P.O. Box 13260
Maumelle AR 72113
Toll Free 866.710.8757
Online : Palcofirst.com

Children's Long Term Supports Personal Options Worker Employment Packet

Welcome to self-direction and to Palco! This packet contains all the forms you need to enroll as a Worker and begin providing services to your participant. Please follow all directions in this packet. You will not be paid for services until all forms are completed, Palco verifies all information, criminal checks, and clears you for hire, and you are notified that you are ready to provide service.
You must complete and return:

- ☐ Worker Intake & Attestation Form
- ☐ IRS Form W-4
- ☐ I-9 Form with Supporting Documents
- ☐ Background Information Disclosure
- ☐ CLTS Waiver Qualified Provider Standards Verification Form
- ☐ WI Medicaid Program Provider Agreement Form
- ☐ Payroll Information Worksheet
- ☐ State Tax Withholding Form - WI WT-4
- ☐ Pay Selection and Direct Deposit Form
- ☐ Training Checklist
- ☐ CLTS Worker Pay Rate Form

We encourage you to use the checklist above as a final review before you return the forms to Palco. Failure to return these forms will delay enrollment. The other documents, including information on how to complete forms, the payment schedule, Palco's Notice of Privacy Practices, F.A.Q. and similar instructional forms, are for informational purposes only and do not need to be returned to Palco. Send completed paper forms by fax, email, or mail to Palco at the address below.

Fax: 501-821-0045
Fax (Toll Free): 877-859-8757
Email: enrollment@palcofirst.com
Palco, Inc.
Attn: Enrollment
PO BOX 13260
Maumelle, AR 72113

You can also complete the packet online if you do not wish to complete these forms by hand. To do so, contact our customer support team and request to enroll online or send us the Worker Intake form with the online option selected.

Should you need any assistance during this process, please contact a friendly customer support representative at 1.866.710.0456 or info@palcofirst.com. Customer support is available 8:00 am - 5:00 pm EST, Monday through Friday, except on state and federal holidays. Please visit our website at www.palcofirst.com for more information on forms and frequently asked questions.

We look forward to serving you!

Sincerely,
The Palco Team

P.O. Box 13260
Maumelle AR 72113
Toll Free 866.710.8757
Online : Palcofirst.com

Program: Wisconsin CLTS

Worker/Applicant Intake

Complete this form entirely to begin the enrollment process as a worker in the Children's Long Term Support program. All information on this form is required in order to enroll. Completion of this form does not constitute hiring by the employer. Services should not begin until you receive a notification from Palco that enrollment is approved.

MEMBER INFORMATION	
Full Name	Palco ID

WORKER INFORMATION			
First Name	Middle Name	Last Name	
Social Security Number	Phone	Email	
Mailing Address			
City	State	Zip	County
Physical Address			
City	State	Zip	County

Palco has a fully online enrollment process that is quick and easy. The Member will receive login instructions from Palco via email within 3 business days. Once you receive the email, complete your enrollment right away to avoid any delays.

☐ *Check this box If you are unable to complete Palco's online enrollment process and an enrollment specialist will contact you for further assistance.*

Please return this form to Palco via email: enrollment@palcofirst.com or via fax toll free to 1.877.859.8757 or 501-821-0045.

DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-82064A (01/2022)

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

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

PURPOSE

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

CAREGIVER BACKGROUND CHECK LAW

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

APPLICATION

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

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

FAIR EMPLOYMENT ACT & ELIGIBILITY REQUIREMENTS

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

Wis. Stat. § 50.065(4m)(b) reads:
Notwithstanding s. 111.335, and except as provided in sub. (5), an entity may not employ or contract with a caregiver or permit to reside at the entity a nonclient resident, if the entity knows or should have known any of the following:

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

See Offenses Affecting Eligibility for guidance.

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

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

Refer to DQA form F-82064A, *Instructions*, for additional information.

Reset

Check the box that applies to you.

