	Daytime telephone number ( )	Plan number (if applicable)

2 Appointee. If you wish to name more than one appointee, attach a list to this form.

Name and address

MCFI Fiscal Agent
2020 W. Wells St.
Milwaukee, WI 53233

CAF No. **0307-57985R**
Telephone No. **888-490-3966**
Fax No. **414-918-8130**
Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax matters. The appointee is authorized to inspect and/or receive confidential tax information in any office of the IRS for the tax matters listed on this line. Do not use Form 8821 to request copies of tax returns.

(a) Type of Tax (Income, Employment, Excise, etc.) or Civil Penalty	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s) (see the instructions for line 3)	(d) Specific Tax Matters (see instr.)
Employment	**941**	**2011, 2012, 2013**	

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 on page 4. 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 . . . . ▶ ☑

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

6 Retention/revocation of tax information authorizations. This tax information authorization automatically revokes all prior authorizations for the same tax matters you listed on line 3 above unless you checked the box on line 4. If you do not want to revoke a prior tax information authorization, you **must** attach a copy of any authorizations you want to remain in effect **and** check this box . . . . ▶ ☐

To revoke this tax information authorization, see the instructions on page 4.

7 Signature of taxpayer(s). If a tax matter applies to a joint return, **either** husband or wife must sign. 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/periods on line 3 above.

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

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

Signature: Enrollee signs & dates here — Date
Print Name — Title (if applicable): Employer (HHCSR)
☐☐☐☐☐ PIN number for electronic signature

Signature: Legal Guardian signs & dates here if Enrollee under age 18 — Date
Print Name — Title (if applicable): POA/Guardian
☐☐☐☐☐ PIN number for electronic signature

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
c/o MCFI Fiscal Agent

4a Mailing address (room, apt., suite no. and street, or P.O. box)
2020 W. Wells St.

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

4b City, state, and ZIP code (if foreign, see instructions)
Milwaukee, WI 53233

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

6 County and state where principal business is located
Milwaukee County, WI

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
	1-5	

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. ☐ Health care & social assistance ☐ Wholesale-agent/broker ☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ 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
MCFI Fiscal Agent

Designee's telephone number (include area code)
(**414**) **937-2175**

Address and ZIP code
2020 W. Wells St. Milwaukee, WI 53233

Designee's fax number (include area code)
(**414**) **918-8130**

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.

Applicant's telephone number (include area code) ( )

Name and title (type or print clearly) ▶

Applicant's fax number (include area code) ( )

Signature ▶ Date ▶

Do I Need an EIN?

File Form SS-4 if the applicant entity does not already have an EIN but is required to show an EIN on any return, statement, or other document.[1] See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
Started a new business	Does not currently have (nor expect to have) employees	Complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–14 and 16–18.
Hired (or will hire) employees, including household employees	Does not already have an EIN	Complete lines 1, 2, 4a–6, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–18.
Opened a bank account	Needs an EIN for banking purposes only	Complete lines 1–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Changed type of organization	Either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership)[2]	Complete lines 1–18 (as applicable).
Purchased a going business[3]	Does not already have an EIN	Complete lines 1–18 (as applicable).
Created a trust	The trust is other than a grantor trust or an IRA trust[4]	Complete lines 1–18 (as applicable).
Created a pension plan as a plan administrator[5]	Needs an EIN for reporting purposes	Complete lines 1, 3, 4a–5b, 9a, 10, and 18.
Is a foreign person needing an EIN to comply with IRS withholding regulations	Needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits[6]	Complete lines 1–5b, 7a–b (SSN or ITIN optional), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is administering an estate	Needs an EIN to report estate income on Form 1041	Complete lines 1–6, 9a, 10–12, 13–17 (if applicable), and 18.
Is a withholding agent for taxes on non-wage income paid to an alien (i.e., individual, corporation, or partnership, etc.)	Is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	Complete lines 1, 2, 3 (if applicable), 4a–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is a state or local agency	Serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581[7]	Complete lines 1, 2, 4a–5b, 9a, 10, and 18.
Is a single-member LLC	Needs an EIN to file Form 8832, Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes[8]	Complete lines 1–18 (as applicable).
Is an S corporation	Needs an EIN to file Form 2553, Election by a Small Business Corporation[9]	Complete lines 1–18 (as applicable).

1 For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity does not have employees.

2 However, do not apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

3 Do not use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

4 However, grantor trusts that do not file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

5 A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

6 Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

7 See also *Household employer* on page 4 of the instructions. **Note.** State or local agencies may need an EIN for other reasons, for example, hired employees.

8 See *Disregarded entities* on page 4 of the instructions for details on completing Form SS-4 for an LLC.

9 An existing corporation that is electing or revoking S corporation status should use its previously-assigned EIN.

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

SAMPLE

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested
Fill in youth/enrollee name here

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

3 Executor, administrator, trustee, "care of" name
c/o MCFI Fiscal Agent

4a Mailing address (room, apt., suite no. and street, or P.O. box)
2020 W. Wells St.

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

4b City, state, and ZIP code (if foreign, see instructions)
Milwaukee, WI 53233

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

6 County and state where principal business is located
Milwaukee County, WI

7a Name of responsible party

7b [redacted], ITIN, or EIN youth/enrollee SS#

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.

youth/enrollee SS#

- ☑ Sole proprietor [redacted]
- ☐ 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
	1-5	

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.
☐ Health care & social assistance ☐ Wholesale-agent/broker
☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ 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
Milwaukee Center for Independence -- Financial Services Agency

Designee's telephone number (include area code)
(414) 937-2175

Address and ZIP code
2020 W. Wells St. Milwaukee, WI 53233

Designee's fax number (include area code)
(414) 937-2037

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.

Applicant's telephone number (include area code)
( ) youth/enrollee telephone #

Name and title (type or print clearly) ▶ Print name of legal guardian + their relationship, i.e. mother

Applicant's fax number (include area code)
( )

Signature ▶ Signature of legal guardian Date ▶ Date signed

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

Do I Need an EIN?

File Form SS-4 if the applicant entity does not already have an EIN but is required to show an EIN on any return, statement, or other document.[1] See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
Started a new business	Does not currently have (nor expect to have) employees	Complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–14 and 16–18.
Hired (or will hire) employees, including household employees	Does not already have an EIN	Complete lines 1, 2, 4a–6, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–18.
Opened a bank account	Needs an EIN for banking purposes only	Complete lines 1–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Changed type of organization	Either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership) [2]	Complete lines 1–18 (as applicable).
Purchased a going business [3]	Does not already have an EIN	Complete lines 1–18 (as applicable).
Created a trust	The trust is other than a grantor trust or an IRA trust [4]	Complete lines 1–18 (as applicable).
Created a pension plan as a plan administrator [5]	Needs an EIN for reporting purposes	Complete lines 1, 3, 4a–5b, 9a, 10, and 18.
Is a foreign person needing an EIN to comply with IRS withholding regulations	Needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits [6]	Complete lines 1–5b, 7a–b (SSN or ITIN optional), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is administering an estate	Needs an EIN to report estate income on Form 1041	Complete lines 1–6, 9a, 10–12, 13–17 (if applicable), and 18.
Is a withholding agent for taxes on non-wage income paid to an alien (i.e., individual, corporation, or partnership, etc.)	Is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	Complete lines 1, 2, 3 (if applicable), 4a–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is a state or local agency	Serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581 [7]	Complete lines 1, 2, 4a–5b, 9a, 10, and 18.
Is a single-member LLC	Needs an EIN to file Form 8832, Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes [8]	Complete lines 1–18 (as applicable).
Is an S corporation	Needs an EIN to file Form 2553, Election by a Small Business Corporation [9]	Complete lines 1–18 (as applicable).

[1] For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity does not have employees.

[2] However, do not apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

[3] Do not use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

[4] However, grantor trusts that do not file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

[5] A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

[6] Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

[7] See also *Household employer* on page 4 of the instructions. **Note.** State or local agencies may need an EIN for other reasons, for example, hired employees.

[8] See *Disregarded entities* on page 4 of the instructions for details on completing Form SS-4 for an LLC.

[9] An existing corporation that is electing or revoking S corporation status should use its previously-assigned EIN.