☐ Applicant / Employee ☐ Student / Volunteer

☐ Contractor ☐ Other – Specify:

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

Full Legal Name – *First*	*Middle*	*Last*

Other Names (including prior to marriage)

Position Title (applied for or existing)	Birth Date *(MM/DD/YYYY)*	Sex ☐ Male ☐ Female

Home Address	City	State	Zip Code

Business Name and Address – Employer (Entity)
Palco Inc. PO BOX 13260 Maumelle AR 72113

Answering "NO" to all questions does not guarantee employment, a contract, or service agreement.
If more space is required, attach additional documentation to this form and indicate "see attached" in your answer.

SECTION A – DISCLOSURES

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.
   Yes ☐ No ☐

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

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

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.
   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? Yes ☐ No ☐
   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**? Yes ☐ No ☐
   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? Yes ☐ No ☐
   If **Yes**, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes ☐ No ☐
   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? Yes ☐ No ☐
   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? Yes ☐ No ☐
   If **Yes**, indicate the year of discharge:
   Attach a copy of your DD214, if you were discharged within the last three (3) years.

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

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

6. Have you had a caregiver background check done within the last four (4) years? Yes ☐ No ☐
   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.

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

Read and initial the following statement.

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

NAME – Person Completing This Form	Date Submitted

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

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

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

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

Children's Long-Term Support (CLTS) Waivers Qualified Provider Standards Verification Provider Service: Respite Care

The information collected via this form is required to ensure the qualifications of unregulated providers and should be updated annually. While the completion of this form is voluntary, county waiver agencies must verify and document all of the information regarding provider standards that is collected on this form. In lieu of this form, agencies may use locally designed forms with prior approval from the Children's Services Section.

A. PROVIDER / EMPLOYEE INFORMATION

Provider/Employee Name Last	First	Middle Initial

Street Address	City	State	Zip Code

B. SERVICE DESCRIPTION

Respite care services are those services provided on a short term basis, to relieve the participant's primary caregiver(s) from care demands. Institutional and residential respite services may involve over night or partial day stays by the participant. Costs for room and board in institutional and residential settings may be included in the charge to the CLTS Waiver. Costs for room and board in home based or other settings may not be included in the charge to the CLTS Waiver.

C. QUALIFIED PROVIDER STANDARDS

Providers of respite care services must meet the following minimum training and qualified provider standards in order to be authorized to receive CLTS Waiver funding. By checking off each box below and signing at the bottom, employing entities (i.e., agencies or families) acknowledge the requirements of this service and have verified that the employee named above has met these standards.

☐ The provider meets the standards required of a certified Medicaid hospital, nursing home or ICF-MR (**NOTE**: STOP HERE and keep as part of child's record as this is a regulated setting)

OR

Meets the following CLTS waiver qualified provider service standards and training requirements of home-based respite, as described in the Wisconsin Medicaid Home and Community Based Services Waiver Manual:

☐ a. Is not listed on the Wisconsin Caregiver Misconduct Registry; does not have a substantiated finding of abuse, neglect or misappropriation, and has not committed a crime that is substantially related to the provision of care or supervision of this service.

☐ b. Is trained to safely deliver services, so as not to endanger the participant.

☐ c. Is trained to recognize and appropriately respond in the event of an emergency, including a protocol for contacting local emergency response systems and the prompt notification of the county waiver agency.

☐ d. Is trained on participant-specific information, including individual needs, functional capacities, strengths, abilities and preferences. Understanding and respecting participant preferences in the provision of assistance with activities of daily living including such services as bathing, feeding, grooming, dressing, transfer, ambulation and the use of adaptive aids and equipment (Include these training details in Section E below).

☐ e. Is trained on general information about the target population(s) which are applicable to the individuals the provider intends to serve (☐ DD ☐ PD ☐ SED/MH).

☐ f. Is trained in: working effectively with participants; developing professional ethics and interpersonal skills; understanding and respecting participant direction, individuality, independence, and rights; understanding procedures for handling conflict and complaints; respecting personal property, cultural differences and family relationships.

☐ g. Is trained in: providing quality homemaking and household services, including understanding good nutrition, special diets and meal planning and preparation; understanding and maintaining a clean, safe and healthy home environment; respecting participant preferences in housekeeping, -shopping and homemaking tasks.

☐ h. Is trained on the county waiver agency and contract agency policies, procedures and expectations for providers including confidentiality of participant information according to federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules. Training must address billing and payment processes, record keeping, incident reporting and other reporting requirements, arranging of back up services and must include the name and telephone number of both the waiver agency care manager/support and service coordinator and the primary contact person at the agency.

D. EXEMPTION FROM TRAINING REQUIREMENTS

Prior to employment, the county waiver agency or contract agency may exempt a prospective service provider from the personal services training requirements (Section C, e, f, and g listed above) when it is determined that the provider already has sufficient comparable knowledge or experience. However, the following applies:

☐ a. The rationale for exempting a prospective provider from the personal services training requirements (Section C, e, f, and g above) must be described in writing. A copy of the exemption and the written rationale shall be maintained in the participant record or in another central location, as determined by the county waiver agency.

☐ b. When the participant/guardian functions as the employer s/he may exercise the authority to exempt providers from training requirements for reasons described above. However, the county waiver agency must document and maintain the written rationale for the exemption.

E. PROVIDER / EMPLOYEE TRAINING AND EXPERIENCE

List below the participant-specific training and/or experience and date completed by employee named above *(additional training and experience may be included on a separate document):*

Training	Date	Experience	Date

F. COMPARABILITY TRAINING STANDARDS

A provider who is a Medicaid certified personal care worker, a home health aide, a certified nursing assistant, a licensed practical nurse, or a registered nurse automatically meets the training comparability standards. Providers who have met the training comparability standard do not need a written rationale for the exemption from training requirements. However, the county waiver agency shall ensure that copies of credentials, certification or other documentation establishing that the provider meets the comparability of training standards must be available for review. This individual is a:

☐ personal care worker ☐ home health aide ☐ certified nursing assistant

☐ licensed practical nurse ☐ registered nurse

G. SIGNATURES

By signing below I attest my qualifications for this service meet all CLTS Waivers standards at this time.

Signature of Employee	Date
CG	

By signing below, I attest the above named person meets all necessary provider standards for this service at this time.

Signature of Employing Entity Representative	Title	Date
M	Managing Party	

09552

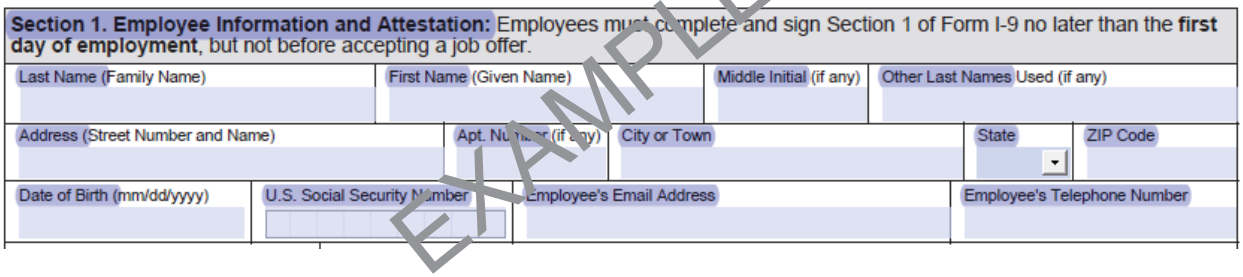
Instructions for I-9

The United States Department of Homeland Security, Citizenship, and Immigration Services (CIS) department, requires all U.S. employers and workers to complete the I-9. The purpose is to verify that the applicant worker can be legally employed in the United States. Palco verifies all workers through the U.S. CIS online system.