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Milwaukee
CENTER · FOR
INDEPENDENCE
ESTABLISHED BY JVS • SERVING PEOPLE WITH DISABILITIES • SINCE 1938

MCFI – Fiscal Agent

Dear Employee:

MCFI now has direct deposit available for Fiscal Agent employees. Employees can avoid the hassle of waiting for checks to be delivered by mail. No more worries about lost or stolen checks. No more hassles on payday when you or your employer are on vacation, sick or traveling because on payday, we will mail an earnings statement listing gross pay, deductions, and the net payroll amount will be transmitted to your bank account. The money will be available two banking days after it is transmitted by MCFI. That means if payday is on Monday, your net payroll amount will be at your bank on Wednesday morning. If payday is on Friday, the funds will be at your bank on Tuesday morning. Your money will be available for your use at the beginning of the day.

If you wish to enroll in the direct deposit program of MCFI - Fiscal Agent, you need to complete the authorization form enclosed with this letter. Attach a voided check to the authorization form and return in the business reply envelope. The voided check will be used to verify account and routing numbers.

Once the authorization form is received, the information will be transmitted and verified. For accuracy the first payroll run after account information input will be a trial run between our bank and yours. This gives your bank time to let us know if we have any incorrect numbers. The following payroll should go directly to your account. Some banks do not verify the account numbers until there is a money transaction, which may result in the direct deposit not being live when we first expect it.

MCFI has added this service to alleviate mail problems experienced by some of our providers. If you have any questions, please call our payroll department at 414- 937-2172.

Sincerely,

Pat Keefer

Pat Keefer
Payroll Manager

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MCFI – Fiscal Services

Direct Deposit Authorization

Phone: 888-490-3966

Fax: 414-918-8130

******To ensure accurate direct deposit, please enclose a voided check for verification of numbers******

I hereby authorize MCFI – Fiscal Agent to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my bank account as indicated below at the *depository* (bank) named below.

Bank Name ____________________ Branch ________________________

Routing Number ________________ Account No. __________________

Type of Account: Checking ______ Savings __________

This authorization is to remain in full force and effect until MCFI has received writtten notification from me of its termination in such time and in such manner as to afford MCFI and *Depository* a reasonable opportunity to act on it.

Name _________________________________ Employee Number ____________
(Please Print)

Signature ______________________________ Date ____________

Client Name ____________________________

MCFI-FISCAL AGENT
Employee Time Report

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Service Provider (Employee) Name -- Please Print: Mary Marks

Service Period End 10/31/11

Employer/Client Name and Address -- Please Print
John Doe
31 N. Flowers St.
Milwaukee, WI 99999

Date Worked	# of Hours to be paid	# of Days to be Paid	Service Type
1st			
2nd	2		R
3rd			
4th			
5th	3		R
6th			
7th			
8th	2.5		R
9th			
10th			
11th			
12th	7		R
13th			
14th			
15th	2		R
TOTALS	10.5		

Service Types:
A=Attendant Care S=SHC P=Personal Care R=Respite
O=Outside Chores

Date Worked	# of Hours to be paid	# of Days to be Paid	Service Type
16th			
17th			
18th	2		R
19th			
20th			
21st	1		R
22nd			
23rd			
24th	3		R
25th			
26th			
27th	1.5		R
28th			
29th			
30th			
31st			
TOTALS	7.5		

A=Attendant Care S=SHC P=Personal Care R=Respite
O=Outside Chores

I (We) certify that the information provided on this form is a true and accurate statement of the services provided. I (We) understand that payment for services provided are subject to payroll taxes.

Note: Time Reports Must be submitted within 60 days of service. Reports for service provided more than 60 days ago will not be paid.

Service Provider's (Employee's) Signature	Date
Mary Marks	11/1/11

Client/Employer/Representative's Signature	Date
Sandra Doe	11/3/11

Mail this time report, in the envelope provided to:
MCFI Fiscal Agent
2020 W. Wells St.
Milwaukee, WI 53233

Email: fiscal@mcfi.net
Fax Number: 414-918-8130
For additional forms, go to www.mcfi-fiscalagent.com

Please call MCFI Fiscal Agent at 888-490-3966 with any questions on how to fill out this form.