Use the instructions and checklist below to guide you through completing this form. The applicant worker should complete all fields highlighted in blue. The employer should complete all fields highlighted in yellow.

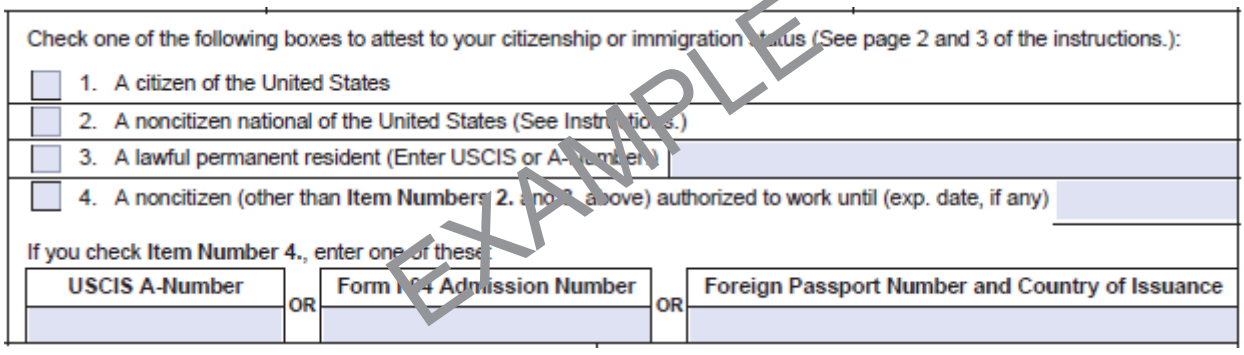
1. Complete Section 1 at the top of page 1.Must be completed by the applicant worker.

☐ Complete all fields in Section 1. The name here must match the name on your verification documents. (See #3 on this checklist.)

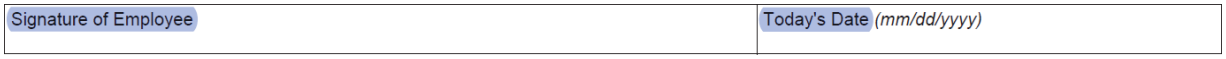


☐ Select the following box that applies to you.

- If you select box 3, supply your alien registration or USCIS number.
- If you select box 4, supply your work expiration date and complete any one of the three fields that follow.



☐ Sign and date.



☐ If necessary, complete the Preparer and/or Translator Certification boxes on page 3.

2. Complete Section 2 at the bottom of page 1. Must be completed by the employer.

☐ Refer to page 2 of the I-9 for appropriate verification documents. Complete all lines associated with the documents provided in the space designated. You must complete one, but not both, of the following two options for submission:

- ☐ One document from List A.
- ☐ One document from List B **and** One document from List C.

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

☐ Attach copies of the verification documents listed on page 1 of the I-9. The employer must review the worker's verification documents.

☐ Provide the employee's first day of employment in the space provided. This date must match the date the worker signed on page 1.

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

☐ Complete the next two rows of information in Section 2, including signing and dating the form.

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name	**Employer's Business or Organization Address, City or Town, State, ZIP Code**	

☐ Complete page 4 *only* if the worker had a name or citizenship status change, or if the worker previously worked for the employer within the last three years. If none of these apply, leave page 4 blank.

For more information and assistance on how to complete this form, visit https://www.uscis.gov/i-9.

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

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

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

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

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Pay Selection and Direct Deposit Authorization Agreement

HOW WOULD YOU LIKE TO BE PAID? (please select only one option)

OPTION 1

☐ Money Network Services

*If you choose the Money Network Services Option, Palco will enroll you with our partners at Fiserv: Money Network Services. Fiserv will send you a Money Network Card in 1-2 weeks and Palco will begin depositing funds directly to the card. Activate your card as soon as it arrives to begin using it. You will receive paper checks during the 1-2 weeks it takes to receive your card.

OPTION 2

☐ Direct Deposit

Request Type (check one):

☐ New Account Setup ☐ Change in Existing Account ☐ Cancellation

DIRECT DEPOSIT ACCOUNT INFORMATION		
Account Holder's Full Name		ID or Last 4 of SSN
Bank Name	Routing Number	Account Number
Type of Account (select one): ☐ Checking ☐ Savings ☐ Pre-paid card		

REQUIRED The following validating documentation is attached:

☐ Voided check with account holder name printed on the check. *Check cannot be a temporary check*

OR

☐ Official documentation from financial institution listing account holder name, account, and routing number. This includes letters from banks and paperwork from pre-paid cards.

I authorize Palco, Inc. to initiate deposits and debit entries for the purpose of correcting an erroneous deposit to the account indicated herein. In the event Palco is unable to initiate debit entries, I authorize the repayment to Palco from future amounts owed to me. I understand Palco is not responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. I understand that it is my responsibility to verify the crediting of funds by my financial institution prior to initiating debits against my account. I understand the risks of sharing an account with others, including my employer or worker. Palco is not responsible for any charges I incur from my financial institution. Any changes to my account must be submitted to Palco immediately. This authorization will remain in full force and effect until Palco has received written cancellation in such time and in such manner as to afford Palco and all appropriate financial institutions a reasonable opportunity to act on it

_____

Printed Name

_____ _____

Signature **Date**

***Please return this form to Palco via email: enrollment@palcofirst.com* or via fax to 1.877.859.8757.**

Contact Customer Service by calling 888-913-0900, by mail at 2900 Westside Pkwy, Alpharetta, GA 30004, or visit moneynetwork.com. For general information about prepaid accounts, visit cfpb.gov/prepaid. If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit cfpb.gov/complaint.

PW D1P Core 24/12

Balance and Transaction Limits Schedule

Load Limitations [1,2,3]	Limit Amount [1,2,3]
Maximum Account Balance	$8,000
ACH Deposit of Other Funds (Direct Deposit)	$4,000 per day | $8,000 per calendar month
Load Check Funds Via Mobile App*	$25-2,500 per check | $5,000 per day | $10,000 per month
Load Cash at Load Location	$2,500 per transaction and per day | $5,000 per month
Secondary Account	$8,000 maximum account balance
Secondary Account Transfer	$1,000 per day | $2,000 per month

Withdrawal Limitations [1,2]	Limit Amount [1,2]
ATM Withdrawal Limit	$600 per transaction and per day
Money Network Check Limit	$9,999.99 per Check and per day
Bank/Teller Over the Counter Withdrawal	$8,000 per transaction and per day
ACH Transfer to Domestic Bank	$8,000 per transaction | $16,000 per day | $64,000 per month
ACH Transfer to International Bank	$1,000 per transaction and per day | $2,000 per month

Spend Limitations [1,2]	Limit Amount [1,2]
PIN Debit Transactions	$3,000 per transaction and per day
Signature Debit Transactions	$3,000 per transaction and per day

1 Third parties may impose additional limitations or charge a separate fee. Reload providers may set a minimum load amount. For security or regulatory reasons, we may impose additional limits on the amount, number, or types of Money Network® Service transactions you may make. 2 These limits apply to the transaction types identified. Your Fee Schedule identifies the transaction types available to you and the applicable fees.

3 If you are participating in the payroll program of the employer that initially enrolled you into the Money Network® Service, the Maximum Account Balance does not apply to wage deposits received from that employer. Loads via other load transactions may be rejected if you have reached the Maximum Account Balance or the load will cause your Balance to exceed the Maximum Account Balance

[4] *Standard message and data rates apply.

HOW DO I…

REPORT A LOST OR STOLEN CARD OR CHECK? Call **1-888-913-0900** immediately to report it.

DISPUTE A TRANSACTION? If you don't recognize a transaction in your recent transaction history, promptly call the Customer Service number on the back of your Card to dispute the transaction.

For questions about your Account call 1-888-913-0900 or visit moneynetwork.com.

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

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

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

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

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

    a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

    b) The names and addresses of all persons who have a controlling interest in the provider;

c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;

d) The names and addresses of any subcontractors who have had business transactions with the provider;

e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.

12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.
13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.
14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.
15. To refrain from influencing an individual to either not enroll in or to disenroll from another managed care organization or the IRIS program.

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

Name – Provider (Typed or Printed)

SIGNATURE – Provider	Date Signed

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)	
SIGNATURE – Department of Health Services	Date Signed

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

WT-4

Employee's Section (Print clearly)

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

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

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

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

Signature _____ Date Signed _____, _____

EMPLOYEE INSTRUCTIONS:

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

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

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

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

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

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

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

- **LINE 1:**
  (a)-(c) Number of exemptions – Do not claim more than the correct number of exemptions. If you expect to owe more income tax for the year than will be withheld if you claim every exemption to which you are entitled, you may increase your withholding by claiming a smaller number of exemptions on lines 1(a)-(c) or you may enter into an agreement with your employer to have additional amounts withheld (see instruction for line 2).

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

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

- **LINE 3:**
  Exemption from withholding – You may claim exemption from withholding of Wisconsin income tax if you had no liability for income tax for last year, and you expect to incur no liability for income tax for this year. You may not claim exemption if your return shows tax liability before the allowance of any credit for income tax withheld. If you are exempt, your employer will not withhold Wisconsin income tax from your wages.

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

Employer's Section

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

EMPLOYER INSTRUCTIONS for Department of Revenue:

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

EMPLOYER INSTRUCTIONS for New Hire Reporting:

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

Applicable Laws and Rules

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

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

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

Payroll Information Worksheet

As an employer or home care worker in self-direction, payroll wages and tax withholdings are subject to special tax and overtime rules, and residency may impact benefits under labor laws. Completing this form accurately will ensure that taxes and benefits are calculated properly. For more information, visit IRS Publication 15, as well as relevant State tax and labor agency websites. To claim exemptions on either Federal or State (if applicable) Income Tax Withholdings, please mark EXEMPT on your W-4 or State Withholding Certificate, if applicable.

REQUIRED INFORMATION	
Employee Name	Palco ID
Member Name	Palco ID

Part A: FICA (Social Security and Medicare) Tax Exemption

The IRS exempts some employers and workers from paying FICA (Social Security and Medicare) taxes.

- **Non-Exempt.** None of these selections apply.
- **Exempt.** I am under 18 and a fulltime student.
- **Exempt.** I am a non-resident alien holding a visa for household services.
- **Exempt.** I am the spouse of my employer.
- **Exempt.** I am the child of my employer and under 21.
- **Exempt.** I am the parent of my employer. This includes adoptive and stepparents.

Exception: **If you are the parent of the employer and select any of the following you are non-exempt:**

- I am the parent of the employer, and I also provide care for my grandchild or step-grandchild in my child's home.
- I am the parent of the employer, and my grandchild or step-grandchild is under 18 or has a physical or mental condition that requires personal care of an adult for at least four weeks in a row during the calendar quarter in which services are provided.
- I am the parent of my employer, and my child is widowed, divorced, not remarried, or living with a spouse who has a mental or physical condition so the spouse cannot care for my grandchild for at least four weeks in a row during the calendar quarter in which services are performed.

If any of the above are **YES,** please select EXEMPT.

☐ **Exempt.** I answered Yes to one of the questions above.

☐ **Non-Exempt.** None of the selections apply.

Part B: Federal Unemployment Tax Exemption

The IRS exempts some wages from FUTA (Federal Unemployment).

- **Exempt.** I am the child of my employer and under 21.
- **Exempt.** I am the parent of my employer. This includes adoptive and stepparents.
- **Exempt.** I am the spouse of my employer.
- **Exempt.** I am a non-resident alien holding a visa for household services.
- **Non-Exempt.** None of the selections apply.

If any of the above are **YES,** please select EXEMPT.

☐ **Exempt.** I answered Yes to one of the questions above.

☐ **Non-Exempt.** None of the selections apply.

Part C: State Unemployment Tax Exemption

The State exempts some wages from SUTA (State Unemployment).

- **Exempt.** I am the spouse of my employer.
- **Exempt.** I am the domestic partner (live in) of my employer.
- **Exempt.** I am the parent of my employer.
- **Exempt.** I am the grandparent of my employer.
- **Exempt.** I am a child of my employer.
- **Non-Exempt.** None of the selections apply.

Part D: Overtime Exclusion

There are several factors that may qualify a worker as being exempt from overtime payments or ineligible for overtime based on program specific rules. Palco is not your employer and cannot decide whether you are exempt or not. By checking the appropriate box, you are telling Palco how to pay overtime wages

☐ **Non-Exempt.** Overtime rates will be paid on time worked beyond 40 hours in a work week.

☐ **Exempt.** Exempt from overtime pay for any reason, including program rules or qualifying for the DOL Home Care Rule Exclusion, as the live-in caregiver residing at the participant's residence at least 5 days per week. (See 29 CFR §552.102 and DOL Fact Sheet #79B). By checking this box, any hours that exceed 40 per week will NOT be paid at overtime rates.

Part E: Income Tax Withholding Difficulty of Care (DOC) Exclusion Information.

Per IRS Notice 2014-7, when **a worker lives full time with a Medicaid self-direction program participant, for whom the worker provides care**, the wages may be exempt from federal income tax withholding, which means the W-2 will show $0.00 wages paid. This is known as the Difficulty of Care exemption. Claiming this exemption may impact your Social Security benefits, so complete this section under penalties of perjury as an individual care provider receiving payments under a state Medicaid Home and Community-Based Services program for care provided by you to the participant(s), named in this document, who live(s) in your home under the care recipients' plan of care. If you would like to be excluded from Federal and State Income Tax withholding, due to Difficulty of Care, mark EXCLUDED below.

☐ **Not Excluded**

☐ **Excluded**

If any of the information in this document changes at any time, complete a new document and submit to Palco immediately. Failure to notify Palco may result in a tax bill to you or other employment-related matters for your employer. Palco is not responsible for incorrectly calculating or withholding pay due to your failure to complete and submit corrected information. By completing this form, you certify that the information above is correct; you understand that you have the burden to notify Palco immediately of any changes; and you hold Palco harmless for any incorrect information supplied herein.

_____ _____

Employee Signature **Date**

Please return this form to Palco via email: enrollment@palcofirst.com or via fax toll free to 1.877.859.8757 or 501-821-0045.

Wisconsin Worker Pay Rate Information

REQUIRED INFORMATION	
Member/Employer Name	ID
Worker Name	ID or Last 4 of SSN
Authorized Representative Name (if applicable)	ID (if applicable)

Below, please indicate the Pay Rate you agree to. The Pay Rate is the amount that the Worker will receive per hour worked. **Please provide a Pay Rate for ONLY services approved.**

Approved Service Code	Regular Rate

By signing below, the Member/Employer and Worker certify that the information in this form is correct and was agreed to by both parties. For changes to existing rates, please allow five (5) days for processing. Once processed, the change will take effect the next pay period. Changes will not be applied retroactively to payments already made.

Worker Signature _____ **Date** _____

Member/Employer Signature _____ **Date** _____

Please return this form to Palco via fax: toll free)1-877-859-8757 or 501-821-0045, email: *enrollment@palcofirst.com or mail: PO Box 13260, Maumelle, AR 72113*